



KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation

Portland, Oregon

Large Group Deductible Dental Plan Evidence of Coverage

**Group Name: Willamette University
Group Number: 2014**

This EOC is effective April 1, 2009, through March 31, 2010.

Printed: April 2, 2009

Membership 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

From Portland..... 503-286-6868

From Vancouver..... 360-254-9158

From Salem..... 503-370-4311

From Longview..... 360-575-4800

TTY

All areas..... 1-800-735-2900

Language interpretation services

All areas..... 1-800-324-8010

kaiserpermanente.org

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 chart does not fully describe benefits, the benefit limitations, or exclusions in full. To see what is covered for each benefit (including exclusions and limitations), for complete explanations, and for additional benefits that are not included in this summary, please refer to the “Copayment, Coinsurance, and Benefits” and “Exclusions and Limitations” sections of this *EOC*, which is listed in the same order as in the “Benefit Summary.” Exclusions and limitations that apply to all benefits are described in the “Exclusions and Limitations” section of this *EOC*.

Some works-in-progress may be reduced to a 50 percent payment of the Usual and Customary Charges. Please refer to the “Exclusions and Limitations” section of this *EOC* for details.

Benefit Maximum	
	\$1,500
Deductible	
Individual	\$0
Family	\$0
Dental Office Visit Charge	You Pay
	\$15
Preventive and Diagnostic Services (Not applicable to the Deductible)	You Pay
Oral exam	No additional charge
X-rays	No additional charge
Teeth cleaning	No additional charge
Fluoride treatments	No additional charge
Space maintainers	No additional charge
Basic Restorative Services	You Pay
Routine fillings	No additional charge
Crowns (plastic/acrylic and steel)	No additional charge
Simple extractions	No additional charge
Oral Surgery	You Pay
Surgical tooth extractions including diagnosis and evaluation	20% Coinsurance
Major oral surgery	20% Coinsurance
Periodontics	You Pay
Diagnosis and evaluation	20% Coinsurance
Treatment of gum disease	20% Coinsurance
Scaling and root planing	20% Coinsurance
Endodontics	You Pay
Root canal, related therapy, including diagnosis and evaluation	20% Coinsurance
Major Restoration Services	You Pay
Gold or porcelain crowns	20% Coinsurance
Inlays	20% Coinsurance
Bridge abutments	20% Coinsurance
Pontics	20% Coinsurance

Removable Prosthetic Services	You Pay
Full and partial dentures	20% Coinsurance
Relines	20% Coinsurance
Rebases	20% Coinsurance
Emergency Services	You Pay
From Dental Group Providers	\$25 for Emergency Care and Urgent Care visits on the same or next business day plus any other Charges that normally apply.
From non-Dental group providers	All Charges over \$100
Other Benefits	You Pay
Nightguards	10% of the full price
Nitrous oxide	
Adults and children age 13 years and older	\$15
Children age 12 years and younger	No charge
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INTRODUCTION

This *Evidence of Coverage (EOC)*, including the “Benefit Summary” and any benefit riders attached to this *EOC*, describes the health care coverage of the Large Group Deductible Dental Plan provided under the *Agreement* between Kaiser Foundation Health Plan of the Northwest and your Group. This plan is not a federally qualified health benefit plan. 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 waiting period.

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

Dental Group provides Services directly to you and your Dependents through an integrated dental care system. Company, hospitals, and Dental Group 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 Dentist and other benefits described in the “Deductible, Copayments, Coinsurance, and Benefits” section.

For more information contact Membership Services at 503-813-2000, for outside the Portland area 1-800-813-2000, and TTY at 1-800-735-2900.

DEFINITIONS

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

If you are covered for orthodontic Services, please note that orthodontic Services do not count toward your Benefit Maximum. Your orthodontic coverage may include a separate maximum.

Benefit Summary. A brief description of your dental plan benefits and what you pay for covered Services, found in the front of this booklet.

Calendar Year. The 12-consecutive-month time period of January 1 through December 31 of the same year.

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

- For Services provided by Dental Group, the charges in Company’s schedule of Dental Group charges for Services provided to Member.
- For Services for which a provider (other than Dental Group) 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 Kaiser Permanente, 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 Deductible, Copayment, or Coinsurance from its payment, the amount it would have paid if it did not subtract the Deductible, Copayment, or Coinsurance).

Coinsurance. A percentage of Charges that you must pay when you receive a covered Service as described in the “Deductible, Copayments, Coinsurance, and Benefits” 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 “Deductible, Copayments, Coinsurance, and Benefits” section.

Deductible. The amount you must pay in a Calendar Year for certain Services before we will cover those Services at the Copayment or Coinsurance in that Calendar Year. Deductible amounts include the annual Deductible take-over amount as described under “Deductible Take-Over” in the “Deductible, Copayments, Coinsurance, and Benefits” section of this *EOC*.

Dental Group. The Permanente Dental Associates, PC, is a professional corporation of Dentists organized under the laws of the state of Oregon. Dental Group contracts with Kaiser Permanente to provide professional dental Services to Members and others primarily on a capitated, prepaid basis.

Dentally Necessary and Dentally Appropriate. A Service that, in the judgment of a licensed Dentist, is required to prevent, diagnose, or treat a dental condition. A Service is Dentally Necessary only if a 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.

Dental Office. Any facility listed in the Kaiser Permanente *Dental Directory* for our Service Area. Dental Offices are subject to change. If you have questions about the current locations of Dental Office facilities, please call Membership Services.

Dentist. Any licensed doctor of dental science (DDS) or doctor of medical dentistry (DMD) who is an employee of the Dental Group, or any licensed Dentist who, under a contract directly or indirectly with the Dental Group, has agreed to provide covered Services to Members with an expectation of receiving payment, other than Copayments, Coinsurance, or Deductibles, from Dental Group rather than from the Member.

Dependent. A Member who meets the eligibility requirements as a Dependent (Dependent eligibility requirements are described under “Who is Eligible” in the “Premiums, Eligibility, and Enrollment” section).

Emergency Care. Dentally Necessary Services that require immediate treatment for acute infection, hemorrhage, relief of extreme pain, or on account of injury.

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/her Spouse and/or Dependents.

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

Kaiser Permanente. Kaiser Foundation Hospitals (a California nonprofit corporation), Company, and the Dental Group delivery system.

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*.

Premium. Monthly membership charges paid by Group.

Provider. (a) A person regulated under state law, to practice dental or dental-related Services or otherwise practicing dental care Services consistent with state law; or (b) an employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment either of whom, under a

contract directly or indirectly with Dental Group, has agreed to provide covered Services to Members with an expectation of receiving payment, other than Copayments, Coinsurance, or Deductibles, from Kaiser Permanente rather than from the Member.

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

Services. Dental care Services, supplies, or items.

Spouse. Your legal husband or wife. 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 “Premiums, Eligibility, and Enrollment” section).

Urgent Care. Treatment for a condition that requires prompt dental attention to keep it from becoming more serious, but is not an emergency dental condition.

Usual and Customary Charge. With respect to any one Service or supply:

A charge for treatment which is the lesser of the following:

- the usual charge made by the Provider for that treatment; or
- the customary charge made by other Providers of similar professional standing within the same, or a similar, geographic area for that treatment.

Utilization Review. The formal application of criteria and/or other organizational approved criteria designed to ensure that each Member is receiving care at the appropriate level, used as a technique to monitor the use of or evaluate the dental necessity, appropriateness, effectiveness, or efficiency of a specific Service, procedure, or setting.

PREMIUM, ELIGIBILITY, AND ENROLLMENT

Premium

Your Group is responsible for paying the Premium. If you are responsible for any contribution to the Premium, your Group will tell you the amount and how to pay your Group.

Who is Eligible

To be eligible to enroll and to remain enrolled, you must meet all of the following requirements listed below:

- 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 one of the Subscriber or Dependent eligibility requirements described below, unless your Group has different eligibility requirements that we have approved.
- You must live or physically work inside our Service Area at least 50 percent of the time. Our Service Area is described in the “Definitions” section of this *EOC*. For assistance about the Service Area or eligibility, please contact Membership Services. The Subscriber’s or the Subscriber’s Spouse’s otherwise eligible children are not ineligible solely because they live outside our Service Area.

Subscribers

To be eligible to enroll as a Subscriber, you must be one of the following:

- An employee of your Group.
- 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.

Dependents

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

- Your Spouse.
- An unmarried person who is under the over-age Dependent limit shown on the “Benefit Summary” and who is any of the following:
 - Your or your Spouse’s child.
 - Your enrolled Dependent’s newborn child.
 - A child adopted by or placed for adoption with you or your Spouse.
 - Any other person primarily supported by you or your Spouse and for whom you or your Spouse is a court-appointed guardian.
- An unmarried person who is under the over-age student limit shown on the “Benefit Summary” and 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 or placed for adoption with you or your Spouse.
 - Any other person primarily supported by you or your Spouse and for whom you or your Spouse is a court-appointed guardian.

You may be asked to provide proof of Dependency annually until the Dependent reaches the over-age student limit shown on the “Benefit Summary” and his/her coverage ends.

An unmarried person of any age who is chiefly 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 over-age Dependent limit shown on the “Benefit Summary,” if the person is any of the following:

- Your or your Spouse’s child.
- 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 over-age Dependent limit shown on the “Benefit Summary” established by the Group.

You must provide proof of incapacity and dependency annually upon request, but only after the two-year period following attainment of the over-age Dependent limit shown on the “Benefit Summary.”

Company will not deny enrollment of a newborn child, newly adopted child, or child newly placed for adoption solely on the basis that:

- The child was born out of wedlock.
- The child is not claimed as a Dependent on the parent’s federal tax return.

When You Can Enroll and When Your Coverage Begins

Your Group is required to inform you when you are eligible to enroll and your effective date of coverage. Your effective date of coverage will depend upon how and when you enroll. If you are eligible to enroll as described under “Who is Eligible” in this “Premiums, Eligibility, and Enrollment” section, enrollment is

permitted as described below and membership begins at 12 a.m. on the membership effective date unless your Group has different requirements that we have approved. You may contact Membership Services or discuss this with your employer Group to find out if your Group has different requirements.

New Employees and Their Dependents

When your Group informs you that you are eligible to enroll as a Subscriber, you may enroll yourself and any eligible Dependents by submitting a Company-approved enrollment application to your Group within 31 days.

Open Enrollment

You may enroll as a Subscriber if you were not previously enrolled (along with any eligible Dependents) and if you are an existing Subscriber, you may add eligible Dependents not previously enrolled, by submitting a Company-approved enrollment application to your Group during the open enrollment period. Your Group will inform you of your open enrollment period and effective date of coverage. If you do not enroll when you are first eligible or during open enrollment and later want to enroll, you must wait until the next open enrollment unless one of the sections described below applies.

Adding New Dependents

To enroll a Dependent who first becomes eligible to enroll after you became a Subscriber, you must submit a Company-approved enrollment application to your Group as follows:

Newborn child. Newborns are covered from the moment of birth for the first 31 days of life. If additional Premium is required, in order for coverage to continue beyond this 31-day period, you must submit an enrollment application to your Group within 60 days after the child's birth. If additional Premium is not required, the application requirement is waived; however, please notify Membership Services so that we may add the child to your plan in our system.

Newly adopted child. Newly adopted children or children placed for adoption are covered for 31 days following the date of adoption or placement for adoption. If additional Premium is required, in order for coverage to continue beyond this 31-day period, you must submit an enrollment application to your Group within 60 days after the date of adoption or placement for adoption. If additional Premium is not required, the application requirement is waived; however, please notify Membership Services so that we may add the child to your plan in our system.

Placement for adoption means when the adopting parent assumes and retains the legal obligation for total or partial support of the child in anticipation of the adoption of the child. Placement terminates upon termination of such legal obligations.

Special Enrollment of a Family due to Marriage

Along with your new Spouse and other Dependents, you may enroll yourself as a Subscriber by submitting a Company-approved enrollment application within 31 days of marriage. Your Group may have a different special enrollment period that is greater than 31 days if approved by Company.

The effective date of an enrollment resulting from marriage is no later than the first day of the month following the timely submission of your enrollment application.

Special Enrollment due to Loss of Other Coverage

You may enroll as a Subscriber if you were not previously enrolled (along with any eligible Dependents), or if you are an existing Subscriber, you may add eligible Dependents not previously enrolled, by submitting a Company-approved enrollment or change of enrollment application to your Group within 30 days after loss of other coverage, if the following is true.

- You or your eligible Dependent had other coverage when you or the eligible Dependent previously declined Company coverage.
- You did not enroll when you were first eligible and your Group did not provide us a written statement that verifies you signed a document that explained restrictions about enrolling in the future.
- The loss of the other coverage is due to one of the following:
 - Exhaustion of COBRA coverage.
 - In the case of non-COBRA coverage, loss of eligibility or termination of employer contributions (but not termination for cause or for failure to make timely Premium payments).

Note: If you are enrolling as a Subscriber along with at least one eligible Dependent, only one of you is required to meet the provisions above.

The effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives the enrollment application from the Subscriber.

Enrollment of Child due to Court or Administrative Order

A court or administrative agency may order a child who meets the eligibility requirements to be added as a Dependent outside of the open enrollment period or at a time other than when you are first eligible to enroll yourself and your Dependents. If the order is received, the Group will let us know who to enroll under the order and the effective date of the enrollment.

How to Obtain Services Using Your Identification Card

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

Your ID card is for identification only. 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 identity.

Getting Assistance

We want you to be satisfied with the dental care you receive from Kaiser Permanente. If you have any questions or concerns, please discuss them with your primary care Dentist or with other Providers who are treating you. They are committed to your satisfaction and want to help you with your questions.

Most Dental Offices have an administrative office staffed with representatives who can provide assistance if you need help obtaining Services. Membership Services representatives are also available to assist you Monday through Friday (except holidays), from 8 a.m. to 6 p.m. From Portland, call 503-813-2000; from all other areas, call 1-800-813-2000. For TTY for the hearing and speech impaired, call 1-800-735-2900. For language interpretation services, call 1-800-324-8010. You can also e-mail us by registering on our Web site at kaiserpermanente.org.

Membership Services representatives can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. 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 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

as described in the “Requesting Dental Services and Benefits” section, or if you want to file a complaint, grievance or appeal as described in the “Dispute Resolution” section.

Emergency Care

Dental Emergency Care is available 24 hours a day, every day of the week. Call the Dental Appointment Center to receive advice or arrange to be seen for a dental emergency. You pay the amount shown on the “Benefit Summary.”

There will be an additional \$25 Charge added to any other Copayments or Coinsurance when you receive emergency dental Services for an Urgent Care appointment on the same or next business day.

Outside the Service Area. If you require Emergency Care when you are outside the Service Area, you will be reimbursed up to \$100 per incident for Dentally Necessary Services that are needed immediately for the treatment of acute infection, hemorrhage, relief of extreme pain, and for necessary treatment, including local anesthesia and premedication, due to injury.

Elective care and care for conditions that could have been reasonably foreseen are not covered under your Emergency Care benefit. Follow-up and continuing care is covered only at our Dental Offices. You pay the amount shown on the “Benefit Summary” located in the front of this *EOC*.

Dental Appointment Center

From Portland 503-286-6868

From Vancouver 360-254-9158

From Salem 503-370-4311

From Longview 360-575-4800

TTY 1-800-735-2900

Choosing a Primary Care Dentist

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

DEDUCTIBLE, COPAYMENTS, COINSURANCE, AND BENEFITS

The Services described in this “Deductible, Copayments, Coinsurance, and 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 Dentist determines that the Services are Dentally Necessary.
- The Services are provided, prescribed, authorized, and/or directed by a Dentist or Provider inside our Service Area, except where specifically noted to the contrary under “Emergency Care” in the “How to Obtain Services” section.

Deductible

Note: Check the “Benefit Summary” to determine what your Deductible is, if any.

In any Calendar Year, we will not cover Services that are subject to the Deductible until you meet the Member Deductible or the Family Deductible listed in the “Benefit Summary” during that Calendar Year. The only payments that count toward the Deductible are those you make for covered Services that are subject to the Deductible under this *EOC*.

For Services that are subject to the Deductible, you must pay Charges for the Services when you receive them, until you meet your Deductible. After you meet the Deductible, you pay the applicable Copayment or Coinsurance for those Services for the remainder of the Calendar Year. Services that are subject to the Deductible are so noted in the “Benefit Summary.”

Deductible Take-Over

If this *EOC* replaces prior coverage through the same group, amounts that were applied toward a deductible under the prior coverage will be credited toward the Deductible under this *EOC* if you provide documentation demonstrating that:

- the Services were received between January 1 and the effective date of this *EOC*, not to exceed a 12-month period, and
- the Services would have been covered and subject to the Deductible under this *EOC* if you had received them or if Dental Group had provided or authorized them during the term of this *EOC*.

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service is described in the “Benefit Summary.” Copayments or Coinsurance are due when you receive the Service. If we must bill you, an accounting fee of \$10 or more will be added to offset handling costs.

Benefit Maximum

Note: Check the “Benefit Summary” to determine if the preventive and diagnostic services Charges are subject to your “Deductible” or count toward your “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 Calendar Year to the amount shown in the “Benefit Summary.” The value of benefits you receive (other than the dental office visit Charges and, for some plans, preventive and diagnostic Services), less Deductibles, Copayments, or Coinsurance you pay, counts toward the Benefit Maximum. After you reach the Benefit Maximum, you pay 100 percent of Charges for Services incurred during the balance of the Calendar Year. If you are covered for orthodontic Services, please note that orthodontic Services do not count toward your benefit maximum. Your orthodontic coverage may include a separate maximum.

Your Benefits Described

You are covered for the Services described in this booklet when you receive Services from a Company Provider. Your dental “Benefit Summary” describes your benefits and lists your Deductible, Copayment, Coinsurance, and Benefit Maximum. Below are additional details about some of the covered Services.

Preventive and Diagnostic Services

Diagnostic examination. Examination of your mouth, X-rays to check for cavities and determining the condition of your teeth and gums.

Preventive Services. Preventive care includes such Services as routine teeth cleaning (prophylaxis) and fluoride treatments.

Prophylaxis. Preventive cleaning of the teeth. You are covered for no more than two visits for oral prophylaxis treatments in any 12-consecutive-month period, except when you are receiving periodontal treatment.

Space maintainer. Appliance used to maintain spacing after removal of a tooth or teeth.

Basic Restorative Services

Basic restorative Services. Your plan covers routine fillings and stainless steel and plastic/acrylic crowns.

Simple extractions. Your plan covers simple tooth extractions.

Oral Surgery Services

Oral surgery. Surgical tooth extractions, including diagnosis and evaluation, are covered.

Periodontics

Periodontics (gum treatment). Treatment of disease of the gums. Diagnosis, evaluation, and treatment of disease of the gums, including scaling and root planing, are provided.

Endodontics

Endodontics (root canal therapy). Treatment of the root canal or tooth pulp. Your benefit includes root canal and related therapy, including diagnosis and evaluation.

Major Restoration Services

Major restorative Services. Your plan covers gold and porcelain crowns, inlays, bridge abutments and pontics, and other cast metal restorations. If you request a procedure or material not covered, or in excess of what is recommended by your Provider, you will be responsible for the additional fees. Repair or replacement of prosthetic appliances that are less than five years old is not covered.

Pontic. An artificial tooth on a dental bridge.

Removable prosthetic Services. Covered Services include full and partial dentures, relines, and rebases. Your plan covers repair and adjustment of dentures and other prosthetic devices damaged through normal use. If a prosthetic device cannot be repaired, we will cover replacement once every five years.

Prosthetic device. Artificial teeth such as dentures or bridges.

Rebase. Replacement of the entire denture base, except the teeth, to improve the bite and/or fit.

Reline. Adding a new layer of plastic material to the inside of a set of full or partial dentures to improve the fit.

Urgent condition. A dental problem such as 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.

Emergency Care. Care for a condition requiring immediate treatment for acute infection, hemorrhage, injury to the gums and/or teeth, or relief of extreme pain that would lead a prudent layperson possessing an average knowledge of health and medicine to reasonably expect that immediate dental attention is needed. Coverage includes local anesthesia and premedication.

Other Benefits

Nightguard. A removable dental appliance designed to minimize the effects of grinding and other occlusal factors. Members pay 10 percent Coinsurance for nightguards.

Nitrous oxide. Covered for adults and children age 13 years and older with a \$15 charge. Children age 12 years and under receive nitrous oxide without charge when administered by a pediatric Dentist, oral surgeon, or periodontist.

Work-in-progress. The following Services and related materials: a) a prosthetic or other appliance, or modification of one, where an impression was made before your coverage became effective; or b) a crown, bridge, or gold restoration for which a tooth was prepared before your coverage became effective, are considered works-in-progress.

EXCLUSIONS AND LIMITATIONS

Exclusions

- Conditions for which Service or reimbursement is required by law to be provided at or by a government agency.
- 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; and Services associated with postoperative conditions and complications arising from implants.
- Experimental or investigational treatments, procedures, and other Services that are not commonly considered standard dental practice or that require governmental approval.
- Full mouth reconstruction and occlusal rehabilitation, including appliances, restorations, and procedures needed to alter vertical dimension, occlusion, or correct attrition or abrasion.
- Genetic testing.
- Medical and hospital services.
- Orthodontic Services, unless your Group has purchased orthodontic coverage as an additional benefit.
- Prescription drugs obtainable with or without a prescription. These may be covered under your medical benefits.
- Prosthetic devices following your decision to have a tooth (or teeth) extracted for nonclinical reasons or when a tooth is restorable.
- Replacement of prefabricated, noncast crowns, including noncast stainless steel crowns.
- Restorative or reconstructive treatment for specific congenital or developmental malformations.
- Services for conditions that are covered by workers' compensation or that are the employer's responsibility.
- Services provided or arranged by criminal justice institutions for Members confined therein, unless care would be covered as Emergency Care.
- Speech aid prosthetic devices and follow up modifications.
- Surgery to correct malocclusion or temporomandibular joint disorders; treatment for problems of the jaw joint, including temporomandibular joint 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 to restore tooth structure lost due to attrition, erosion, or abrasion.

Limitations

- Repair or replacement needed due to normal wear and tear of fixed and removable prosthetics appliances that are less than five years old.
- Sedation and general anesthesia including, but not limited to, intramuscular IV sedation, non-IV sedation and inhalation sedation (including Nitrous Oxide, except when administered by an oral surgeon, periodontist or pediatric Dentist for covered Services).

- Works-in-progress started prior to your effective date are not covered and are the liability of the Member, or a prior dental insurance carrier. The only exception is a root canal in which the pulpal debridement has been completed. Dental Services to complete the root canal following pulpal debridement will be covered at 50 percent of the Usual and Customary Charges, subject to Deductibles and Benefit Maximum as indicated on the “Benefit Summary.”

REDUCTIONS

Coordination of Benefits

The coordination of benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern 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

- A. A Plan is any of the following that provides benefits or services for medical or 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 insurance contracts, health maintenance organization (HMO) contracts, closed panel Plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
 - (2) Plan does not include: 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 means, in a COB provision, the part of the contract providing the health 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 health 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. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health 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% of the total Allowable expense.

- D. Allowable expense is a health care expense, including deductibles, coinsurance, copayments, that is covered at least in part by any Plan covering the person. Plan provides benefits in the form of services, the reasonable cash value of each will be considered an Allowable expense and a benefit paid. An expense that covered by any Plan covering the person is not an Allowable expense. In addition, expense that a

provider by law or in accordance with a contractual agreement 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 a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
 - (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 is a Plan that provides health 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 is 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.
- (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. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel Plan to provide out-of-network benefits.

- 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 health care expenses or health 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 health care expenses or health 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 health care expenses or health 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 health care expenses or health 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 health 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 health 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 health 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 it needs 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, it 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 received covered Services for an injury or illness alleged to be caused by a third party’s acts or omissions or 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 pay us Charges for covered Services that you received for the injury or illness, except that you do not have to pay us more than the amount you received 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 Deductible, Copayment, and Coinsurance payments for these covered Services, but we will credit any such payments towards the amount you must pay us under this paragraph.

If you do not recover anything from or on behalf of the third party, you are responsible only for any applicable Deductible, Copayment, 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 of Charges for the relevant 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:

Patient Business Services—TPL
Kaiser Foundation Health Plan of the Northwest
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 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.

If you are entitled to Medicare, Medicare law may apply with respect to Services covered by Medicare.

REQUESTING DENTAL SERVICES AND BENEFITS

Post-Service Claims—Services Already Received

If you have a dental bill from a Non-Kaiser Permanente (non-participating) Provider or facility, Claims Administration will handle the claim. Membership Services can assist you with questions about a specific claim or about the claim procedures in general.

If you receive non-participating Services following an authorized referral from Kaiser Permanente, the non-participating provider will send the bill to us directly. You are not required to file the claim. However, if you receive Services from a non-participating Provider or non-participating facility without an authorized referral and you believe Company should cover the Services, you need to send a medical claim form and the itemized bill to:

Claims Administration
Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099

You can request a claim form from Membership Services or download it from our Web site. To download a claim form, go to kaiserpermanente.org and select the appropriate link. When you submit the claim, include a copy of your dental records from the non-participating facility if you have them. If you don't submit the dental records and we determine they are necessary to decide your claim, we will notify you.

The non-participating provider may bill us directly. We accept the American Dental Association (ADA) and CMS 1500 claim forms for professional Services and UB-92 form for hospital claims. You still need to send the dental claim form even if the provider bills us directly.

You must submit a claim within 90 days after receiving care, or as soon as reasonably possible. We will not review a claim if we do not receive a complete claim form within 12 months from the time the completed claim form is due, unless you lack legal capacity to file the claim within 12 months.

We will reach a decision on your claim and pay the covered charges within 30 calendar days unless additional information 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. The written notice will tell you how long the time period may be extended depending on the requirements of applicable state and federal laws, including the Employee Retirement Income Security Act of 1974 (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 Kaiser Permanente, contact Membership Services for an explanation. If you believe the charges are not appropriate, Membership Services will advise you how to proceed. If you believe the charges are not appropriate due to concerns involving our Services or your benefits, you may file a written grievance. If you think the charges are in error (such as a bill for Services you did not receive or that you paid at the time of Service), the Dental Office or Membership Services can assist you. If records indicate the charges are accurate you will be given an explanation along with information about how to file a grievance if you are dissatisfied. Refer to "Complaints, Grievances, and Appeals—Member Satisfaction" in the "Dispute Resolution" section for more information on filing a grievance.

Pre-Service Claims—Requesting Future Services

When you need care, talk with your dental care provider about your dental needs or request for dental Services. We provide treatment and Services based on dental necessity and appropriateness. Your dental care provider will use his or her judgment to determine if a treatment or Service is Dentally Appropriate. If you think you need a specific treatment or Service, talk with your Kaiser Permanente dental care provider. Your dental care provider will discuss your needs with you and recommend the most appropriate course of treatment.

If you request treatment, Service, or a dental appliance that your dental care provider believes is not Dentally Appropriate or necessary and you disagree, you may ask for a second opinion from another dental care provider at Kaiser Permanente. Contact the manager in the dental office where your dental care provider is located. Membership Services can connect you with the correct manager, who will listen to your issues and discuss your request with your dental care provider and facilitate a second opinion if necessary. If your dental care provider continues to believe the treatment, Service, or dental appliance you requested is not Dentally Necessary, you may file a written grievance with Member Relations.

If you request treatment, Service, or a dental appliance but you learn there may be coverage limitations or exclusions, and you have questions, contact Membership Services. If you are not satisfied after talking with Membership Services, you may file a written grievance with Member Relations.

If you are covered under an ERISA benefit plan and additional information is required to make a determination on your pre-Service request, you will be notified and given a specified period of time to provide the information.

Expedited procedures are available if your request for treatment, Service, or a dental appliance is considered urgent. A request is urgent if the normal decision time frames would cause a delay that would seriously jeopardize your life, health, or ability to regain maximum function. It also applies if a dental care provider who is familiar with your dental condition believes the delay would subject you to severe pain that cannot be adequately managed without the care or treatment at issue. In urgent situations, we will respond to you as quickly as your condition requires, not to exceed 24 to 72 hours depending on applicable state and federal laws.

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 regulates employee benefits, including the claim and appeal procedures for benefit plans offered by certain employers. If your employer's benefit plan is subject to ERISA, each time you request care or Services that must be approved before the care or 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 you have already received. You must follow our procedures for filing claims, and we must follow certain rules established by ERISA for responding to your claim.

If you are not satisfied with the decision made on your pre-Service or post-Service claim, you are only required to file one appeal before you have the right to take legal action under Section 502(a) of ERISA to resolve your claim. Appeals are reviewed by an appropriate named fiduciary. Additional levels of voluntary appeal may be available within Kaiser Permanente. We do not impose fees as part of any appeal process. If you are not sure whether these ERISA laws apply to your benefit plan, please contact your employer for more information.

DISPUTE RESOLUTION

Complaints, Grievances, and Appeals—Member Satisfaction

Everyone associated with Kaiser Permanente wants you to receive the best care and Service possible. If you have questions about your coverage or how to use our Services, or if you need help finding the right dental care resource, call Membership Services. If you have a compliment or suggestion, please call or send a letter to the administrator of the facility where you received care. We'll share your comments with the employees who assisted you and their supervisors.

Discuss any issues about your care with your dental care provider or another member of your dental care team. If you are not satisfied with your dental care provider, you may request another. Contact Membership Services for assistance. You always have the right to a second opinion within Kaiser Permanente.

Most issues can be resolved with your dental care team. If you feel that additional assistance is needed, complaint and grievance procedures are available to help. All complaints and grievances are handled in a confidential manner.

Oral Complaints

If you want to talk with someone because you are dissatisfied with the availability, delivery, or quality of our Services, benefits, or other administrative matters, you can file an oral complaint. Examples include, but are not limited to, things like appointment delays, the manner of communication by our staff, or concerns about our policies and procedures. If you have a concern involving a denial of future care or payment for Services you already received, refer to “Written Grievances.”

To file a complaint, contact the administrative office in the facility where you are having the problem or contact Membership Services for assistance. Discuss your complaint fully with the staff and be specific about how you want the matter to be resolved.

If you remain dissatisfied, you can file a written grievance. If you decide to file a written grievance, follow the procedures described in “Written Grievances.”

Written Grievances

A grievance is a written complaint requesting a specific action, submitted by or on behalf of a Member.

You can file a written grievance:

- If you are not satisfied with our response to your complaint about the availability, delivery, or quality of our Services, benefits, or other administrative matters. Examples include complaints that you want reported and resolved about delays in receiving care, or dissatisfaction with care that you already received.
- If you disagree with charges on a bill from Kaiser Permanente. (This is an initial claim for benefits under ERISA.)
- If we denied your claim for Services that you received from a non-participating provider or facility and you disagree with the claim determination, you must file the grievance within 185 days of the denial notice. (These grievances are post-Service appeals under ERISA.)
- If you disagree with your dental care provider's determination that the care, Service or equipment you requested is not dentally necessary or appropriate, or if you disagree with an explanation about benefits, copayments, or exclusions for care that you have not yet received, you may file a written grievance. (These are initial pre-Service claims under ERISA.)

Grievance procedures

To file a written grievance, outline your concerns in writing and be specific about your request. You may submit any written comments, documents, records, and other information related to your grievance. Send your grievance to:

Member Relations
Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099

If you need assistance filing a written grievance, or if your grievance is urgent, contact Member Relations. We will acknowledge receipt of your grievance within seven days. An independent review will be conducted and we will provide you with a written response. Most grievance decisions will be provided within 30 days except as follows. If you submit a grievance that is an initial pre-Service claim under ERISA, a decision will be provided within 15 days. If you fail to provide necessary information to make a determination on a grievance that is an initial claim under ERISA and you are covered under an ERISA benefit plan, we will allow you 50 days from the date on our written notification to submit the information. A decision will be reached within 15 days after receiving the information or within 15 days after the end of the 50-day period if we don't receive the information.

We will expedite a response on all grievances according to the clinical urgency of the situation, not to exceed 72 hours, if your grievance involves a denial of urgently needed care.

If your grievance included a specific request and that request is denied, the decision letter you receive will include detailed information about the basis for the decision and how to appeal the decision.

Appeals

The process for requesting reconsideration of a denied grievance is outlined in the following appeal procedures. These procedures reflect the requirements of state and federal laws. Receipt of appeals will be acknowledged within seven days.

- If you disagree with the decision rendered following a written grievance, you have 185 days to submit an appeal. (For Members covered under an ERISA benefit plan, this is the one required level of appeal. Exception: If your grievance was classified as an appeal to a post-Service claim denial as described above, this appeal is voluntary under ERISA).
- If your appeal involves urgently needed care, a request for an expedited appeal may be submitted orally or in writing.

To submit an appeal, follow the instructions in the denial letter you receive, or send your appeal to Member Relations. You have the right to include with your appeal any written comments, documents, records, and other information relating to the claim.

Appeals will be decided within 30 days after we receive your appeal. A decision will be expedited to meet the clinical urgency of the situation, not to exceed 72 hours if it involves a denial of urgently needed care. Member Relations will conduct an independent review of your appeal and provide a written response. If your appeal is denied, the written notice you receive will explain the basis for the decision, along with other important disclosures as required under state and federal laws.

TERMINATION OF MEMBERSHIP

Your Group is required to inform the Subscriber in your Family of the date your membership terminates. 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 terminates. Company, Dentists, and Providers 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 divorce or a Dependent's marriage, leaving school, or reaching the Dependent age limit. If you no longer meet the eligibility requirements described in "Who is Eligible" in the "Premiums, Eligibility, and Enrollment" section, 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 to the Subscriber at least 31 days before the membership termination date:

- You abuse or threaten the safety of Company personnel or of any person or property at a Dental Office;
- You fail to comply with the provisions of the *EOC*;
- You knowingly commit fraud in connection with membership, Company, or a Provider. Some examples of fraud include:
 - Misrepresenting eligibility information about you or a Dependent.
 - Presenting an invalid prescription or dental order.
 - Misusing an ID card (or letting someone else use it).
 - 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 or Dental Group from any payment we make to you.

Termination of *Group Agreement*

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 *Group 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 just 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 *Group 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. You must continue to reside or work for any employer at least 50 percent of the time within our Service Area to remain eligible for COBRA coverage. 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.

State Continuation Coverage for Surviving, Divorced, or Separated Spouses 55 or older in COBRA Groups

If your Group is subject to COBRA law, you and your Dependents may be able to continue your coverage under this *EOC* through your Group if you meet all of the following criteria:

- You are the Subscriber's Spouse.
- You are age 55 or older.
- The Subscriber died, or you divorced or are legally separated from the Subscriber.
- You are not eligible for Medicare.

To continue coverage, you must notify Membership Services in writing within 60 days after legal separation or divorce, or the Group must notify us in writing within 30 days after the death of the Subscriber. Within 14 days after we receive the notice, we will send you an election form, payment information, and instructions for electing continuation coverage. You must return the completed election form no later than 60 days after the date we mailed it to you.

Your premium may be up to 102 percent of the applicable Premium. The first premium payment must be paid within 45 days of your coverage election date. Your right to continue coverage as a surviving, separated, or divorced Spouse will end upon the earliest of the following events:

- You fail to pay your premium.
- The Group's *Agreement* with us terminates.
- You are covered under another group health coverage.
- You become, eligible for Medicare.

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*.

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

Except as provided under the "Dispute Resolution" section of this *EOC*, in any dispute between a Member and Company or Providers, each party will bear its own attorneys' fees and other expenses.

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 set forth in this *EOC*.

Group and Members not Company's Agents

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

Litigation Venue

Venue for all litigation between you and Company shall lie in Multnomah County, Oregon.

Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this *EOC*, and we have the discretionary authority to review and evaluate claims that arise under this *EOC*. We conduct this evaluation independently by interpreting the provisions of this *EOC*. If this *EOC* is part of a health benefit plan that is subject to the Employee Retirement Income Security Act (ERISA), then we are a "named fiduciary" to review claims under this *EOC*.

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 age, race, color, national origin, religion, sex, sexual orientation, or physical or mental disability.

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 in address. Subscribers who move should call Membership 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 such 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 and facilities to protect your PHI. PHI is health information that includes your name, social security number, or other information that reveals who you are. 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, and health care operations purposes, including health research and measuring the quality of care and Services. We are sometimes required by law to give PHI to government agencies or in judicial actions. In addition, we may share your PHI with employers 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 authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* explains our privacy practices in detail. To request a copy, please call Membership Services. Our *Notice of Privacy Practices* is also available on the Internet at **kaiserpermanente.org**.

Unusual Circumstances

Kaiser Foundation Health Plan of the Northwest (KFHPNW) is not responsible for delay or failure to render Service because of unusual circumstances, such as wars, riots, labor disputes not involving KFHPNW, or major disasters or epidemics affecting KFHPNW, Kaiser Permanente facilities or personnel, or Providers contracted with KFHPNW. Nonemergency care may be postponed in the event of labor disputes involving KFHPNW, Kaiser Permanente organizations, or KFHPNW contracted Providers.

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST ORTHODONTIC SERVICES RIDER PLAN E

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* “Copayments, Coinsurance, and Benefits” section except for the “Orthodontic Services Rider Plan E Benefit Summary,” which becomes part of the *EOC* “Benefit Summary.” This entire rider is therefore subject to all the terms and provisions of the *EOC*.

Orthodontics. Orthodontic treatment for abnormally aligned or positioned teeth. Treatment under this provision will be completed so long as you meet the following conditions:

- Maintain continuous eligibility under this or any other Company dental contract containing an orthodontic benefit.
- Allow no significant lapse in the continuous orthodontic treatment process.
- Make timely payment of amounts due.
- Comply with the orthodontic treatment plan.
- Treatment must be started prior to a Member becoming 18 years of age.

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:

- Replacement of broken appliances.
- Re-treatment of Orthodontic cases.
- Changes in treatment necessitated by an accident.
- Maxillofacial surgery (subrogate with medical insurance).
- Miofunctional therapy (TMJ).
- Treatment of cleft palate.
- Treatment of micrognathia.
- Treatment of macroglossia.
- Treatment of primary/transitional dentition.

Orthodontic Services Rider Plan E Benefit Summary

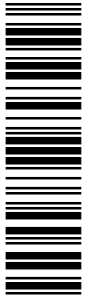
Orthodontics	You Pay
Members under 18	50% of Charges up to a maximum payment by Plan of \$1,500
Members over 18	50% of Charges up to a maximum payment by Plan of \$1,500

NOTES

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