



Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation
Portland, Oregon

Large Group Dental Choice Preferred Provider Organization Dental Plan Evidence of Coverage

Group Name: <114>

Group Number: <90> - <4>

This EOC is effective <110> through <116>.

Printed: <92>

Member Services

Monday through Friday (except holidays)

8 a.m. to 6 p.m. PT

Portland area503-813-2000

All other areas1-800-813-2000

Dental Choice Customer Service

Monday through Friday (except holidays)

7 a.m. to 7 p.m. PT

All areas1-866-653-0338

TTY

All areas711

Language interpretation services

All areas1-800-324-8010

kp.org/dental/nw/ppo

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SAMPLE

INTRODUCTION

This *Evidence of Coverage (EOC)*, including the “Benefit Summary” and any benefit riders attached to this *EOC*, describes the dental care coverage of the Large Group Dental Choice Preferred Provider Organization (PPO) Dental Plan provided under the *Group Agreement (Agreement)* between Kaiser Foundation Health Plan of the Northwest and your Group. In the event of a conflict in language between the *Agreement* and the *EOC*, the *EOC* will govern. For benefits provided under any other plan, refer to that plan’s evidence of coverage.

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

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. The service area for this plan is the state of Washington.

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*

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

DEFINITIONS

Benefit Maximum. The maximum amount of benefits that will be paid in a Year as more fully explained in the “Benefit Maximum” section of this *EOC*. The amount of your Benefit Maximum is shown in the “Benefit Summary.” Specific Services may have separate lifetime 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 Kaiser Permanente, the amount the pharmacy would charge a Member for the item if a Member’s benefit plan did not cover the item. (This amount is an estimate of the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing pharmacy Services to Members, and the pharmacy program’s contribution to the net revenue requirements of Company.)

- For all other Services, the payment that Company makes for the Services (or, if Company subtracts a Cost Share from its payment, the amount Company would have paid if it did not subtract the Cost Share).

Coinsurance. A percentage of the Maximum Allowable Charges or the Usual and Customary Charges that you must pay when you receive a covered Service.

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.

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.

Dentally Necessary. A Service that, in the judgment of a Dentist, is required to prevent, diagnose, or treat a dental condition. A Service is Dentally Necessary and appropriate only if we determine 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 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) be under the Dependent Limiting Age in order to be eligible for membership. The “Benefit Summary” shows the Dependent Limiting Age (the student Dependent Limiting Age is for students, and the general Dependent Limiting Age is for non-students).

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

Emergency Dental Condition. A dental condition, or exacerbation of an existing dental condition, occurring suddenly and unexpectedly, involving injury, swelling, bleeding, or extreme pain in or around the teeth and gums 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. This document, on its own, is not designed to meet the requirements of a summary plan description (SPD) under ERISA.

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

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

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

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

Maximum Allowable Charge (MAC). The Charges in Company's schedule of Charges for Services provided to a Member.

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 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, their Dependent, or other individual who is eligible and has enrolled under this *EOC*.

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

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

Non-Participating Provider. A person who is either:

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

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

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

Preferred Provider Organization (PPO). An organization of preferred providers who have signed a contract to provide care to Members.

Premium. Monthly membership charges paid by Group.

Prior Authorization. The required assessment of the necessity, efficiency, and/or appropriateness of specified dental care Services or treatment.

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, validly registered as your domestic partner under the laws of another state, or otherwise recognized as your domestic partner under criteria agreed upon, in writing, by Kaiser Foundation Health Plan of the Northwest and your Group.

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

Temporomandibular Joint (TMJ) Disorders. Disorders which have one or more of these characteristics: pain in the musculature associated with the temporomandibular joint; internal derangements of the temporomandibular joint; arthritic problems with the temporomandibular joint; or an abnormal range of motion or limitation of motion of the temporomandibular joint.

Urgent Dental Care. Treatment for an Urgent Dental Condition.

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

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

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

PREMIUM, ELIGIBILITY, AND ENROLLMENT

Premium

Your Group is responsible for making Premium payments to Company. If your Group requires you to pay any part of the Premium, your Group will tell you the amount and how to pay your Group.

Who Is Eligible

General

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

- You must meet your Group’s eligibility requirements that we have approved. (Your Group is required to inform Subscribers of its eligibility requirements.)

- You must meet one of the Subscriber or Dependent eligibility requirements described below unless your Group has different eligibility requirements that we have approved.

Subscriber

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

- You are an employee of your Group; or
- You are otherwise entitled to coverage through your Group under a trust agreement, retirement benefit program, employment contract, or the rules of a professional, trade, or bona fide association.

Dependents

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

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

You may be asked to provide proof of dependency annually until the Dependent reaches the student Dependent Limiting Age shown in the “Benefit Summary” and their coverage ends.

Students who suffer a severe illness or injury that causes them to lose full-time student status will continue to be considered full-time students for eligibility purposes, provided that within 31 days after the loss of full-time student status, we receive written certification from the child’s treating physician that the child is suffering from a serious illness or injury and that the leave of absence or other change of enrollment is Medically Necessary. Eligibility as a full-time student under this provision may then continue for up to 12 months from the date that your child’s medical leave of absence began, or until your child reaches the student Dependent Limiting Age shown in the “Benefit Summary,” whichever comes first.

- A person who is of any age and 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 general Dependent Limiting Age shown in the “Benefit Summary,” if the person is any of the following:
 - Your or your Spouse’s child.
 - A child adopted by you or your Spouse, or for whom you or your Spouse have assumed legal obligation in anticipation of adoption.

- Any other person for whom you or your Spouse is a court-appointed guardian and was a court-appointed guardian prior to the person reaching the general Dependent Limiting Age shown in the “Benefit Summary” established by the Group.

You must provide proof of incapacity and dependency annually upon request, but only after the two-year period following attainment of the general 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 21 days of life, including the date of birth, unless: (a) you or your Spouse adopts them or assumes a legal obligation in anticipation of adoption; (b) they are primarily supported by you or your Spouse and you or your Spouse is their court-appointed guardian; or, (c) your Group has different eligibility requirements that we have approved.

Company will not deny enrollment of a newborn child, newly adopted child, 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; or (c) the child does not reside with the child’s parent or in our service area; or (d) the mother of the child used drugs containing diethylstilbestrol prior to the child’s birth. Also, Company does not discriminate between married and unmarried persons, or between children of married or unmarried persons.

When You Can Enroll and When Coverage Begins

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

New Employees and Their Dependents

When a Group informs an employee that they are eligible to enroll as a Subscriber, they may enroll themselves and any eligible Dependents by following the instructions from the Group.

Open Enrollment

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

Special Enrollment

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

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

- Loss of 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.

The individual must notify the Group within 31 days of a qualifying event, 60 days if they are requesting enrollment due to a change in eligibility for Medicaid or Child Health Insurance Program (CHIP) coverage. The Group will determine if the individual is eligible to select or change coverage. Contact the Group for further instructions on how to enroll.

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

Adding New Dependents to an Existing Account

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

Newborns, newly adopted children, children newly placed for adoption, or newly placed foster children are covered for 21 days after birth, adoption, placement for adoption, or placement for foster care. In order for coverage to continue beyond this 21-day period, you must notify your Group 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 your Group and Dental Choice Customer Service to add the child to your Plan.

To add all other newly eligible Dependents (such as a new Spouse), you must submit an enrollment application to your Group within 60 days after the qualifying event.

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

When Coverage Begins

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

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

HOW TO OBTAIN SERVICES

General Information

You may choose to receive covered Services from Participating Providers or from Non-Participating Providers inside the United States. Your out-of-pocket costs will typically be less when you receive covered Services from Participating Providers. Also, Participating Providers will obtain any necessary Prior Authorization on your behalf and will submit claims to us.

Participating Providers include Permanente Dental Associates, P.C. and other dental care providers who are either employed by us or contract directly or indirectly with us to provide covered Services for Members enrolled in this Plan. To locate a Participating Provider, visit kp.org/dental/nw/ppo. If you need assistance finding a Participating Provider, verifying the current participation status of a provider, or setting an appointment, or if you do not have access to the online directory, please contact Dental Choice Customer Service.

When you receive covered Services from Non-Participating Providers, your Cost Share may be higher than when you receive covered Services from Participating providers. You are responsible for assuring your

Non- Participating Provider has obtained any necessary Prior Authorization. If you choose to receive covered Services from a Non-Participating Provider, those Services are still subject to the provisions of this *EOC*.

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 Dental Choice Customer Service. If you need to replace your ID card, call Dental Choice Customer Service.

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 Dentist

We recommend each Member choose a personal Dentist. You may designate a Participating Provider who is a general dentist and who is available to accept you. Your personal Dentist and their dental care team can provide most of your dental care and, when needed, arrange for Dentally Necessary care with other dental providers. For information on how to select or change your personal Dentist, and for a searchable list of participating general Dentists, visit kp.org/dental/nw/ppo or call Dental Choice Customer Service. Before receiving Services, you should confirm your Dentist has continued as a Participating Provider.

Getting Assistance

We want you to be satisfied with the dental care you receive. If you have any questions or concerns about Services you received from a Participating Provider, please first discuss them with that provider or the provider’s office. Dental Choice Customer Service representatives are available to assist you in resolving any problems you may have.

The Dental Choice Customer Service representatives can answer any questions you have about your benefits, how to find Participating Providers and Participating Dental Offices, how to make your first appointment, and how to replace your ID card. These representatives can also provide you with forms and instructions that will help you file a claim, grievance, or appeal as described in the “Grievances, Claims, and Appeals” section of this *EOC*. Upon request, Dental Choice Customer Service can also provide you with written materials about your coverage.

Dental Choice Customer Service representatives are available by phone Monday through Friday (except holidays), from 7 a.m. to 7 p.m. PT, by calling 1-866-653-0338.

Prior Authorization

Services listed in the “Benefits” section require Prior Authorization in order for us to cover them if they are either of the following:

- A Service for which the Charges are more than \$500 or more per procedure.
- The procedure is periodontal treatment with the procedure code D4341 or D4342.

You are responsible for getting Prior Authorization, though Participating Providers and Non-Participating Providers may request Prior Authorization on your behalf. To request Prior Authorization, you or your provider must call our Dental Choice Customer Service representatives at 1-866-653-0338 or mail material to the address on the back of your ID card. Providers may also request Prior Authorization electronically. We

will send a response within five calendar days after we receive the request. Prior authorization determinations shall expire no sooner than forty-five days from the date of approval.

If you receive a Service for which Prior Authorization is required but for which we have not given Prior Authorization (including any Services that exceed the Services for which we have given Prior Authorization), then we will not cover that Service unless we review the Service and determine that it was Dentally Necessary. If we determine that the Service met a dental need but was not Dentally Necessary because a less expensive Service would have met the same dental need, then we will partially cover the Service by paying the amount we would have paid if you had received the less expensive Service. You will be responsible for paying for any Services that we do not cover.

Prior Authorized Services are subject to the Copayment or Coinsurance and Benefit Maximum, if any, shown in the “Benefit Summary.” When we conduct a Prior Authorization review, you will receive a written explanation of benefits. Each Service where Prior Authorization was requested, and the acceptance or denial of each Service, will be listed on the explanation of benefits. To learn more about Prior Authorization, refer to the “Grievances, Claims, and Appeals” section of this *EOC*.

You do not need Prior Authorization for Emergency Dental Care. In the case of Urgent Dental Care, a pre-service claim for Prior Authorization may be filed with us requesting urgent review. To learn more about pre-service claims, refer to the “Grievances, Claims, and Appeals” section of this *EOC*.

For more information about Prior Authorization, or a copy of the review criteria used to make the Prior Authorization determination, please contact Dental Choice Customer Service.

Obtaining Emergency and Urgent Dental Care

If you have an Emergency Dental Condition, or you need Urgent Dental Care, call your Dentist’s office. Emergency Dental Care is available 24 hours a day, every day of the week. Call Kaiser Permanente at 1-800-813-2000 (TTY 711), and a representative will assist you or arrange for you to be seen for an Emergency Dental Condition.

See “Emergency Dental Care and Urgent Dental Care” in the “Benefits” section for details about your coverage.

POST-SERVICE CLAIMS—SERVICES ALREADY RECEIVED

If you receive Services from a Participating Provider, they will send the bill to us directly. You are not required to file a claim form. Dental Choice Customer Service representatives can assist you with questions about specific claims or about the claim procedures in general.

If you receive Services from a Non-Participating Provider, you can request a claim form from Dental Choice Customer Service . When you submit the claim, please include a copy of your dental records from the Non-Participating Provider if you have them.

We accept American Dental Association (ADA) Dental claim forms. If the Non-Participating Provider bills us 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, including ERISA.

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

If you have questions or concerns about the claim determination, you may contact Dental Choice Customer Service for an explanation. If you believe the Charges are not appropriate, Dental Choice Customer Service will advise you on how to proceed.

WHAT YOU PAY

You may choose to receive covered Services from Participating Providers or from Non-Participating Providers inside the United States. The amounts you pay for covered Services may differ depending on the provider you choose. Your out-of-pocket costs will typically be less when you receive covered Services from Participating Providers.

You pay the In-Network Cost Share shown in your “Benefit Summary” when you receive covered Services from Participating Providers. You pay the Out-of-Network Cost Share shown in your “Benefit Summary” when you receive covered Services from Non-Participating Providers.

We pay for covered Services from Participating Providers and Non-Participating Providers up to either the Maximum Allowable Charge (MAC) or the Usual and Customary Charge (UCC), depending on your Plan. If a Non-Participating Provider charges more than the MAC or UCC, that provider may bill you directly for the additional amount that is not covered by us. This is called balance billing. A Participating Provider will not balance bill you for amounts over the Maximum Allowable Charge.

Copayments and Coinsurance

When you receive covered Services, you are responsible for Copayments and Coinsurance, as shown in the “Benefit Summary.” Any applicable Copayments or Coinsurance are generally due when you receive the Service.

For covered Services from Participating Providers, we have financial arrangements for what we pay to the provider. Coinsurance is based on the Maximum Allowable Charge we have negotiated with the Participating Provider.

We do not have financial arrangements for what we pay to Non-Participating Providers. For covered Services from Non-Participating Providers, Coinsurance is based on the Maximum Allowable Charge (MAC) or the Usual and Customary Charge (UCC). If a Non-Participating Provider charges more than the MAC or UCC, you may be responsible for paying the additional amount not covered by us, in addition to your Copayment and Coinsurance.

Benefit Maximum

Your dental plan may be subject to a Benefit Maximum selected by your Group. If your plan includes a Benefit Maximum, your benefit is limited during each Year to the amount shown in the “Benefit Summary.” The “Benefit Summary” also shows what Services do not count toward your Benefit Maximum. Otherwise, Charges for Services we cover, less 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.

If your plan includes Orthodontic Services or Dental Implant Services, please note that these Services may not count toward the plan Benefit Maximum. Your orthodontic coverage and your implant coverage may each have a separate benefit maximum.

For plans with a single Benefit Maximum, we add up the amounts we pay for covered Services you receive from Participating Providers and the amounts we pay for covered Services you receive from Non-Participating Providers and count both of them toward the single Benefit Maximum. If you reach the Benefit Maximum, then for the remainder of that Year we will not cover additional Services.

For plans with a different in-network and out-of-network Benefit Maximum, the amounts we pay for covered Services you receive from a Participating Provider count toward the in-network Benefit Maximum, and the amounts we pay for covered Services you receive from a Non-Participating Provider count toward the out-of-network Benefit Maximum. The Benefit Maximums cross accumulate. This means that the amounts we pay for covered Services that count toward the in-network Benefit Maximum also count toward the out-of-network Benefit Maximum, and the amounts we pay for covered Services that count toward the out-of-network Benefit Maximum also count toward the in-network Benefit Maximum. If the out-of-network Benefit Maximum is lower than the in-network Benefit Maximum and you have reached the out-of-network Benefit Maximum, you may continue to use your in-network benefits until you reach the in-network Benefit Maximum. Check your “Benefit Summary” to learn if your plan has a different in-network and out-of-network Benefit 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.
- The Services are Dentally Necessary.
- The covered Services are provided, prescribed, authorized, or directed by a Dentist.

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 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*.

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

Endodontic Services

We cover the following endodontic Services:

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

Major Restorative Services

We cover the following major restorative Services:

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

Removable Prosthetic Services

We cover the following removable prosthetic Services:

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

- Repairs.

Emergency Dental Care and Urgent Dental Care

We cover Emergency Dental Care, including local anesthesia and medication when used prior to dental treatment to avoid any delay in dental treatment, and Urgent Dental Care, 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 or Urgent Dental Care.

Non-Participating Providers may charge additional fees for Emergency Dental Care and Urgent Dental Care visits, based on that dental office’s policy.

Other Dental Services

We cover other dental Services as follows:

- Medically Necessary general anesthesia and covered dental Services in conjunction with Medically Necessary anesthesia. We cover Medically Necessary general anesthesia services when provided in conjunction with the dental Services described in the “Benefits” section, if the general anesthesia services are Medically Necessary because the Member is a child under age seven or is physically or mentally disabled. We cover the dental Services described in the “Benefits” section when provided in a hospital or ambulatory surgical center, if the Services are performed at that location in order to obtain Medically Necessary general anesthesia for a Member who is a child under age seven, or who is physically or mentally disabled, along with the Medically Necessary general anesthesia.
- 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 your Dentist.
- Temporomandibular Joint (TMJ) Disorders. We cover Dental Services related to treatment of Temporomandibular Joint (TMJ) Disorders when received from a Participating Provider or a Non-Participating Provider subject to the benefit limitations shown in the “Benefit Summary,” except that we do not cover Orthodontic Services related to treatment of Temporomandibular Joint (TMJ) Disorders. For purposes of this benefit, Dental Services means:
 - Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case; and
 - Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: Pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food; and
 - Dentally Necessary; and
 - Not experimental or primarily for cosmetic purposes.

EXCLUSIONS AND LIMITATIONS

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

Exclusions

- Additional fees a Non-Participating Provider may charge for an Emergency Dental Care or Urgent Dental Care visit after our payment for covered Services.
- Continuation of Services performed or started prior to your coverage becoming effective.
- Continuation of Services performed or started after your membership terminates.
- Cosmetic Services, supplies, or prescription drugs that are intended primarily to improve appearance, repair, and/or replace cosmetic dental restorations.
- Dental 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, unless your Group has purchased coverage for dental implants as an additional benefit.
- Dental Services not listed in the “Benefits” section of this *EOC*.
- Drugs obtainable with or without a prescription. These may be covered under your medical benefits.
- Experimental or investigational treatments, procedures, and other Services that are not commonly considered standard dental practice or that require 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.
- Full mouth reconstruction, including, but not limited to, occlusal rehabilitation, appliances, restorations, and procedures needed to alter vertical dimension, occlusion, or correct attrition or abrasion.
- Genetic testing.
- Maxillofacial surgery.
- Medical or Hospital Services, unless otherwise specified in the *EOC*.
- Myofunctional therapy.
- Non-orthodontic recording of jaw movements or positions.
- Orthodontic Services unless your Group has purchased orthodontic coverage as an additional benefit.
- Orthodontic treatment of primary/transitional dentition.
- Orthognathic surgery, except this exclusion does not apply to orthognathic surgical Services performed by a 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 lost or damaged space maintainers.
- Replacement of prefabricated, noncast crowns, including noncast stainless steel crowns, except when the Member has five or more years of continuous dental coverage with Company.
- Services performed by someone other than a Participating Provider or Non-Participating Provider are not covered.
- Speech aid prosthetic devices and follow up modifications.
- Treatment of cleft palate.
- Treatment of macroglossia.
- Treatment of micrognathia.
- Treatment to restore tooth structure lost due to attrition, erosion, or abrasion.
- Use of alternative materials for 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.

Limitations

- Amalgam, silicate, acrylic, or composite restorations are limited to once per tooth surface every 24 months for the same tooth.
- Benefits for prophylaxis will not be covered if performed on the same date of Service with periodontal cleaning treatment.
- 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. Subsequent debridement within this period will require Prior Authorization.
- “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 seven or who is physically or mentally disabled.
- Periodontal scaling and root planing is limited to once per quadrant every 24 months and requires Prior Authorization before the initiation of Services. Prior Authorization submitted by the provider must include a copy of the periodontal chart with documented periodontal disease which must include at least four teeth per quadrant with four millimeters or greater periodontal pockets.
- 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 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 are limited to once per tooth per lifetime and re-treatment of root canal is limited to not more than once in 24 months for the same tooth.
- 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 treatment of the occlusal surfaces of permanent molars for persons 15 years and younger.
- Sedation and general anesthesia (including, but not limited to, intramuscular IV sedation, non-IV sedation, and inhalation sedation) are not covered, except nitrous oxide when pursuant to the “nitrous oxide” provision described in the “Other Dental Services” section, and when Medically Necessary for Members who are under age seven, developmentally or physically disabled, pursuant to the “Medically Necessary general anesthesia and covered dental Services in conjunction with Medically Necessary anesthesia” provision as described in the “Other Dental Services” section.
- X-rays are limited to:
 - one full mouth complete series or one panoramic radiographic image every three years;
 - supplementary bite wing series once per year;
 - periapical x-rays and occlusal x-rays as Dentally Necessary; and
 - those that are necessary to document the need for oral surgery.

A Member may qualify for a different x-ray frequency based on the Dentist’s assessment of the Member’s oral health and risk factors.

REDUCTIONS

Notice to Covered Persons

If you are covered by more than one dental benefit plan, and you do not know which is your primary plan, you or your provider should contact any one of the dental plans to verify which plan is primary. The dental plan you contact is responsible for working with the other plan to determine which is primary and will let you know within thirty calendar days.

CAUTION: All dental plans have timely claim filing requirements. If you or your provider fail to submit your claim to a secondary dental plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary dental plan, you or your provider will need to submit your claim to the secondary dental plan within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage.

Coordination of Benefits

This Coordination of Benefits (COB) provision applies when you have dental care coverage under more than one Plan. You and your provider should file all your claims with each Plan at the same time. If Medicare is your Primary Plan, Medicare may submit your claims to your Secondary Plan for you.

Plan, and other important terms that apply only to this provision, are defined below.

The order of benefit determination rules described under this “Coordination of Benefits” section determines the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its contract terms without regard to the possibility that another Plan may cover some expenses.

The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100 percent of the total Allowable Expense. If the Secondary Plan receives a claim without the Primary Plan’s payment details, the Secondary Plan will notify the submitting provider and/or you as soon as possible and within 30 days of receipt of the claim that the claim is incomplete. After receiving the missing information, the Secondary Plan will promptly process the claim. If the Primary Plan has not processed the claim within 60 days and is not waiting for additional information, the provider and/or you may submit the claim to the Secondary Plan with a notice that the Primary Plan has failed to pay the claim. The Secondary Plan must pay the claim as the Primary Plan within calendar 30 days. After payment information is received from the Primary Plan, the Secondary Plan may recover any excess amount paid under the “Right of Recovery” provision.

Definitions for this “Coordination of Benefits” section

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

Plan. A Plan is any of the following that provides benefits or Services for dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate Plan.

- Plan includes: Group, individual, or blanket disability insurance contracts, and group or individual insurance contracts issued by health care service contractors or health maintenance organizations (HMO), Closed Panel Plans or other forms of group coverage; and Medicare or any other federal governmental Plan, as permitted by law.
- Plan does not include: medical care coverage, hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental Plans, unless permitted by law.

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

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

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

When This Plan is primary, we determine payment for the benefits first before those of any other Plan without considering any other Plan's benefits. We will not reduce your benefits under This Plan. When This Plan is secondary, we determine the benefits after those of another Plan and must make payment in an amount so that when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim equal 100 percent of the total Allowable Expense for that claim. This means that when This Plan is secondary, we must pay the amount which, when combined with what the Primary Plan

paid, cannot be less than the same Allowable Expense the Secondary Plan would have paid if it had been the Primary Plan. In addition, if This Plan is secondary, we must calculate the savings (the amount paid subtracted from the amount we would have paid had we been the Primary Plan) and record these savings as a dental benefit reserve for the covered person. This reserve must be used to pay any dental expenses during that calendar year, whether or not they are an Allowable Expense under This Plan. If This Plan is Secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

Allowable Expense. Allowable Expense is a dental care expense, including deductibles, copayment, and coinsurance, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of Services, the Charges of each Service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense.

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

- The difference between the cost of an amalgam filling and a composite filling for certain teeth is not an Allowable Expense unless one of the Plans provides coverage for composite fillings for those teeth.
- If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit.
- If a person is covered by two or more Plans that provide benefits or Services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees.

Closed Panel Plan. Closed Panel Plan is a Plan that provides dental care benefits to covered persons in the form of Services through a panel of providers who are primarily contracted by the Plan, and that excludes coverage for Services provided by other providers, except in cases of emergency or referral by a panel provider.

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

Order of Benefit Determination Rules

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

- The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
- A Plan that does not contain a COB provision that is consistent with state regulations is always primary unless the provisions of both Plans state that the complying Plan is primary.
- Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the Plan provided by the contract holder.
- A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

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

Subscriber or Dependent. The Plan that covers the person as a Subscriber is the Primary Plan and the Plan that covers the person as a Dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a Dependent, and primary to the Plan covering the person as a Subscriber (e.g., a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as Subscriber is the Secondary Plan and the other Plan is the Primary Plan.

Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

- For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
 - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
- For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - If a court decree states that one of the parents is responsible for the Dependent child's dental care expenses or dental care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods commencing after the Plan is given notice of the court decree;
 - If a court decree states one parent is to assume primary financial responsibility for the Dependent child but does not mention responsibility for dental care expenses, the Plan of the parent assuming financial responsibility is primary;
 - If a court decree states that both parents are responsible for the Dependent child's dental care expenses or dental care coverage, the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan or if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan;
 - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental care expenses or dental care coverage of the Dependent child, the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan or if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan; or
 - If there is no court decree allocating responsibility for the Dependent child's dental care expenses or dental care coverage, the order of benefits for the child are as follows:
 1. The Plan covering the Custodial Parent
 2. The Plan covering the spouse of the Custodial Parent
 3. The Plan covering the non-Custodial Parent
 4. The Plan covering the spouse of the non-Custodial Parent
- For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the above provisions determine the order of benefits as if those individuals were the parents of the child.

Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Order of Benefit Determination Rules" section can determine the order of benefits.

COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the Primary Plan and the COBRA or state or other federal

continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the “Order of Benefit Determination Rules” section can determine the order of benefits.

Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber, or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

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

Effect on the Benefits of This Plan. When This Plan is secondary, we may reduce the benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim equal 100 percent of the total Allowable Expense for that claim. Total Allowable Expense cannot be less than the same Allowable Expense the Secondary Plan would have paid if it had been the Primary Plan. In addition, the Secondary Plan must credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other dental care coverage.

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

Facility of Payment. If payments that should have been made under This Plan are made by another Plan, we have the right, at our discretion, to remit to the other Plan the amount we determine appropriate to satisfy the intent of this provision. The amounts paid to the other Plan are considered benefits paid under This Plan. To the extent of these payments, we are fully discharged from liability under This Plan.

Right of Recovery. We have the right to recover excess payment whenever we pay Allowable Expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. We may recover excess payment from any person to whom or for whom payment was made or any other issuers or Plans.

Questions About Coordination of Benefits?

Contact Your State Insurance Department

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.

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.

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. 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 subject to your obligation to reimburse us to the extent of a payment or any other benefit, including any amount received as a settlement that you receive under such law.

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

GRIEVANCES, CLAIMS, AND APPEALS

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

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

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 is our decision to do any of the following:
 - 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

Kaiser Permanente is committed to providing quality care and a timely response to your concerns. We encourage you to discuss any questions or concerns about your care with your Participating Provider or another member of your dental care team. If you are not satisfied with your Participating Provider, you may request another. Contact Dental Choice Customer Service for assistance. You always have the right to a second opinion from a qualified Participating Provider 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 grievance, you may do so by following one of the procedures listed below.

- Contact the administrative office in the Participating Dental Office where you are having the problem.
- Call Dental Choice Customer Service; or
- Send your written complaint to Dental Choice Customer Service at:

Kaiser Foundation Health Plan of the Northwest
Dental Choice Customer Service
P.O. Box 6927
Columbia, SC 29260
Fax: 1-803-870-8012

You may appoint an authorized representative to help you file your complaint. A written authorization must be received from you before any information will be communicated to your representative. Contact Dental Choice Customer Service for information about how to appoint a representative. You must pay the cost of anyone you hire to represent or help you.

All complaints are handled in a confidential manner.

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

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

We will forward your grievance to the appropriate manager or department, which may include Company, for resolution. An independent review will be conducted and we will provide you with a written decision within 30 days except as follows: if you fail to provide information necessary for us to make a determination on a grievance that is an initial claim, we will allow you 50 days from the date on our written notification to submit the information. We will make a decision within 15 days after receiving the information or within 15 days after the end of the 50-day period if we do not receive the information.

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

We want you to be satisfied with our facilities, Services, and Participating Providers. Using this grievance 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. If you have quality issues with your Non-Participating Provider, you will need to discuss it with that provider or the state dental society.

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 an adverse benefit determination, we will include a notice of language assistance (oral translation). You may request language assistance with your claim and/or appeal by calling 1-800-324-8010. 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 Dental Choice Customer Service 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 Dental Choice Customer Service.

Providing Additional Information Regarding Your Claim

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

Kaiser Foundation Health Plan of the Northwest
Dental Choice Customer Service
P.O. Box 6927
Columbia, SC 29260
Fax: 1-803-870-8012

When you appeal, you may give testimony in writing or by telephone. Please send your written testimony to the Dental Choice Customer Service:

Kaiser Foundation Health Plan of the Northwest
Dental Choice Customer Service
P.O. Box 6927
Columbia, SC 29260
Fax: 1-803-870-8012

To arrange to give testimony by telephone, you should contact Dental Choice Customer Service at 1-866-653-0338.

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 Dental Choice Customer Service.

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 or orally 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.

- If you request Services but learn there may be coverage limitations or exclusions, and you have questions or disagree, you should contact Dental Choice Customer Service at 1-866-653-0338.
- You may also request a pre-service claim in writing. You must mail your claim to:

Kaiser Foundation Health Plan of the Northwest
 Dental Choice Customer Service
 P.O. Box 6927
 Columbia, SC 29260
 Fax: 1-803-870-8012

- 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 five calendar days to send the information.
- We will make a decision and send notification within four 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 two calendar days to send the information.
- We will notify you of our decision within two calendar days 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 written confirmation within three days after the oral notification.
- If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

Non-Urgent Pre-service Appeal

- Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing or orally that you want to appeal our denial of your pre-service claim. Please include the following:
 - (1) Your name and health record number;

- (2) Your dental condition or relevant symptoms;
- (3) The specific Service that you are requesting;
- (4) All of the reasons why you disagree with our adverse benefit determination; and
- (5) All supporting documents.

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

Kaiser Foundation Health Plan of the Northwest
Dental Choice Customer Service
P.O. Box 6927
Columbia, SC 29260
Fax: 1-803-870-8012

- We will acknowledge your appeal in writing within seventy-two 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 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 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 mail, call, or fax your appeal to us at:

Kaiser Foundation Health Plan of the Northwest
Dental Choice Customer Service
P. O. Box 6927
Columbia, SC 29260
Phone: 1-866-653-0338
Fax: 1-803-870-8012

- 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 three days after the oral notification.
- If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal.

Concurrent Care Claims and Appeals

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

Unless you are appealing an urgent care claim, if we either (a) deny your request to extend your current authorized ongoing care (your concurrent care claim) or (b) inform you that authorized care that you are currently receiving is going to end early and you appeal our adverse benefit determination at least 24 hours before your ongoing course of covered treatment will end, then during the time that we are considering your appeal, you may continue to receive the authorized Services. If you continue to receive these Services while we consider your appeal and your appeal does not result in our approval of your concurrent care claim, then you will have to pay for the Services that we decide are not covered.

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

Non-Urgent Concurrent Care Claim

- Tell us that you want to make a concurrent care claim for an ongoing course of covered treatment. Inform them in detail of the reasons that your authorized ongoing care should be continued or extended. Your request and any related documents you give them constitute your claim. You must submit your claim by mailing them to:
 Kaiser Foundation Health Plan of the Northwest
 Dental Choice Customer Service
 P.O. Box 6927
 Columbia, SC 29260
- If you want us to consider your claim on an urgent basis and you contact them at least 24 hours before your authorized care ends, you may request that we review your concurrent claim on an urgent basis. We will decide whether your claim is urgent or non-urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life or health or your ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of your dental condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting, or (c) your attending dental care provider requests your claim be treated as urgent.
- We will review your claim, and if we have all the information we need, we will make a decision within a reasonable period of time.

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

If your authorized care ended before you submitted your claim, we will make the decision 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 will give you until your care is ending or, if your care has ended, five calendar days to send them the information.

We will make the decision and send notification as soon as possible if your care has not ended. If your care has ended, we will make the decision within four calendar days after we first receive any information (including documents) requested or by the deadline for receiving the information, whichever is sooner.

You are encouraged to send all the requested information at one time, so that we will be able to consider it all when we make the decision.

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

Urgent Concurrent Care Claim

- If your concurrent care claim is considered on an urgent basis, we will notify you of the decision orally or in writing as soon as your clinical condition requires, but no later than 24 hours after the claim was received.

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

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

Non-Urgent Concurrent Care Appeal

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

- (1) Your name and health record number;
- (2) Your dental condition or relevant symptoms;
- (3) The ongoing course of covered treatment that you want to continue or extend;
- (4) All of the reasons why you disagree with our adverse benefit determination; and
- (5) All supporting documents.

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

Kaiser Foundation Health Plan of the Northwest
Dental Choice Customer Service
P.O. Box 6927
Columbia, SC 29260
Phone: 1-866-653-0338
Fax: 1-803-870-8012

- We will acknowledge your appeal in writing within seventy-two 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 as soon as possible if your care has not ended but no later than 14 days after we receive your appeal. We may extend the time for making a decision on your appeal for up to an additional 16 days if there is good cause.

- If we deny your appeal, our adverse benefit determination decision will tell you why we denied your appeal.

Urgent Concurrent Care Appeal

- Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent care claim. Please include the following:
 - (1) Your name and health record number;
 - (2) Your dental condition or relevant symptoms;
 - (3) The ongoing course of covered treatment that you want to continue or extend;
 - (4) All of the reasons why you disagree with our adverse benefit determination; and
 - (5) All supporting documents.

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

Kaiser Foundation Health Plan of the Northwest
Dental Choice Customer Service
P.O. Box 6927
Columbia, SC 29260
Phone: 1-866-653-0338
Fax: 1-803-870-8012

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

Post-service Claims and Appeals

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

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 a letter to us explaining the Services for which you are requesting payment. Provide 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 Dental Choice Customer Service to obtain a claim form. You must mail your claim to the Claims Department at:

Kaiser Foundation Health Plan of the Northwest
Dental Choice Customer Service
P.O. Box 6927
Columbia, SC 29260

- 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, you will receive a written decision within 30 days after the claim is received.
- We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 30 days after we receive your claim.
- If more information is needed to make a decision, we will ask you for the information before the initial decision period ends, and will give you 45 days to send them the information.

We will make a decision within 15 days after we receive the first piece of information (including documents) that were 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 the requested information (including documents) is not received within 45 days after the request is sent, a decision based on the information we have will be made within 15 days following the end of the 45-day period.

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

Post-service Appeal

- Within 180 days after you receive our adverse benefit determination, tell us in writing or orally that you want to appeal our denial of your post-service claim. Please include the following:
 - (1) Your name and health record number;
 - (2) Your dental condition or relevant symptoms;
 - (3) The specific Services that you want us to pay for;
 - (4) All of the reasons why you disagree with our adverse benefit determination; and
 - (5) All supporting documents.

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

Kaiser Foundation Health Plan of the Northwest
Dental Choice Customer Service
P.O. Box 6927
Columbia, SC 29260
Fax: 1-803-870-8012

- We will acknowledge your appeal in writing within seventy-two 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 days after we receive your appeal. We may extend the time for making a decision on your appeal for up to an additional 16 days if there is good cause.
- If we deny your appeal, our adverse benefit determination 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.

Additional Review

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

TERMINATION OF MEMBERSHIP

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

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

Termination due to Loss of Eligibility

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

Termination for Cause

If you or any other Member in your Family is proven to have committed one of the following acts, we may terminate your membership under the *Agreement* 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.

If we terminate your membership for cause we will:

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

We may deduct any amounts you owe Company or a Participating Provider from any payment we make to you.

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

Termination of Your Group's Agreement With Us

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

Termination of a Plan or All Plans

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

CONTINUATION OF MEMBERSHIP

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

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

Federal or State-Mandated Continuation of Coverage

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

Strike, Lock-Out, or Other Labor Disputes

If your compensation is suspended directly or indirectly as a result of a strike, lock-out, or other labor dispute, you may continue membership under this *EOC* by paying Premium for yourself and eligible Dependents directly to the Group for up to six months. If the Group's coverage is terminated by Company, reinstatement with Company is subject to all terms and conditions of your Group's *Agreement* with Company. When your Group continuation coverage under this *EOC* stops, you and your Dependents may be eligible to purchase an individual plan offered by Company.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

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

MISCELLANEOUS PROVISIONS

Administration of Agreement

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

Agreement Binding on Members

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

Amendment of Agreement

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

Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this *EOC*.

Assignment

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

Attorney Fees and Expenses

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

Governing Law

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

Group and Members not Company's Agents

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

Litigation Venue

Venue for all litigation between you and Company shall lie in 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, or impair our right thereafter to require your strict performance of any provision.

Nondiscrimination

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

Notices

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

Overpayment Recovery

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

Privacy Practices

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

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

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

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.

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
Phone: **1-800-813-2000** (TTY: 711)
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/online-services/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).

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

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

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

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

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

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

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

ខ្មែរ (Khmer) ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ **1-800-813-2000** (TTY: 711)។

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

ລາວ (Laotian) ໂປດຄວາມ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ **1-800-813-2000** (TTY: 711).

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

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

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

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

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

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

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

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

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

SAMPLE