KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST

A Nonprofit Corporation

Kaiser Permanente Individuals and Families
KP WA Family Dental 80
Evidence of Coverage Face Sheet

Shown below are the Premium amounts referenced under "Premium" in the "Premium, Eligibility, and Enrollment" section of the Kaiser Permanente Individuals and Families Dental Plan *Evidence of Coverage (EOC).*

MONTHLY PREMIUM

Premium Due Date is last day of the month preceding the month of membership.

For renewing Members, the Premium amount you pay is based on each Member's age as of January 1, 2024. For new Members, the Premium amount you pay is based on each Member's age on the effective date of their enrollment in 2024.

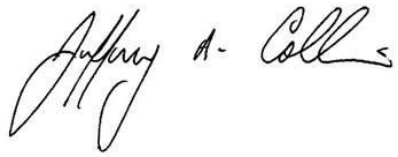
If you enroll more than three children under age 21 in one Family account, we charge Premium only for the three oldest children.

Premium

Member Age	Premium
18 and under	[$31.19]
19+	[$38.98]

EFFECTIVE DATE: January 1, 2024 through December 31, 2024

Kaiser Foundation Health Plan of the Northwest



Jeffrey A. Collins
President, Kaiser Foundation Health Plan
and Hospitals of the Northwest

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation
Portland, Oregon

Kaiser Permanente Individuals and Families Dental Plan Evidence of Coverage

Group Number: <90> - <4>

This *Evidence of Coverage* is effective <110> through <116>.

Printed: <92>

READ THIS *EVIDENCE OF COVERAGE* CAREFULLY. IT IS IMPORTANT THAT YOU READ AND UNDERSTAND THE INFORMATION IN THIS *EVIDENCE OF COVERAGE*. YOUR DENTAL PLAN COVERAGE UNDER THIS PLAN MAY BE DIFFERENT FROM THE DENTAL PLAN COVERAGE WITH WHICH YOU ARE FAMILIAR. IF YOU HAVE ANY QUESTIONS ABOUT YOUR COVERAGE, PLEASE CALL US.

10-DAY CANCELLATION POLICY:

If you are not satisfied with this *Evidence of Coverage* for any reason, you can rescind the contract and cancel the coverage within 10 days of the date of delivery by notifying and returning this *Evidence of Coverage* to us. If you cancel the coverage, your Premium and other payments, if any, will be refunded, and your coverage will be void from the beginning. As a result, you will be charged as a non-member for Services and benefits you received during the period to which the refund applies. If we do not pay the refund within 30 days from the date that this *Evidence of Coverage* is returned, an additional 10 percent will be added to the refund.

Member Services

Monday through Friday (except holidays)
8 a.m. to 6 p.m. PT
All 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/

KP WA FAMILY DENTAL 80 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 applicable Cost Share, unless otherwise noted.

Benefit Maximum (Applies to covered Services you receive on or after the first day of the month after you turn 19 years of age)	
Per Member per Year	$2,000
Deductible	
For one Member per Year	$100
For an entire Family per Year	$300
Out-of-Pocket Maximum (Applies to covered Services you receive until the end of the month in which you turn 19 years of age)	
For one Member per Year	$400
For an entire Family per Year	$800
Benefits	**You Pay**
Preventive and Diagnostic Services (not subject to the Deductible)	
Oral exam, including evaluations and diagnostic exams	20% Coinsurance
X-rays	20% Coinsurance
Teeth cleaning	20% Coinsurance
Fluoride treatments	20% Coinsurance
Space maintainers	20% Coinsurance
Sealants	20% Coinsurance
Minor Restorative Services	**You Pay**
Routine fillings	50% Coinsurance after Deductible
Simple extractions	50% Coinsurance after Deductible
Restorations (composite/acrylic and steel)	50% Coinsurance after Deductible
Oral Surgery Services	**You Pay**
Major oral surgery	50% Coinsurance after Deductible
Surgical tooth extractions	50% Coinsurance after Deductible
Periodontic Services	**You Pay**
Scaling and root planing	50% Coinsurance after Deductible
Periodontal surgery	50% Coinsurance after Deductible
Treatment of gum disease	50% Coinsurance after Deductible
Endodontic Services	**You Pay**
Root canal and related therapy	
Anterior Tooth	50% Coinsurance after Deductible
Bicuspid Tooth	50% Coinsurance after Deductible
Molar Tooth	50% Coinsurance after Deductible
Major Restorative Services	**You Pay**
Bridge abutments	50% Coinsurance after Deductible
Noble metal gold or porcelain crowns	50% Coinsurance after Deductible
Inlays	50% Coinsurance after Deductible

Benefits	You Pay
Pontics	50% Coinsurance after Deductible
Removable Prosthetic Services	**You Pay**
Full upper and lower dentures	50% Coinsurance after Deductible
Partial dentures	50% Coinsurance after Deductible
Rebases	50% Coinsurance after Deductible
Relines	50% Coinsurance after Deductible
Orthodontic Services	**You Pay**
Medically Necessary orthodontics (diagnosis of cleft palate/lip) (Covered until the end of the month in which the Member turns 19 years of age)	50% Coinsurance after Deductible
Emergency Dental Care	**You Pay**
From Participating Providers	The Cost Share that normally applies for non-emergency dental care Services
From Non-Participating Providers outside the Service Area	The Cost Share that normally applies for non-emergency dental care Services, plus amounts that exceed Usual and Customary Charges for qualifying claims
Other Dental Services (not subject to or counted toward the Deductible or Benefit Maximum)	**You Pay**
House/extended care facility calls and hospital calls (Covered until the end of the month in which the Member turns 19 years of age)	$0
Nightguards	10% Coinsurance
Nitrous oxide	
Members age 13 years and older	$25
Members age 12 years and younger	$0
Dependent Limiting Age	**Limiting Age**
Dependent Limiting Age	26

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INTRODUCTION

This *Evidence of Coverage* (*EOC*), including the "Benefit Summary," describes the dental care coverage of the Kaiser Permanente Individuals and Families Dental Plan. Members are entitled to covered Services only at Participating Dental Offices and from Participating Providers, except as noted in this *EOC*. For benefits provided under any other plan, refer to that plan's evidence of coverage.

The provider network for this Family Dental Plan is the Dental network. Permanente Dental Associates, PC, is included in the Dental network.

Kaiser Foundation Health Plan of the Northwest uses health care benefit managers to administer this Plan. For a current list of the health care benefit managers we use and the services they provide, please visit **kp.org/disclosures**; look under "Choose your region"; select Oregon / SW Washington; click on "Coverage information"; expand the "Getting care" list; and open the document titled *List of Health Care Benefit Managers*.

The provisions of this *EOC* must be considered together to fully understand the benefits available under the *EOC*. 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*, including 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 and Renewal

Term of This *EOC*

Dental benefit coverage under this *EOC* for the effective period stated on the cover page will be provided only for the period for which Company has received the applicable Premium.

Renewal

This *EOC* is guaranteed renewable during the effective period subject to receipt of applicable Premium and will not be terminated, except as described in the "Termination of Membership" section.

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.

To obtain information about Participating Providers and Participating Dental Offices go to **kp.org/dental/nw/directory** or call Member Services.

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

DEFINITIONS

Annual Renewal Date. The Annual Renewal Date is January 1 of each year.

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." Specific Services may have separate benefit maximum amounts, as shown in the "Benefit Summary."

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 Cost Share from its payment, the amount Company would have paid if it did not subtract the Cost Share).

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.

Cost Share. The Deductible, Copayment, or Coinsurance you must pay for covered Services.

Deductible. The amount you must pay for certain Services you receive in a Year before we will cover those Services, subject to any applicable Copayment or Coinsurance, in that Year.

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 and appropriate 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 a Service does not, in itself, make such 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 and disabled Dependents as described in the "Dependents" section) be under the Dependent Limiting Age in order to be eligible for membership. The "Benefit Summary" shows the Dependent Limiting Age.

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 such that a prudent layperson possessing an average knowledge of health and medicine could reasonably expect the absence of immediate dental attention to result in:

- Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Evidence of Coverage (EOC). This *Evidence of Coverage* document provided to the Member that specifies and describes benefits and conditions of coverage.

Family. A Subscriber and their Spouse and/or Dependents.

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 a Service does not, in itself, make such 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 Premium. This *EOC* sometimes refers to a Member as "you." The term Member may include the Subscriber or their Dependent.

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.

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

Out-of-Pocket Maximum. The total amount of Deductibles, Copayments, and Coinsurance you will be responsible to pay in a Year, as described in the "Out-of-Pocket Maximum" section of this *EOC*.

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 Deductible, Copayment, or Coinsurance, from Company rather than from the Member, and who is listed in the *Dental Provider Directory*. Participating Dentists are subject to change.

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 Deductible, 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, pediatric dental assistant, registered nurse, or advanced registered nurse practitioner, and who is an employee or agent of a Participating Dentist.

Participating Providers are subject to change.

Premium. Monthly membership charges paid by, or on behalf of, each Member. The Premium is in addition to and does not include any Cost Share.

Premium Due Date. Last day of the month preceding the month of membership.

Service Area. Our Service Area consists of Clark and Cowlitz counties in the state of Washington.

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 who is legally recognized as your domestic partner in a valid Certificate of State Registered Domestic Partnership issued by the state of Washington or validly registered as your domestic partner under the laws of another state.

Subscriber. A Member who is eligible for membership on their own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber, who is enrolled, and for whom we have received the applicable Premium.

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

Only Members for whom Company has received the applicable Premium are entitled to membership under this EOC, and then only for the period for which Company has received the applicable Premium.

Monthly Premium

Subscriber must pay Company the applicable Premium for each month so that Company receives it on or before the Premium Due Date.

If we receive advance payment of the premium tax credit on your behalf, then you are responsible for paying the portion of the monthly Premium that equals the full Premium minus the advance payment of the premium tax credit that we receive on your behalf for that month.

Who Is Eligible

General

Enrollment in this plan is subject to the approval of your application for this Kaiser Permanente Individuals and Families Dental Plan by the Washington Health Benefit Exchange.

Subscriber

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

- You must submit a completed application for this Kaiser Permanente Individuals and Families Dental Plan.
- You must live in our Washington Service Area. If you move outside our Washington Service Area, you will not be eligible to continue membership under this plan. 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 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 child placed with you or your Spouse for foster care.
- 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 a developmental disability, mental illness, or a physical disability that occurred prior to the person reaching the 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."

You must provide proof of incapacity and dependency annually upon request, but only after the two-year period following attainment of the Dependent Limiting Age shown in the "Benefit Summary."

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; or (b) they are primarily supported by you or your Spouse and you or your Spouse is their court-appointed guardian.

Company will not deny enrollment of a newborn child, newly adopted child, child for whom legal obligation is assumed in anticipation of adoption, child newly placed for adoption, or newly placed foster child 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

An individual may enroll for coverage in a Kaiser Permanente Individuals and Families Dental Plan during the annual open enrollment period, or within 60 days after a qualifying event occurs as defined in applicable state and federal law.

There are requirements that you must meet to take advantage of a special enrollment period, including providing proof of your own or your Dependent's qualifying event. To learn more about qualifying events, special enrollment periods, how to enroll or change your plan (if permitted), timeframes for submitting information to Company, and other requirements, contact Member Services or visit **kp.org/specialenrollment** to obtain a copy of our *Special Enrollment Guide*.

Note: During the enrollment process if we discover that you or someone on your behalf intentionally provided incomplete or incorrect material information on your enrollment application, we will rescind your membership. This means that we will completely cancel your membership so that no coverage ever existed. You will be responsible for the full Charges of any Services received by you or your Dependents. Please refer to "Rescission of Membership" in the "Termination of Membership" section for details.

Annual Open Enrollment Period

An individual may apply for enrollment as a Subscriber, and may also apply to enroll eligible Dependents, by submitting an application to Washington Healthplanfinder (**wahealthplanfinder.org**) during the annual open enrollment period. If Washington Healthplanfinder accepts the application, Washington Healthplanfinder will notify the individual of the date coverage begins. Membership begins at 12 a.m. PT of the effective date specified in the notice.

Special Enrollment

A special enrollment period is open to individuals who experience a qualifying event, as defined in applicable state and federal law. We will administer special enrollment rights in compliance 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, placement for adoption or placement for foster care, or through a child support order or other court order.
- Loss of a Dependent through divorce or legal separation, or if the enrollee, or their 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.

An individual may apply for enrollment as a Subscriber, and may also apply to enroll eligible Dependents, by submitting an application to Washington Healthplanfinder (**wahealthplanfinder.org**) within 60 days after a qualifying event, as defined in applicable state and federal law.

There are requirements that you must meet to take advantage of a special enrollment period, including providing proof of your own or your Dependent's qualifying event. To learn more, contact Member Services or visit **kp.org/specialenrollment.**

Adding New Dependents to an Existing Account

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

Newborns, newly adopted children, children newly placed for adoption, or newly placed foster children are covered for 31 days after birth, adoption, placement for adoption, or placement for foster care. In order for coverage to continue beyond this 31-day period, you must submit an enrollment application within 60 days after the date of birth, adoption, placement for adoption, or placement for foster care if additional Premium is required to add the Dependent. If additional Premium is not required, the application requirement is waived; however, please notify Washington Healthplanfinder (**wahealthplanfinder.org**) 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 within 60 days after the qualifying event. Enrollment in this Plan is subject to verification of your eligibility by Washington Healthplanfinder.

Selecting and Switching Your Benefit Plan

If you are currently a Member on a Kaiser Permanente Individuals and Families Dental Plan you may switch to another Kaiser Permanente Individuals and Families Dental Plan that we offer during the annual open enrollment period, or if you experience a qualifying event as defined in applicable state and federal law.

When Coverage Begins

Washington Healthplanfinder will notify the enrollee of the date coverage will begin. Membership begins at 12 a.m. PT of the effective date specified in the notice.

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

HOW TO OBTAIN SERVICES

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*. To locate a Participating Provider, visit **kp.org/dental/nw/directory**.

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. Any amounts you pay for non-covered Services will not count toward your Deductible or Out-of-Pocket Maximum.

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 they receive. 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. Only the Services and number of visits that are listed on the referral will be covered, subject to any benefit limitations and exclusions applicable to the Services.

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 Cost Share 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. Only the Services and number of visits that are listed on the referral will be covered, 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.

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

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.

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 of this *EOC*. Upon request, Member Services can also provide you with written materials about your coverage.

Member Services representatives are available to assist you Monday through Friday (except holidays), from 8 a.m. to 6 p.m. PT.

All areas 1-800-813-2000

TTY for the hearing and speech impaired 711

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

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

Participating Providers and Participating Dental Office Compensation

Participating Providers and Participating Dental Offices may be paid in various ways, including salary, per diem rates, fee-for-service, incentive payments, and capitation payments. Capitation payments are based on a total number of Members (on a per-Member, per-month basis), regardless of the amount of Services provided. Company may directly or indirectly make capitation payments to Participating Providers and Participating Dental Offices only for the professional Services they deliver, and not for Services provided by other providers, dental offices, or facilities. Please call Member Services if you would like to learn more about the ways Participating Providers and Participating Dental Offices are paid to provide or arrange Services for Members.

Our contracts with Participating Providers provide that you are not liable for any amounts we owe. However, you will be liable for the cost of non-covered Services that you receive from a Participating Provider or from Participating Dental Offices, as well as unauthorized Services you obtain from Non-Participating Providers and Non-Participating Dental Offices.

Hold Harmless

We agree to hold you harmless from any claim or action by a Participating Provider for any amounts we owe for the provision of covered Services under this *EOC*. This provision shall not apply to (1) your Cost Share; (2) Charges for Services provided after exhaustion of benefits under this *EOC*; or (3) Services not covered under this *EOC*.

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, the itemized bill, and your receipt or proof of payment to:

Kaiser Permanente
National Claims Administration – Northwest
PO Box 370050
Denver, CO 80237-9998

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. If the provider bills Company directly, you will not 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.

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 the claim determination, 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. 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 Cost Share 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.

Deductible

In any Year, we will not cover Services that are subject to the Deductible until you meet the Member Deductible or the Family Deductible as shown in the "Benefit Summary" during that 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*. The "Benefit Summary" indicates which Services are subject to the Deductible.

For Services that are subject to the Deductible, you must pay all Charges for the Services when you receive them, until you meet your Deductible. If you are the only Member in your Family, then you must meet the Member Deductible. If there is at least one other Member in your Family, then you must each meet the Member Deductible, or your entire Family must meet the Family Deductible, whichever occurs first. Each Member Deductible amount counts toward the Family Deductible amount. Once the Family Deductible is satisfied, no further Member Deductible amounts will be due for the remainder of the Year. The Member and Family Deductible amounts are shown in the "Benefit Summary."

After you meet the Deductible, you pay the applicable Copayment or Coinsurance for covered Services for the remainder of the Year until you meet your Out-of-Pocket Maximum (see "Out-of-Pocket Maximum" in this "What You Pay" section).

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service (after you meet any applicable Deductible) is shown in the "Benefit Summary." Copayments or Coinsurance are due when you receive the Service.

Out-of-Pocket Maximum

This Out-of-Pocket Maximum section applies to covered Services you receive until the end of the month in which you turn 19 years of age. Out-of-Pocket Maximum means there is a maximum to the total dollar amount of Deductible, Copayments, and Coinsurance that you must pay for covered Services that you receive within the same Year under this *EOC*.

Out-of-Pocket Maximum amounts are shown in the "Benefit Summary." If you are the only Member in your Family under 19 years of age, then you must meet the Member Out-of-Pocket Maximum. If there is at least one other Member in your Family under 19 years of age, then either you must each meet the Member Out-of-

Pocket Maximum, or all Members under 19 years of age must meet the Family Out-of-Pocket Maximum, whichever occurs first.

All Deductible, Copayments, and Coinsurance count toward the Out-of-Pocket Maximum, unless otherwise indicated. Once the applicable Out-of-Pocket Maximum amount has been met, no further Copayments or Coinsurance for Services that count toward the Out-of-Pocket Maximum will be due for the remainder of the Year.

Member Services can provide you with the amount you have paid toward your Out-of-Pocket Maximum.

BENEFITS

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

- You are a Member on the date you receive the Services.
- A Participating Dentist determines that the Services are Dentally Necessary.
- The covered 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 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 your Cost Share 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*.

Pediatric Dental Services

Pediatric dental Services are covered for Members age 18 and younger. Coverage for pediatric dental Services will end of the last day of the month in which the Member turns 19 years of age. Covered Services are described in this section and listed on the "Schedule of Covered Pediatric Dental Procedures" located at the back of this *EOC*.

Preventive and Diagnostic Services

We cover the following preventive and diagnostic Services:

- Examination of your mouth (oral examination) to determine the condition of your teeth and gums, including:.
  - Complete dental/medical history and general health assessment.
  - Complete thorough evaluation of extraoral and intraoral hard and soft tissues.
  - Limited oral evaluations as Dentally Necessary to evaluate a specific dental problem or oral health complaint, assess a dental emergency, or recommend other treatment.
  - Limited visual oral assessments or screenings.

- The evaluation and recording of dental caries, missing or unerupted teeth, restoration, occlusal relationships, periodontal conditions (and periodontal charting), hard and soft tissue anomalies, and oral cancer screening.

- Installation of space maintainers (appliances used to maintain spacing after removal of a tooth or teeth) for Members age 12 and younger for fixed unilateral or bilateral space maintenance, including:
  - Recementation of space maintainers;
  - Removal of space maintainers; and
  - Replacement space maintainers when dentally appropriate.
- Oral hygiene instruction, including individualized oral hygiene instructions, tooth brushing techniques, flossing, and use of oral hygiene aids.
- Routine preventive teeth cleaning (prophylaxis).
- Sealants when used on mechanically and/or chemically prepared enamel surface.
- Topical fluoride treatments including fluoride rinse, foam or gel, and disposable trays.
- X-rays to check for cavities and to determine the condition of your teeth and gums, subject to frequency limits detailed in the "Pediatric Dental Services Limitations" section. Covered Services include:
  - Bitewing X-rays.
  - Cephalometric films.
  - Intraoral complete series.
  - Medically Necessary periapical X-rays that are not included in a complete series for diagnosis in conjunction with definitive treatment.
  - Occlusal intraoral X-rays.
  - Panoramic X-rays.
  - X-rays not listed above on a case-by-case basis when Dentally Necessary.

Minor Restorative Services

We cover the following minor restorative dental Services:

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

Oral Surgery Services

We cover the following oral surgery Services:

- Frenulectomy or frenuloplasty care for Members age six and younger.
- Major oral surgery.
- Orthognathic surgical Services performed by a dentist for treatment of cleft palate diagnosed at birth or cleft lip diagnosed at birth when the Services are required for a covered Dependent child and the Dependent is not enrolled under a Company medical plan that covers these Services.
- Surgical tooth extractions.

Periodontic Services

We cover the following periodontic Services:

- Periodontal maintenance for Members age 13 and older.
- Periodontal non-surgical Services (scaling, root planing, and full-mouth debridement) for Members age 13 and older.
- Periodontal surgical Services and postoperative care for gingivectomy/gingivoplasty.
- Treatment of gum disease.

Endodontic Services

We cover the following endodontic Services:

- Root canal and related therapy, including:.
  - Apexification for apical closures of anterior permanent teeth.
  - Apicoectomy and retrograde filling for anterior teeth.
  - Retreatment for the removal of post, pin, old root canal filing material and all procedures Dentally Necessary to prepare the canal with placement of new filing material.
  - Therapeutic pulpotomy on primary teeth and pulpal debridement on permanent teeth only.
  - Treatment for permanent anterior, bicuspid, and molar teeth.
  - Treatment with resorbable material for primary maxillary incisor teeth D, E, F, and G if the entire root is present at treatment.
- Treatment of the root canal or tooth pulp.

Major Restorative Services

We cover the following major restorative Services:

- Bridge Abutments.
- Cast post and core or prefabricated post and core, on permanent teeth when performed in conjunction with a crown.
- Core buildup, including pins, only on permanent teeth, when performed in conjunction with a crown.
- Indirect crown for permanent anterior teeth for Members age 12 and older.
- Occlusal restorations for the upper molars if restorations are anatomically separated by sound tooth structure.
- Pontics. Artificial tooth on a fixed partial denture (a bridge).
- Prefabricated stainless steel crowns for primary and permanent posterior teeth.
- Recementation of permanent indirect crown for Members age 12 and older.

Removable Prosthetic Services

We cover the following removable prosthetic Services:

- Full upper and lower dentures.

- Maintenance prosthodontics:
  - Adjustments.
  - Rebase and reline of complete or partial dentures.
  - Repairs.
- Resin-based partial upper and lower dentures.

Medically Necessary Orthodontic Services

We cover Medically Necessary Orthodontic Services for treatment of malocclusions associated with a diagnosis of:

- Cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement; or
- Craniofacial anomalies for (i) hemifacial microsomia, (ii) craniosynostosis syndromes, (iii) arthrogryposis, or (iv) Marfan syndrome.

These Services are covered for Members age 18 and younger or whose treatment began and was not completed prior to turning age 19.

Other Pediatric Dental Services

We cover other dental Services as follows:

- Nightguards. We cover removable dental appliances designed to minimize the effects of bruxism (teeth grinding) and other occlusal factors.
- Nitrous oxide, once per day. We cover use of nitrous oxide during Dentally Necessary treatment as deemed appropriate by the Participating Provider.
- Regional blocks and local anesthesia in conjunction with covered dental Services.

Adult Dental Services

Adult dental Services are covered for Members age 19 and older. This section describes covered Services received on or after the first day of the month after the Member turns 19 years of age.

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.

Other Adult Dental Services

We cover other dental Services as follows:

- 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.

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.

Emergency Dental Care outside the Service Area will be reimbursed at the Usual and Customary Charge. Non-Participating Providers may charge additional fees for Emergency Dental Care, based on that Non-Participating Dental Office's policy. You are responsible for any balance owed after our payment of the Usual and Customary Charge and your payment of any applicable Cost Share.

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.

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*.

Limitations

Pediatric Dental Services Limitations

- Amalgam, silicate, acrylic, or composite restorations are limited to once per tooth surface every 24 months for the same tooth.
- Bitewing X-rays are limited to two sets once a year for a total of four bitewing X-rays per year.
- Cephalometric films are limited to once in a two-year period.
- Dental implant crown and Abutment related procedures are limited to one per Member per tooth in a seven-year period.

- Dentures, bridges, crowns (per tooth), and replacement needed due to normal wear and tear of permanent fixed or removable prosthetic devices are limited to once every five years (except resin-based partial dentures which are replaceable once every three years).
- Examination and prophylaxis (routine preventive teeth cleaning), including scaling and polishing, is limited to once every six months for Members six months of age and older.
- Examinations are limited to once every six months for Members beginning before one year of age, plus limited oral evaluations when necessary to evaluate for a specific dental problem or oral health complaint, dental emergency or referral for other treatment.
- Extraction of asymptomatic or nonpathologic third molars (wisdom teeth) is not covered unless performed in conjunction with orthodontic or periodontal treatment and prescribed by an orthodontist or periodontist.
- Fluoride treatments are limited to three times in a 12-month period for Members age six and younger; two times in a 12-month period for Members age seven and older; and three times in a 12-month period for Members receiving Medically Necessary Orthodontic Services.
- Frenulectomy or frenuloplasty is limited to Members six years of age and younger.
- Full mouth gross debridement is limited to a frequency of once every 24 months.
- "Hospital call fees," "call fees" or similar Charges associated with Dentally Necessary Services that are performed at ambulatory surgical centers or hospitals are not covered, unless the Services are provided in that setting in order to obtain Medically Necessary general anesthesia for a Member who is a child under age eight, or who is physically or mentally disabled.
- House/extended care facility calls are limited to two per facility per Participating Provider per Member.
- Indirect crowns are limited to once every five years, per tooth, for permanent anterior teeth for Members age 12 and older.
- Intraoral complete series radiographs are limited to once in a three-year period unless a panoramic X-ray for the same Member has been performed in the same three-year period.
- Occlusal intraoral X-rays are limited to once in a two-year period.
- One complete denture (upper and lower) and one replacement denture per lifetime after at least five years from the seat date.
- One resin-based partial denture, if provided at least three years after the seat date.
- Oral hygiene instruction is limited to two times in a 12-month period for Members age eight and younger, if not billed on the same day as a prophylaxis treatment.
- Panoramic X-rays are limited to once every three years.
- Periapical X-rays are not covered unless included in a complete series for diagnosis in conjunction with definitive treatment.
- Periodontal maintenance is limited to once per quadrant in a 12-month period for Members age 13 and older.
- Periodontal scaling and root planing is limited to once per quadrant in a two-year period for Members age 13 and older.
- Relines and rebases of complete or partial dentures are limited to once every 36 months, if performed at least six months from the seat date.
- Repair of implant supported prosthesis or Abutment is limited to one per tooth per Member lifetime.

- Repair or replacement needed due to normal wear and tear of interim fixed and removable prosthetic devices is limited to once every 12 months.
- Repair or replacement needed due to normal wear and tear of permanent fixed and removable prosthetic devices is limited to once every five years.
- Root canals on baby teeth are limited to primary posterior teeth only.
- Root canals on permanent teeth are limited to anterior, bicuspid, and molar teeth, excluding teeth 1, 16, 17, and 32.
- Routine fillings are limited to amalgam (silver) or glass ionomer fillings on posterior teeth and composite (tooth-colored) fillings on anterior and bicuspid teeth.
- Sealants are limited to once every three years for permanent bicuspids and molars only.
- Sedation and general anesthesia (including, but not limited to, intramuscular IV sedation, non-IV sedation, and inhalation sedation) are not covered, except when administered by an oral surgeon, periodontist or pediatric Dentist pursuant to the provisions described in the "Other Pediatric Dental Services" section, and when Medically Necessary for Members who are under age eight, developmentally or physically disabled, or those who would be at medical risk without sedation or general anesthesia.
- Stainless steel crowns are limited to:
  - Once every three years, for Members age 13 and older, for primary anterior teeth.
  - Once every three years for primary posterior teeth.
  - Once every three years for permanent posterior teeth (excluding teeth 1, 16, 17 and 32).

Adult Dental Services Limitations

- Dentures, bridges, crowns (per tooth), and replacement needed due to normal wear and tear of permanent fixed or removable prosthetic devices are limited to once every five years (except resin-based partial dentures which are replaceable once every three years).
- Examination and prophylaxis (routine preventive teeth cleaning), including scaling and polishing, is limited to two visits per Year as Dentally Necessary.
- Extraction of asymptomatic or nonpathologic third molars (wisdom teeth) is not covered unless performed in conjunction with orthodontic or periodontal treatment and prescribed by an orthodontist or periodontist.
- Full mouth gross debridement is limited to a frequency of once every 36 months.
- "Hospital call fees," "call fees" or similar Charges associated with Dentally Necessary Services that are performed at ambulatory surgical centers or hospitals are not covered, unless the Services are provided in that setting in order to obtain Medically Necessary general anesthesia for a Member who is physically or mentally disabled.
- Repair or replacement needed due to normal wear and tear of interim fixed and removable prosthetic devices is limited to once every 12 months.
- Repair or replacement needed due to normal wear and tear of permanent fixed and removable prosthetic devices is limited to once every five years.
- Routine fillings are limited to amalgam (silver) or glass ionomer fillings on posterior teeth and composite (tooth-colored) fillings on anterior and bicuspid teeth.
- Sedation and general anesthesia (including, but not limited to, intramuscular IV sedation, non-IV sedation, and inhalation sedation) are not covered, except for "nitrous oxide" as described in the "Other Adult Dental Services" section, and when Medically Necessary for Members who are developmentally or

physically disabled, as described under "Medically Necessary general anesthesia and covered dental Services in conjunction with Medically Necessary anesthesia" in the "Other Adult Dental Services" section.

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.
- Cosmetic Services, supplies, or prescription drugs that are intended primarily to improve appearance, repair, and/or replace cosmetic dental restorations.
- Dental conditions for which Service or reimbursement is required by law to be provided at or by a government agency. 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. This exclusion does not apply to Medicaid.
- 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.
- Dental Services not listed in the "Benefits" section or on the "Schedule of Covered Pediatric Dental Procedures," located at the back 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 U.S. 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.
- For Members age 19 years and older, 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.
- Full mouth reconstruction, including, but not limited to, the extensive restoration of the mouth with crowns, bridges, or implants; and occlusal rehabilitation, including crowns, bridges, or implants used for the purpose of splinting, altering vertical dimension, restoring occlusions, or correcting attrition, abrasion, or erosion.
- Genetic testing.
- Maxillofacial surgery.
- Medical or Hospital Services, unless otherwise specified in the *EOC*.
- Myofunctional therapy.
- Non-orthodontic recording of jaw movements or positions.
- Orthodontic Services, except as described in the "Medically Necessary Orthodontic Services" section.

- Orthodontic treatment of primary/transitional dentition.
- Orthognathic surgery, except this exclusion does not apply to orthognathic surgical Services performed by a Participating Dentist for treatment of a congenital anomaly such as cleft palate when the Services are required for a covered Dependent child and the Dependent is not enrolled under a Company medical plan that covers these Services.
- 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 broken orthodontic appliances.
- Replacement of lost or damaged space maintainers.
- Re-treatment of orthodontic Services cases.
- 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) disorder; treatment of 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 for Members age 19 years and older.
- Treatment of macroglossia.
- Treatment of micrognathia.
- Treatment to restore tooth structure lost due to attrition, erosion, or abrasion.
- Use of alternative materials for the removal and replacement of clinically acceptable material or restorations is not covered for any reason, except when the pathological condition of the tooth (or teeth) warrants replacement.

REDUCTIONS

Injuries or Illnesses Alleged to be Caused by Other Parties or Covered by No-Fault Insurance

This "Injuries or Illnesses Alleged to be Caused by Other Parties or Covered by No-Fault Insurance" section applies if you receive covered Services for an injury or illness alleged to be any of the following:

- Caused by another party's act or omission.
- Received on the premises of another party.
- Covered by a no-fault insurance provision.

For purposes of this section, "no-fault insurance" means a type of insurance policy that covers your dental expenses for injury or illness due to an accident, regardless of who caused the accident.

Subject to applicable law, if you obtain a settlement, award, or judgment from or on behalf of another party or insurer, or a payment under a no-fault insurance provision, you must ensure we are reimbursed for covered Services that you receive for the injury or illness, except that we will not collect to the extent that the payment would leave you less than fully compensated for your injury or illness.

This "Injuries or Illnesses Alleged to be Caused by Other Parties or Covered by No-Fault Insurance" section does not affect your obligation to pay any applicable Cost Share for these covered Services. The amount of reimbursement due to the Plan is not limited by or subject to the Out-of-Pocket Maximum provision.

If you do not recover anything from or on behalf of the other party, or no-fault insurance, then you are responsible only for any applicable Cost Share.

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 another 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 another 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, award, or settlement you or we (when we subrogate) obtain against another party or any other insurer, regardless of how those proceeds may be characterized or designated. The proceeds that are subject to our lien include any judgment, award, or settlement that you obtain.

Within 30 days after submitting or filing a claim or legal action against another party, or any insurer, you must send written notice of the claim or legal action to us at:

Equian, LLC
Attn: Subrogation Operations
P.O. Box 36380
Louisville, KY 40233
Fax: 502-214-1291

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

You must provide us written notice before you settle a claim or obtain a judgment or award, or if it appears you will make a recovery of any kind. Subject to applicable law, if you recover any amounts from another party or any other insurer based on your injury or illness, you must pay us after you are reimbursed the total amount of the actual losses and damages you incurred. Sufficient funds to satisfy our claims must be held in a specifically identifiable account until our claims are resolved. Pending final resolution of our claims, you must retain control over the recovered amounts to which we may assert a right.

If reasonable collections costs have been incurred by your attorney in connection with obtaining recovery, we will reduce the amount of our claim by the amount of an equitable apportionment of the collection costs between us and you. This reduction will be made only if:

- We receive a list of the fees and associated costs before settlement, and
- Your attorney's actions were directly related to securing a recovery for you.

If your estate, parent, guardian, or conservator asserts a claim against another party or any insurer based on your injury or illness, your estate, parent, guardian, or conservator, and any settlement, award, 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 other party. We may assign our rights to enforce our liens and other rights.

Workers' Compensation or Employer's Liability

If you suffer from an injury or illness that is compensable under a workers' compensation or employer's liability law, we will provide Services even if it is unclear whether you are entitled to a payment or settlement

under the law. You have an obligation to reimburse us to the extent of a payment or any other benefit, including any amount you receive as a settlement under the law.

In addition, we or our Participating Providers will be permitted to seek reimbursement for these Services directly from the responsible employer or the government agency that administers the law.

GRIEVANCES, CLAIMS, AND APPEALS

Terms We Use in This Section

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 includes:
  - Any decision by our utilization review organization that a request for a benefit under our Plan does not meet our requirements for dental necessity, appropriateness, dental care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part for the benefit;
  - The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by us or our designated utilization review organization regarding a covered person's eligibility to participate in our dental benefit Plan; or
  - Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment in whole or in part for a benefit.
- An appeal is a request for us to review our initial adverse benefit determination.

Grievance 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 Dentist or another member of your dental care team. If you are not satisfied with your Dentist, you may request another. Contact Member Services for assistance. You always have the right to a second opinion from a qualified Dentist at the applicable Cost Share.

A grievance is a written complaint submitted by or on behalf of a covered person regarding Service delivery issues other than denial of payment for dental Services or nonprovision of Services, including dissatisfaction with dental care, waiting time for Services, provider or staff attitude or demeanor, or dissatisfaction with Service provided by the dental carrier.

If you are not satisfied with the Services received at a particular 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:

- Call Member Services; or

- Send 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 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.

Grievance determinations are not adverse benefit determinations. There is not an appeal process for grievance determinations.

We want you to be satisfied with our dental offices, Services, and 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.

While we encourage you to use our grievance procedure, you have the right to contact Washington's designated ombudsman's office, the Washington State Office of the Insurance Commissioner, for assistance with questions and complaints. Contact them by mail, telephone or online at:

Office of the Insurance Commissioner, Consumer Protection Division
P.O. Box 40256
Olympia, WA 98504
1-800-562-6900
www.insurance.wa.gov

Language and Translation Assistance

If we send you a grievance or adverse benefit determination correspondence, we will include a notice of language assistance (oral translation). You may request language assistance with your claim and/or appeal by calling 1-800-324-8010. 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 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 seek assistance from the Office of the Insurance Commissioner. Contact them by mail, telephone, or online at:

Office of the Insurance Commissioner, Consumer Protection Division
P.O. Box 40256
Olympia, WA 98504
1-800-562-6900
www.insurance.wa.gov

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.

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 mail or fax all additional information to:

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

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

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

To arrange to give testimony by telephone, you should contact Member Services.

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

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

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 they be the subordinate of someone who did participate in our original decision.

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

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.

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

Non-Urgent 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 may email your request to us at **https://healthy.kaiserpermanente.org/oregon-washington/support**, call Member Services, mail, or fax your claim to us at:

  Kaiser Foundation Health Plan of the Northwest
  Attn: Utilization Management
  500 N.E. Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 1-877-899-4972

- 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 no later than five calendar days after we receive your claim.

  If more information is needed to make a decision, we will ask you for the information before the initial decision period ends, and we will give you 45 calendar days to send the information.

We will make a decision and send notification within 15 calendar days after we receive the first piece of information (including documents) we requested, or by the deadline for receiving the information, whichever is sooner.

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.

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

Urgent Pre-service Claim

- 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 no later than two calendar days after we receive your claim.

  Within one calendar day after we receive your claim, we may ask you for more information.

- If more information is needed to make a decision, we will give you seven calendar days to send the information.

  We will notify you of our decision within 48 hours of receiving the first piece of requested information or by the deadline for receiving the information, whichever is sooner.

  If we notify you of our decision orally, we will send you, and if applicable, your provider, written confirmation within three calendar 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 calendar 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 call Member Services, 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 72 hours 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 14 calendar days after we receive your appeal, unless you are notified that additional time is needed to complete the review. The extension will not delay the decision beyond 30 calendar days without your consent.

- 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 call Member Services, 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 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 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 72 hours after the decision is made.
- 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, which are all considered urgent, 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.

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 an urgent concurrent care claim 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 call Member Services, mail, or fax your claim to us at:

  Kaiser Foundation Health Plan of the Northwest
  Attn: Utilization Management
  500 N.E. Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 1-877-899-4972

- We will notify you of our decision orally or in writing as soon as your clinical condition requires, but no later than 24 hours after we received your claim. If we notify you of our decision orally, we will send you, and if applicable, your provider, written confirmation within three calendar 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.

Concurrent Care Appeal

- Within 180 calendar 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 call Member Services, 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 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 72 hours after the decision is made.
- If we deny your appeal, our adverse benefit determination decision 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, including dental records.

  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 Foundation Health Plan of the Northwest
  National Claims Administration – Northwest
  PO Box 370050
  Denver, CO 80237-9998

  We will not accept or pay for claims received from you after 12 months from the date of Service, 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 calendar days after we receive your claim.

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

  If more information is needed to make a decision, we will ask you for the information in writing before the initial decision period ends, and we will give you 45 calendar days to send us the information.

  We will make a decision within 15 calendar 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 calendar days after we send our request, we will make a decision based on the information we have within 15 calendar days following the end of the 45 calendar days.

- 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 calendar 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 call Member Services, 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 72 hours 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 14 calendar days after we receive your appeal. We may extend the time for making a decision on your appeal for up to an additional 16 calendar days if there is good cause.
- If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal.

Appeals of Retroactive Membership Termination (Rescission)

We may terminate your membership retroactively (see "Rescission of Membership" in the "Termination of Membership" section). We will send you written notice at least 30 calendar days prior to the termination. If you have general questions about retroactive membership terminations or appeals, please call Member Services.

Here is the procedure for filing an appeal of a retroactive membership termination:

Appeal of Retroactive Membership Termination

- Within 180 calendar days after you receive our adverse benefit determination that your membership will be terminated retroactively, you must tell us, in writing, that you want to appeal our termination of your membership retroactively. Please include the following:

  (1) Your name and health record number;

  (2) All of the reasons why you disagree with our retroactive membership termination; and

  (3) All supporting documents.

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

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

Experimental or Investigational Determination and Appeal

Decisions on appeals about experimental or investigational Services will be communicated in writing within 20 days of receipt of a fully documented request, unless you consent in writing to an extension of time. Appeals that meet the criteria for an urgent appeal, as described in the "Urgent Pre-service Appeal" section, will be expedited to meet the clinical urgency of the situation, not to exceed 72 hours.

If, on appeal, the decision to deny Services is upheld, the final decision will specify (i) the title, specialty, and professional qualifications of the individual(s) who made the final decision and (ii) the basis for the final decision.

TERMINATION OF MEMBERSHIP

Membership continues from month to month subject to payment of applicable Premium. If your membership terminates, all rights to benefits end at 11:59 p.m. PT on the termination date. In addition, Dependents' memberships end at the same time the Subscriber's 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, except as provided under "Payments after Termination" in this "Termination of Membership" section.

If your membership is terminated, you have the right to file an appeal. For more information, please contact Member Services.

How You May Terminate Your Membership

You may terminate your membership by notifying Washington Healthplanfinder at **wahealthplanfinder.org**. Your requested termination date may be as early as the date you submit your notice. Your membership will terminate at 11:59 p.m. PT on the date determined by Washington Healthplanfinder.

Termination Due to Loss of Eligibility

You must immediately report to Washington Healthplanfinder any changes that affect eligibility status, such as moving out of our Service Area, a Spouse's loss of eligibility due to divorce, or a Dependent child who has reached the Dependent Limiting Age. If you meet the eligibility requirements under "Who Is Eligible" in the "Premium, Eligibility, and Enrollment" section on the first day of a month, but later in that month you no longer meet those eligibility requirements, your membership will end at 11:59 p.m. PT on the last day of that

month. For example, if you first became ineligible on January 5, your termination date would be January 31, and your last minute of coverage would be 11:59 p.m. PT on January 31.

Termination for Cause

If you or any other Member in your Family is proven to have committed one of the following acts, we may terminate your membership under the *EOC* by sending written notice, including the specific reason for termination with supporting evidence, to the Subscriber at least 31 days before the membership termination date:

- Commission of a fraudulent act against us.
- Making an intentional misrepresentation of material fact in connection with this coverage.

Examples. We would consider the following acts as fraudulent:

- Intentionally presenting an invalid prescription or dental order for Services.
- Intentionally letting someone else use your ID card to obtain Services while pretending to be you.

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

Termination for Nonpayment of Premium

If we do not receive the applicable Premium on or before the Premium Due Date, we will mail a notice of nonpayment to the Subscriber about the failure to make a timely Premium payment in full and the grace period required by applicable law. The grace period is the time frame in which the overdue Premium must be paid to avoid termination, as required by applicable law. The grace period will not be less than 10 days and will start on the day after the Premium Due Date.

The notice of nonpayment will contain information about the date on which coverage will terminate if all Premium payments owed by the end of the grace period are not paid. During the grace period, coverage will continue in force if, and for the period, required by applicable law. We will mail the notice not less than 10 days before the end of the grace period.

If we do not receive full payment of all outstanding Premiums (including any Premiums for the grace period) on or before the last day of the grace period, we may terminate your membership retroactively (as of 11:59 p.m. PT of the Premium Due Date). We will mail a notice to the Subscriber confirming the date on which the memberships of the Subscriber and any Dependents terminated. Membership ends at 11:59 p.m. PT on the date indicated in the notice.

If we receive advance payment of the premium tax credit on your behalf and we do not receive your portion of the monthly Premium by the Premium Due Date, we will provide a three-month grace period if we receive or will receive advance payment of the premium tax credit on your behalf for the month for which we do not receive your portion of the Premium by the Premium Due Date.

We will send written notice stating when the grace period begins. We will pay for covered Services you receive during the first month of the grace period. If we do not receive your portion of all outstanding Premium (including any Premium for the grace period months that are already due on the date you make your payment) by the end of the grace period, we may terminate your membership so that it ends at 11:59 p.m. PT on the last day of the first month of the grace period.

You will be responsible for paying Company or providers, as applicable, for any Services received after the termination of your coverage.

If your coverage is terminated for nonpayment of Premium, you will not be entitled to a special enrollment period and we may require payment of any outstanding Premiums, as permitted by applicable law.

Payments after Termination

If we terminate your membership for cause or nonpayment of Premium, we will:

- Refund any amounts we owe the Subscriber 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.
- Deduct any amounts you owe Company, Participating Providers, or Participating Dental Offices from any payment we make.

Rescission of Membership

We may rescind your membership after it becomes effective (completely cancel your membership so that no membership ever existed) if we determine you or anyone seeking membership on your behalf did any of the following before your membership became effective:

- Performed an act, practice, or omission that constitutes fraud in connection with your enrollment or enrollment application.
- Made an intentional misrepresentation of material fact in connection with your enrollment or enrollment application, such as intentionally omitting a material fact.
- Intentionally failed to inform us of changes to the information in your enrollment application.

We will send written notice to the Subscriber at least 30 days before we rescind your membership, but the rescission will completely cancel your membership so that no membership ever existed. We will explain the basis for our decision and how you can appeal this decision. You will be required to pay as a non-member for any Services we covered. Within 30 days, we will refund all applicable Premium except that we may subtract any amounts you owe us. You will be ineligible to re-apply for membership until the next open enrollment period.

Termination of a Plan

We may terminate your membership if we discontinue offering this Kaiser Permanente Individuals and Families Dental Plan as permitted by law. If we continue to offer other non-group plans in a market, we may terminate your membership under this plan by sending written notice to the Subscriber.

We may modify this Kaiser Permanente Individuals and Families Dental Plan at the time of renewal. This modification is not considered a non-renewal of a plan.

MISCELLANEOUS PROVISIONS

Administration of *EOC*

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

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

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

EOC 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*.

Exercise of Conscience

We recognize the right to exercise religious beliefs and conscience. If a Participating Provider or Participating Dental Office declines to provide a covered Service for reasons of conscience or religion, we will make arrangements to provide the covered Services.

Governing Law

Except as preempted by federal law, this *EOC* will be governed in accord with Washington 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*.

Litigation Venue

Venue for all litigation between you and Company shall lie in Clark County, Washington.

No Waiver

Our failure to enforce any provision of this *EOC* will not constitute a waiver of that or any other provision, nor will it 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 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

In the event of unusual circumstances that delay or render impractical the provision of Services, such as major disaster, epidemic, war, riot, civil insurrection, labor disputes, disability of a large share of personnel at Participating Dental Offices, and complete or partial destruction of Participating Dental Office facilities, we will make a good faith effort to provide or arrange for covered Services within the limitations of available personnel and facilities. Kaiser Permanente shall have no other liability or obligation if covered Services are delayed or unavailable due to unusual circumstances.

SCHEDULE OF COVERED PEDIATRIC DENTAL PROCEDURES

Code	Description
D0120	Periodic oral exam
D0140	Limited oral evaluation – problem focused
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver
D0150	Comprehensive oral evaluation – new or established patient
D0160	Detailed and extensive oral evaluation, problem focused – by report
D0170	Re-evaluation – limited, problem focused (established patient, not post-operative visit)
D0180	Comprehensive periodontal evaluation
D0190	Screening of patient
D0191	Assessment of patient
D0210	Intraoral – complete series of radiographic images
D0220	Intraoral – periapical, first radiographic image
D0230	Intraoral – periapical, each additional radiographic image
D0240	Intraoral – occlusal radiographic image
D0250	Extraoral – 2D projection radiographic image created using a stationary radiation source and detector
D0251	Extraoral posterior dental radiographic image
D0270	Bitewing – single radiographic image
D0272	Bitewings – two radiographic images
D0273	Bitewings – three radiographic images
D0274	Bitewings – four radiographic images
D0277	Vertical bitewings – 7 to 8 radiographic images

Code	Description
D0330	Panoramic radiographic image
D0340	2D cephalometric radiographic image – acquisition, measurement, and analysis
D0350	Oral/facial photographic images
D0364	Cone beam CT capture and interpretation, limited field of view, less than one whole jaw
D0365	Cone beam CT capture and interpretation, view of one full dental arch – mandible
D0366	Cone beam CT capture and interpretation, view of one full dental arch – maxilla
D0367	Cone beam CT capture and interpretation, view of both jaws
D0368	Cone beam CT capture and interpretation, for TMJ series
D0380	Cone beam CT image capture, limited field of view, less than one whole jaw
D0381	Cone beam CT image capture, view of one full dental arch – mandible
D0382	Cone beam CT image capture, view of one full dental arch – maxilla
D0383	Cone beam CT image capture, view of both jaws
D0384	Cone beam CT image capture, for TMJ series including 2 or more exposures
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report
D0460	Pulp vitality tests
D0470	Diagnostic casts
D0601	Caries risk assessment and documentation, with a finding of low risk
D0602	Caries risk assessment and documentation, with a finding of moderate risk
D0603	Caries risk assessment and documentation, with a finding of high risk
D0604	Antigen testing for a public health related pathogen including coronavirus
D0701	Panoramic radiographic image – image capture only
D0702	2D cephalometric radiographic image – image capture only
D0703	2D cephalometric radiographic image obtained intra-orally or extra-orally – image capture only
D0705	Extra-oral posterior dental radiographic image – image capture only
D0706	Intraoral occlusal radiographic image – image capture only
D0707	Intraoral periapical radiographic image – image capture only
D0708	Intraoral bitewing radiographic image – image capture only
D0709	Intraoral complete series of radiographic images – image capture only
D0801	3D dental surface scan – direct
D0802	3D dental surface scan – indirect; surface scan of a diagnostic cast
D0803	3D facial surface scan – direct
D0804	3D facial surface scan – indirect; surface scan of constructed facial features
D1110	Prophylaxis – adult

Code	Description
D1120	Prophylaxis – child
D1206	Topical application of fluoride varnish
D1208	Topical application of fluoride
D1310	Nutritional counseling for control of dental disease
D1320	Tobacco counseling for the control and prevention of oral disease
D1321	Counseling for the control & prevention of adverse oral, behavioral & systemic health effects associated with high-risk substance use
D1330	Oral hygiene instruction
D1351	Sealant – per tooth
D1352	Preventive resin restoration in a moderate to high caries risk patient, permanent tooth
D1353	Sealant repair – per tooth
D1354	Interim caries arresting medicament application
D1355	Caries preventive medicament application, per tooth
D1510	Space maintainer – fixed unilateral
D1516	Space maintainer – fixed bilateral – maxillary
D1517	Space maintainer – fixed bilateral – mandibular
D1520	Space maintainer – removable unilateral
D1526	Space maintainer – removable bilateral – maxillary
D1527	Space maintainer – removable bilateral – mandibular
D1551	Re-cement or re-bond bilateral space maintainer – maxillary
D1552	Re-cement or re-bond bilateral space maintainer – mandibular
D1553	Re-cement or re-bond bilateral space maintainer – per quadrant
D1556	Removal of fixed unilateral space maintainer – per quadrant
D1557	Removal of fixed bilateral space maintainer – maxillary
D1558	Removal of fixed bilateral space maintainer – mandibular
D1575	Distal shoe space maintainer – fixed-unilateral
D2140	Amalgam – one surface, primary or permanent
D2150	Amalgam – two surfaces, primary or permanent
D2160	Amalgam – three surfaces, primary or permanent
D2161	Amalgam – four or more surfaces, primary or permanent
D2330	Resin-based composite – one surface, anterior
D2331	Resin-based composite – two surfaces, anterior
D2332	Resin-based composite – three surfaces, anterior
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)

Code	Description
D2390	Resin-based composite crown, anterior
D2391	Resin-based composite – one surface, posterior
D2392	Resin-based composite – two surfaces, posterior
D2393	Resin-based composite – three surfaces, posterior
D2394	Resin-based composite – four or more surfaces, posterior
D2510	Inlay – metallic, one surface
D2520	Inlay – metallic, two surfaces
D2530	Inlay – metallic, three or more surfaces
D2542	Onlay – metallic, two surfaces
D2543	Onlay – metallic, three surfaces
D2544	Onlay – metallic, four or more surfaces
D2610	Inlay – porcelain/ceramic, one surface
D2620	Inlay – porcelain/ceramic, two surfaces
D2630	Inlay – porcelain/ceramic, three or more surfaces
D2642	Onlay – porcelain/ceramic, two surfaces
D2643	Onlay – porcelain/ceramic, three surfaces
D2644	Onlay – porcelain/ceramic, four or more surfaces
D2650	Inlay – resin-based composite, one surface
D2651	Inlay – resin-based composite, two surfaces
D2652	Inlay – resin-based composite, three or more surfaces
D2662	Onlay – resin-based composite, two surfaces
D2663	Onlay – resin-based composite, three surfaces
D2664	Onlay – resin-based composite, four or more surfaces
D2710	Crown – resin-based composite (indirect)
D2712	Crown – ¾ resin-based composite (indirect)
D2720	Crown – resin with high noble metal
D2721	Crown – resin with predominantly base metal
D2722	Crown – resin with noble metal
D2740	Crown – porcelain/ceramic substrate
D2750	Crown – porcelain fused to high noble metal
D2751	Crown – porcelain fused to predominantly base metal
D2752	Crown – porcelain fused to noble metal
D2753	Crown – porcelain fused to titanium and titanium alloys

Code	Description
D2780	Crown – ¾ cast to high noble metal
D2781	Crown – ¾ cast to predominantly base metal
D2782	Crown – ¾ cast noble metal
D2783	Crown – ¾ porcelain/ceramic (does not include facial veneers)
D2790	Crown – full cast high noble metal
D2791	Crown – full cast predominantly base metal
D2792	Crown – full cast noble metal
D2794	Crown – titanium
D2799	Provisional crown (not a temporary crown)
D2910	Recement inlay, onlay, or partial coverage restoration
D2915	Recement cast or prefabricated post and core
D2920	Recement crown
D2921	Reattachment of tooth fragment, incisal edge or cusp
D2928	Prefabricated porcelain/ceramic crown – permanent tooth
D2929	Prefabricated porcelain/ceramic crown – primary tooth
D2930	Prefabricated stainless steel crown – primary tooth
D2931	Prefabricated stainless steel crown – permanent tooth
D2932	Prefabricated resin crown
D2933	Prefabricated stainless steel crown with resin window
D2934	Prefabricated aesthetic coated stainless steel crown – primary
D2940	Protective restoration
D2941	Interim therapeutic restoration – primary dentition
D2949	Restorative foundation for an indirect restoration
D2950	Core build-up, including any pins
D2951	Pin retention/tooth, in addition to restoration
D2952	Cast post and core in addition to crown, indirectly fabricated
D2953	Each additional indirectly fabricated cast post – same tooth
D2954	Prefabricated post and core in addition to crown
D2955	Post removal
D2957	Each additional prefabricated post – same tooth
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework. This procedure is in addition to the separate crown procedure documented with its own code.
D2975	Coping
D2980	Crown repair necessitated by restorative material failure

Code	Description
D2981	Inlay repair necessitated by restorative material failure
D2982	Onlay repair necessitated by restorative material failure
D2990	Resin infiltration of incipient smooth surface lesions
D3110	Pulp cap – direct (excluding final restoration)
D3120	Pulp cap – indirect (excluding final restoration)
D3220	Therapeutic pulpotomy (excluding final restoration)
D3221	Gross pulpal debridement
D3222	Partial pulpotomy for apexogenesis
D3230	Pulpal therapy resorbable filling – anterior primary tooth (excluding final restoration)
D3240	Pulpal therapy resorbable filling – posterior primary tooth (excluding final restoration)
D3310	Root canal – anterior (excluding final restoration)
D3320	Root canal – bicuspid (excluding final restoration)
D3330	Root canal – molar (excluding final restoration)
D3331	Treatment of root canal obstruction – non-surgical access
D3332	Incomplete root canal therapy – inoperable, unrestorable, or fractured tooth
D3333	Internal root repair of perforation defects
D3346	Re-treatment previous root canal therapy – anterior
D3347	Re-treatment previous root canal therapy – bicuspid
D3348	Re-treatment previous root canal therapy – molar
D3351	Apexification/recalcification – initial visit
D3352	Apexification/recalcification – interim medication replacement
D3353	Apexification/recalcification – final visit
D3355	Pulpal regeneration – initial visit
D3356	Pulpal regeneration – interim medication replacement
D3357	Pulpal regeneration – completion of treatment
D3410	Apicoectomy – anterior
D3421	Apicoectomy – bicuspid (first root)
D3425	Apicoectomy – molar (first root)
D3426	Apicoectomy (each additional root)
D3428	Bone graft in conjunction with periradicular surgery – per tooth, single site
D3429	Bone graft in conjunction with periradicular surgery – each additional contiguous tooth in same surgical site
D3430	Retrograde filling – per root

Code	Description
D3431	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery
D3432	Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery
D3450	Root amputation – per root
D3470	Intentional reimplantation (including necessary splinting)
D3471	Surgical repair of root resorption – anterior
D3472	Surgical repair of root resorption – premolar
D3473	Surgical repair of root resorption – molar
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar
D3910	Surgical procedure for isolation of tooth with rubber dam
D3911	Intraorifice barrier
D3920	Hemisection – including root removal, not including root canal
D3921	Decoronation or submergence of an erupted tooth
D3950	Canal preparation and fitting of preformed dowel or post
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant
D4245	Apically positioned flap
D4249	Clinical crown lengthening – hard tissue
D4260	Osseous surgery (including flap entry/closure) – four or more contiguous teeth or tooth bounded spaces per quadrant
D4261	Osseous surgery (including flap entry/closure) – one to three contiguous teeth or tooth bounded spaces per quadrant
D4263	Bone replacement graft – first site in quadrant
D4264	Bone replacement graft – each additional site in quadrant
D4266	Guided tissue regeneration – resorbable barrier per site
D4267	Guided tissue regeneration – nonresorbable barrier per site (includes membrane removal)
D4268	Surgical revision procedure, per tooth

Code	Description
D4270	Pedicle soft tissue graft procedure
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)
D4275	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) first tooth, implant, or edentulous tooth position in graft
D4276	Combined connective tissue and pedicle graft, per tooth
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth or edentulous tooth position in graft
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth or edentulous tooth position in same graft site
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites), each additional contiguous tooth, implant or edentulous tooth position in same graft site
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material), each additional contiguous tooth, implant or edentulous tooth position in same graft site
D4341	Periodontal scaling and root planing – four or more teeth per quadrant
D4342	Periodontal scaling & root planing – one to three teeth per quadrant
D4346	Scaling moderate or severe gingival inflammation – full mouth, after oral evaluation
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth
D4910	Periodontal maintenance (following active therapy)
D4920	Unscheduled dressing change (not by treating dentist)
D4921	Gingival irrigation – per quadrant
D5110	Complete denture – maxillary
D5120	Complete denture – mandibular
D5130	Immediate denture – maxillary
D5140	Immediate denture – mandibular
D5211	Maxillary partial denture – resin base (including any clasps, rests, and teeth)
D5212	Mandibular partial denture – resin base (including any clasps, rests, and teeth)
D5213	Maxillary partial denture – metal frame with resin base (including any clasps, rests, and teeth)
D5214	Mandibular partial denture – metal frame with resin base (including any clasps, rests, and teeth)
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)
D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)

Code	Description
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5225	Maxillary partial denture – flexible base (including any clasps, rests, and teeth)
D5226	Mandibular partial denture – flexible base (including any clasps, rests, and teeth)
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)
D5410	Adjust complete denture – maxillary
D5411	Adjust complete denture – mandibular
D5421	Adjust partial denture – maxillary
D5422	Adjust partial denture – mandibular
D5511	Repair broken complete denture base – mandibular
D5512	Repair broken complete denture base – maxillary
D5520	Replace miss/broken teeth – complete denture (each tooth)
D5611	Repair resin partial denture base – mandibular
D5612	Repair resin partial denture base – maxillary
D5621	Repair cast partial framework – mandibular
D5622	Repair cast partial framework – maxillary
D5630	Repair or replace broken clasp, per tooth
D5640	Replace broken teeth – per tooth, partial denture
D5650	Add tooth to existing partial denture
D5660	Add clasp to existing partial denture, per tooth
D5670	Replace all teeth & acrylic – cast metal frame, maxillary
D5671	Replace all teeth & acrylic – cast metal frame, mandibular
D5710	Rebase complete maxillary denture
D5711	Rebase complete mandibular denture
D5720	Rebase maxillary partial denture
D5721	Rebase mandibular partial denture
D5725	Rebase hybrid prosthesis
D5730	Reline complete maxillary denture (chairside)
D5731	Reline complete mandibular denture (chairside)
D5740	Reline maxillary partial denture (chairside)
D5741	Reline mandibular partial denture (chairside)

Code	Description
D5750	Reline complete maxillary denture (laboratory)
D5751	Reline compete mandibular denture (laboratory)
D5760	Reline maxillary partial denture (laboratory)
D5761	Reline mandibular partial denture (laboratory)
D5765	Soft liner for complete or partial removable denture – indirect
D5810	Interim complete denture – maxillary
D5811	Interim complete denture – mandibular
D5820	Interim partial denture – maxillary
D5821	Interim partial denture – mandibular
D5850	Tissue conditioning – maxillary
D5851	Tissue conditioning – mandibular
D5863	Overdenture – complete maxillary
D5864	Overdenture – partial maxillary
D5865	Overdenture – complete mandibular
D5866	Overdenture – partial mandibular
D5875	Modification of removable prosthesis following implant surgery
D5876	Add metal substructure to acrylic full denture, per arch
D5899	Unspecified removable prosthetic procedure, by report
D5986	Fluoride gel carrier
D6051	Interim implant abutment – includes placement and removal. a healing cap is not an interim abutment.
D6056	Prefabricated abutment – includes modification and placement
D6057	Custom fabricated abutment – includes placement
D6058	Abutment supported porcelain/ceramic crown
D6059	Abutment supported porcelain fused to metal crown, high noble metal
D6061	Abutment supported porcelain fused to metal crown, noble metal
D6062	Abutment supported cast metal crown, high noble metal
D6064	Abutment supported cast metal crown, noble metal
D6065	Implant supported porcelain/ceramic crown
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)
D6068	Abutment supported retainer for porcelain/ceramic fixed partial denture
D6069	Abutment supported retainer for porcelain fused to metal fixed partial denture, high noble metal
D6071	Abutment supported retainer for porcelain fused to metal fixed partial denture, noble metal

Code	Description
D6072	Abutment supported retainer for cast metal fixed partial denture, high noble metal
D6074	Abutment supported retainer for cast metal fixed partial denture, noble metal
D6075	Implant supported retainer for ceramic fixed partial denture
D6076	Implant supported retainer for porcelain fused to metal fixed partial denture (titanium, titanium alloy, or high noble metal)
D6077	Implant supported retainer for cast metal fixed partial denture (titanium, titanium alloy, or high noble metal)
D6090	Repair implant supported prosthesis, by report
D6094	Abutment supported crown – titanium
D6095	Repair implant abutment, by report
D6096	Remove broken implant retaining screw
D6097	Abutment supported crown – porcelain fused to titanium and titanium alloys
D6098	Implant supported retainer – porcelain fused to predominantly base alloys
D6099	Implant supported retainer for FPD – porcelain fused to noble alloys
D6100	Surgical removal of implant body
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure
D6103	Bone graft for repair of peri-implant defect – does not include flap entry and closure; placement of a barrier membrane or biologic materials to aid in osseous regeneration, are reported separately
D6104	Bone graft at time of implant placement; placement of a barrier membrane, or biologic materials to aid in osseous regeneration are reported separately
D6110	Implant /abutment supported removable denture for edentulous arch – maxillary
D6111	Implant /abutment supported removable denture for edentulous arch – mandibular
D6112	Implant /abutment supported removable denture for partially edentulous arch – maxillary
D6113	Implant /abutment supported removable denture for partially edentulous arch – mandibular
D6114	Implant/abutment supported fixed denture for completely edentulous arch – maxillary
D6115	Implant/abutment supported fixed denture for completely edentulous arch – mandibular
D6116	Implant/abutment supported fixed denture for partially edentulous arch – maxillary
D6117	Implant/abutment supported fixed denture for partially edentulous arch – mandibular
D6118	Implant/abutment supported interim fixed denture for edentulous arch – mandibular
D6119	Implant/abutment supported interim fixed denture for edentulous arch – maxillary
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys
D6121	Implant supported retainer for metal FPD – predominantly base alloys

Code	Description
D6122	Implant supported retainer for metal FPD – noble alloys
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys
D6190	Radiographic/surgical implant index, by report
D6191	Semi-precision abutment – placement; this procedure is the initial placement, or replacement, of a semi-precision abutment on the implant body.
D6192	Semi-precision attachment – placement; this procedure involves the luting of the initial, or replacement, semi-precision attachment to the removable prosthesis.
D6194	Abutment supported retainer crown for FPD – titanium
D6195	Abutment supported retainer – porcelain fused to titanium and titanium alloys
D6198	Remove interim implant component
D6199	Unspecified implant procedure, by report
D6205	Pontic – indirect resin based composite
D6210	Pontic – cast high noble metal
D6211	Pontic – cast predominantly base metal
D6212	Pontic – cast noble metal
D6214	Pontic – titanium
D6240	Pontic – porcelain fused to high noble metal
D6241	Pontic – porcelain fused to predominantly base metal
D6242	Pontic – porcelain fused to noble metal
D6243	Pontic – porcelain fused to titanium and titanium alloys
D6245	Pontic – porcelain/ceramic
D6250	Pontic – resin with high noble metal
D6251	Pontic – resin with predominantly base metal
D6252	Pontic – resin with noble metal
D6253	Provisional pontic (not temporary)
D6545	Retainer – cast metal for resin bonded fixed prosthesis
D6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis
D6549	Retainer – for resin bonded fixed prosthesis
D6600	Retainer inlay – porcelain/ceramic, two surfaces
D6601	Retainer inlay – porcelain/ceramic, three or more surfaces
D6602	Retainer inlay – cast high noble metal, two surfaces
D6603	Retainer inlay – cast high noble metal, three or more surfaces
D6604	Retainer inlay – cast predominantly base metal, two surfaces
D6605	Retainer inlay – cast predominantly base metal, three or more surfaces

Code	Description
D6606	Retainer inlay – cast noble metal, two surfaces
D6607	Retainer inlay – cast noble metal, three or more surfaces
D6608	Retainer onlay – porcelain/ceramic, two surfaces
D6609	Retainer onlay – porcelain/ceramic, three or more surfaces
D6610	Retainer onlay – cast high noble metal, two surfaces
D6611	Retainer onlay – cast high noble metal, three or more surfaces
D6612	Retainer onlay – cast predominantly base metal, two surfaces
D6613	Retainer onlay – cast predominantly base metal, three or more surfaces
D6614	Retainer onlay – cast noble metal, two surfaces
D6615	Retainer onlay – cast noble metal, three or more surfaces
D6624	Retainer inlay – titanium
D6634	Retainer onlay – titanium
D6710	Retainer crown – retainer – indirect resin based composite
D6720	Retainer crown – bridge retainer – resin with high noble metal
D6721	Retainer crown – bridge retainer – resin predominantly base metal
D6722	Retainer crown – resin with noble metal
D6740	Retainer crown – retainer – porcelain/ceramic
D6750	Retainer crown – retainer – porcelain fused to high noble metal
D6751	Retainer crown – retainer – porcelain fused to predominantly base metal
D6752	Retainer crown – retainer – porcelain fused to noble metal
D6753	Retainer crown – porcelain fused to titanium and titanium alloys
D6780	Retainer crown – retainer ¾ cast high noble metal
D6781	Retainer crown – retainer ¾ predominantly base metal
D6782	Retainer crown – retainer ¾ cast noble metal
D6783	Retainer crown – retainer ¾ porcelain/ceramic
D6784	Retainer crown ¾ – titanium and titanium alloys
D6790	Retainer crown – retainer – full cast high noble metal
D6791	Retainer crown – retainer – full cast predominantly base metal
D6792	Retainer crown – retainer – full cast noble metal
D6793	Provisional retainer crown (not temporary)
D6794	Retainer crown – retainer – titanium
D6920	Connector bar
D6930	Recement fixed partial denture

Code	Description
D6940	Stress breaker
D6950	Precision attachment
D6980	Fixed partial denture repair, necessitated by restorative material failure
D6985	Pediatric partial denture, fixed
D7111	Extraction, coronal remnants – deciduous tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Surgical removal of erupted tooth
D7220	Removal of impacted tooth – soft tissue
D7230	Removal of impacted tooth – partially bony
D7240	Removal of impacted tooth – completely bony
D7241	Removal of impacted tooth – completely bony with unusual complications
D7250	Surgical removal of residual tooth roots (cutting procedure)
D7251	Coronectomy – intentional partial tooth removal
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7270	Reimplantation or stabilization of accidentally evulsed or displaced tooth
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)
D7280	Surgical access of an unerupted tooth
D7282	Mobilization of erupted or malpositioned tooth to aid eruption; not in conjunction with extraction
D7283	Placement of device to facilitate eruption of impacted tooth
D7285	Biopsy of oral tissue – hard (bone, tooth)
D7286	Biopsy of oral tissue – soft
D7287	Exfoliative cytological sample collection
D7288	Brush biopsy – transepithelial sample collection
D7292	Placement of temporary anchorage device (screw retained plate) requiring flap
D7293	Placement of temporary anchorage device requiring flap
D7294	Placement of temporary anchorage device without flap
D7298	Removal of temporary anchorage device (screw retained plate), requiring flap
D7299	Removal of temporary anchorage device, requiring flap
D7300	Removal of temporary anchorage device without flap
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces per quadrant
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant

Code	Description
D7320	Alveoloplasty not in conjunction with extractions –four or more teeth or tooth spaces, per quadrant; no extractions performed in an edentulous area
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant; no extractions performed in an edentulous area
D7340	Vestibuloplasty – ridge extension (secondary epithelization)
D7350	Vestibuloplasty – ridge extension
D7410	Excision of benign tumor lesion up to 1.25 cm
D7411	Excision of benign lesion greater than 1.25 cm
D7412	Excision of benign lesion, complicated
D7413	Excision malignant lesion up to 1.25 cm
D7414	Excision malignant lesion greater than 1.25 cm
D7415	Excision malignant lesion, complicated
D7440	Excision malignant tumor – lesion up to 1.25 cm
D7441	Excision malignant tumor – lesion greater than 1.25 cm
D7450	Removal of odontogenic cyst/tumor/lesion up to 1.25 cm
D7451	Removal of odontogenic cyst/tumor/lesion greater than 1.25 cm
D7460	Removal of nonodontogenic cyst/tumor/lesion up to 1.25 cm
D7461	Removal of benign nonodontogenic cyst or tumor – lesion greater than 1.25 cm
D7465	Lesion destruction
D7471	Removal of lateral exostosis (maxilla or mandible)
D7472	Removal of torus palatinus
D7473	Removal of torus mandibularis
D7485	Surgical reduction of osseous tuberosity
D7490	Radical resection of maxilla or mandible
D7510	Incision and drainage abscess -intraoral soft tissue
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)
D7520	Incision and drainage of abscess – extraoral soft tissue
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)
D7530	Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
D7810	Open reduction of dislocation
D7820	Closed reduction of dislocation

Code	Description
D7830	Manipulation under anesthesia
D7840	Condylectomy
D7850	Surgical disectomy, with/without implant
D7852	Disc repair
D7854	Synovectomy
D7856	Myotomy
D7858	Joint reconstruction
D7860	Arthrotomy
D7865	Arthroplasty
D7870	Arthrocentesis
D7871	Non-arthroscopic lysis and lavage
D7872	Arthroscopy – diagnosis, with or without biopsy
D7873	Arthroscopy – surgical, lavage and lysis of adhesions
D7874	Arthroscopy – surgical, disc repositioning and stabilization
D7875	Arthroscopy – surgical, synovectomy
D7876	Arthroscopy – surgical, disectomy
D7877	Arthroscopy – surgical, debridement
D7880	Occlusal orthotic device, by report
D7881	Occlusal orthotic device adjustment
D7899	Unspecified TMD therapy, by report
D7910	Suture of recent small wounds up to 5 cm
D7911	Complicated suture up to 5 cm, meticulous closure
D7912	Complicated suture greater than 5 cm, meticulous closure
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla
D7951	Sinus augmentation with bone or bone substitutes via lateral open approach
D7952	Sinus augmentation via vertical approach
D7953	Bone replacement graft for ridge preservation – per site
D7961	Buccal/labial frenectomy (frenulectomy)
D7962	Lingual frenectomy (frenulectomy)
D7963	Frenuloplasty
D7970	Excision of hyperplastic tissue – per arch
D7971	Excision of pericoronal gingiva
D7972	Surgical reduction of fibrous tuberosity

Code	Description
D8010	Limited orthodontic treatment – primary dentition
D8020	Limited orthodontic treatment – transitional dentition
D8030	Limited orthodontic treatment – adolescent dentition
D8040	Limited orthodontic treatment – adult dentition
D8070	Comprehensive orthodontic treatment of the transitional dentition
D8080	Comprehensive orthodontic treatment of the adolescent dentition
D8090	Comprehensive orthodontic treatment of the adult dentition
D8660	Pre-orthodontic treatment visit
D8681	Removable orthodontic retainer adjustment
D9110	Palliative (emergency) treatment of dental pain – minor procedure
D9120	Fixed partial denture sectioning
D9210	Local anesthesia not in conjunction with operative or surgical procedures
D9222	Deep sedation/general anesthesia – first 15 minute increment
D9223	Deep sedation/general anesthesia – each 15 minute increment
D9230	Nitrous oxide/analgesia, anxiolysis
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minute increment
D9243	Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment
D9248	Non-intravenous conscious sedation
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician
D9311	Treating dentist consultation with a medical health care professional
D9410	House/extended care facility call
D9420	Hospital or ambulatory surgical center call
D9430	Office visit for observation (regular hours) – no other services performed
D9440	Office visit – after regularly scheduled hours
D9450	Case presentation, detailed and extensive treatment planning established patient – not performed on the same day as evaluation
D9610	Therapeutic parenteral drug, single administration
D9612	Therapeutic parenteral drug, two or more administrations, different medications
D9630	Other drugs and/or medications, by report
D9910	Application of desensitizing medicament
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth
D9912	Pre-visit patient screening
D9920	Behavior management, by report

Code	Description
D9930	Treatment of complications (post-surgical) – unusual circumstances
D9932	Cleaning and inspection of removable complete denture, maxillary
D9933	Cleaning and inspection of removable complete denture, mandibular
D9934	Cleaning and inspection of removable partial denture, maxillary
D9935	Cleaning and inspection of removable partial denture, mandibular
D9942	Repair and/or reline of occlusal guard
D9943	Occlusal guard adjustment
D9951	Occlusal adjustment – limited
D9952	Occlusal adjustment – complete
D9970	Enamel microabrasion
D9971	Odontoplasty 1-2 teeth; includes removal of enamel projections
D9995	Teledentistry – synchronous; real-time encounter
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review
D9997	Dental case management – patients with special health care needs. special treatment considerations for patients/individuals with physical, medical, developmental or cognitive conditions resulting in substantial functional limitations or incapacitation, which require that modifications be made to delivery of treatment to provide customized or comprehensive oral health care services.
D9999	Unspecified adjunctive procedure, by report

Only procedures listed above will be covered under this *EOC*.

See Exclusions and Limitations in this *EOC* for a complete explanation.

NONDISCRIMINATION STATEMENT AND NOTICE OF LANGUAGE ASSISTANCE

Nondiscrimination Notice

Kaiser Foundation Health Plan of the Northwest (Kaiser Health Plan) complies with applicable federal and state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. 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 Member Services at **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, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator, by mail, phone, or fax. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You may contact our Civil Rights Coordinator at:

Member Relations Department
Attention: Kaiser Civil Rights Coordinator
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: **1-855-347-7239**

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 **www.hhs.gov/ocr/office/file/index.html**.

You can also file a complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal, available at **https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status**, or by phone at **1-800-562-6900**, or **360-586-0241** (TDD). Complaint forms are available at **https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx**.

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**).

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

□ □ (Chinese) □ **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。

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¼Ķ Ď► ╘ė ♦╝╬ θ♠Ŷ╬HĎ▲┴▲ė ╫┼**1-800-813-2000** (TTY: **711**)Ĥ

□□□ **(Korean)** □□: □□□□ □□□□□ □□, □□ □□ □□□□ □□□ □□□□ □ □□□□. **1-800-813-2000** (TTY: **711**) □□□ □□□ □□□□.

Í ŐĽ **(Laotian)** ůĐ¯ č Ǫ̧ : ĂŽĽŹĎă ŹĄ̧ťĽŽŒ̧ Őľ ŐÍ ŐĽ, Ş ŐĄ̧ąΦŔŞ ŐĄčŁ đ ťĿţl· ¯ŽĄ̧Ę Őľ Ő̧ ů¯ đ ąΦľň-ĆŹŐ̧
ŮĚźĄ̧ĚŕĘŽ ĚŰ·ŽŹŐĄ. ůă Ĺ **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**).

p§ ~r Å**(Punjabi)** ÄnS o ÄnZ 9c Ňk Ĉûp§ ~r År ÜmŇ Ükùs ~z ~Äyũ {| ~T k~{Ň~k Ç~h ŇwU t Çk Vpwr n | Ö
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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**).