KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation
Portland, Oregon

Dental Choice Preferred Provider Organization
Small Group Family Dental Plan
Evidence of Coverage

Group Name: <114>
Group Number: <90> - <4>

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

Printed: <92>

Dental Choice Customer Service

Monday through Friday (except holidays)
7 a.m. to 7 p.m. PT
All areas.....1-866-653-0338

TTY

All areas.....711

Language interpretation services

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

kp.org/dental/nw/ppo

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INTRODUCTION

This *Evidence of Coverage (EOC)*, including the "Benefit Summary," describes the dental care coverage of the Small Group Dental Choice Preferred Provider Organization (PPO) Family Dental Plan provided under the *Group Agreement (Agreement)* between Kaiser Foundation Health Plan of the Northwest and your Group. This Small Group Family Dental Plan includes pediatric dental care coverage. For benefits provided under any other plan, refer to that plan's evidence of coverage.

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

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

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

Term of This *EOC*

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

Abutment. A tooth or implant fixture used as a support for a prosthesis.

Benefit Maximum. The maximum amount of benefits that will be paid in a Year as more fully explained in the "Benefit Maximum" section of this *EOC*. The amount of your Benefit Maximum is shown in the "Benefit Summary." Specific Services may have separate benefit maximum amounts, as shown in the "Benefit Summary."

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

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

- For Services provided by Permanente Dental Associates, PC, the charges in Company's schedule of charges for Services provided to Members.
- For Services for which a provider (other than Permanente Dental Associates, PC) is compensated on a capitation basis, the charges in the schedule of charges that Company negotiates with the capitated provider.
- For items obtained at a pharmacy owned and operated by Company, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item. (This amount is an estimate of the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Company.)
- For all other Services, the payment that Company makes for the Services (or, if Company subtracts a Cost Share from its payment, the amount Company would have paid if it did not subtract the Cost Share).

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

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

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

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

Deductible. The amount you must pay for certain Services you receive in a Year before we will cover those Services, subject to any applicable Copayment or Coinsurance, in that Year. Deductible amounts include the Deductible take-over amounts as described under "Deductible" in the "What You Pay" section of this *EOC*.

For the Services subject to the Deductible, you must pay 100 percent of the cost when you receive those Services, until your Deductible is met. After you satisfy your Deductible, you pay the applicable Copayment or Coinsurance shown in your dental "Benefit Summary." The individual Deductible applies to each Member covered under your plan each Year. The Family Deductible may be satisfied by applying the Maximum Allowable Charges and Usual and Customary Charges incurred by any enrolled Family member.

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 Implant. An artificial, permanent tooth root replacement used to replace a missing tooth or teeth. It is surgically placed into the upper or lower jawbone and supports a single crown, fixed bridge, or removable partial or full denture.

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 and disabled Dependents as described in the "Dependents" section) be under the Dependent Limiting Age in order to be eligible for membership. The "Benefit Summary" shows the Dependent Limiting Age.

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

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

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

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

Group. The employer, union trust, or association with which we have an *Agreement* that includes this *EOC*. The Group must have employed an average of at least one but not more than 50 full-time equivalent employees on business days during the preceding calendar year and employ at least one common law employee who is enrolled in the plan on the first day of the plan year.

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 for and has enrolled under this *EOC*.

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

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

Non-Participating Provider. A person who is either:

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

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

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

Participating Dental Office(s). Any facility listed in the *Dental Facility Directory*. 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 Copayments 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 Copayments 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, dental therapist, or pediatric dental assistant, and who is an employee or agent of a Participating Dentist.

Participating Providers are subject to change.

Pontic. The term used for an artificial tooth on a fixed partial denture (bridge).

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 Registered Domestic Partnership issued by the state of Oregon, 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).

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 in this plan, you must meet all of the following requirements:

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

Subscriber

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

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

Dependents

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

- Your Spouse.
- A person who is under the Dependent Limiting Age shown in the "Benefit Summary" and who is any of the following:
  - Your or your Spouse's child.
  - A child adopted by you or your Spouse, or for whom you or your Spouse have assumed a legal obligation in anticipation of adoption.
  - Any other person for whom you or your Spouse is a court-appointed guardian.
  - A child placed with you or your Spouse for foster care.
- A person 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 Dependent Limiting Age shown in the "Benefit Summary," if the person is any of the following:
  - Your or your Spouse's child.
  - A child adopted by you or your Spouse, or for whom you or your Spouse have assumed legal obligation in anticipation of adoption.
  - Any other person for whom you or your Spouse is a court-appointed guardian and was a court-appointed guardian prior to the person reaching the Dependent Limiting Age shown in the "Benefit Summary".

  We may request proof of incapacity and dependency annually.

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

Company will not deny enrollment of a newborn child, newly adopted child, child for whom legal obligation is assumed in anticipation of adoption, child newly placed for adoption, or newly placed foster child solely on the basis that: (a) the child was born out of wedlock; (b) the child is not claimed as a dependent on the parent's federal tax return; (c) the child does not reside with the child's parent; or (d) the mother of the child used drugs containing diethylstilbestrol prior to the child's birth. Also, Company does not discriminate between married and unmarried persons, or between children of married or unmarried persons.

When You Can Enroll and When Coverage Begins

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

New Employees and Their Dependents

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

Open Enrollment

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

Special Enrollment

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

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

- Loss of minimum essential coverage for any reason other than nonpayment of Premium, rescission of coverage, misrepresentation, fraud, or voluntary termination of coverage.
- Gaining a Dependent through marriage or entering into a domestic partnership, birth, adoption or placement for adoption, 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 30 days of a qualifying event, 60 days if they are requesting enrollment due to a change in eligibility for Medicaid or Child Health Insurance Program (CHIP) coverage. There are requirements that you must meet to take advantage of a special enrollment period, including providing proof of your own or your Dependent's qualifying event. 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 the first 31 days after birth, adoption, placement for adoption, or placement for foster care. In

order for coverage to continue beyond this 31-day period, you must submit an enrollment application to your Group within 31 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 30 days after the qualifying event.

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

When Coverage Begins

Your Group will notify you of the date 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 in compliance with 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*.

We will not directly or indirectly prohibit you from freely contracting at any time to obtain non-covered Services. However, if you choose to receive non-covered Services, you will be responsible for the full price of the Services. Company is not responsible for any amounts you are billed for non-covered Services. Any amounts you pay for non-covered Services will not count toward your Deductible or Out-of-Pocket Maximum.

Using Your Identification Card

We provide each Member with a Company identification (ID) card that contains the Member health record number. Have your health record number available when you call for advice, make an appointment, or seek Services. We use your health record number to identify your dental records, for billing purposes and for membership information. You should always have the same health record number. If we ever inadvertently issue you more than one health record number, let us know by calling 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 and on the "Schedule of Covered Pediatric Dental Procedures" located at the back of this *EOC*, 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 two business days after we receive the request.

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 Cost Share 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.

Benefit Maximum

This Benefit Maximum section applies to covered Services you receive on or after the first day of the month after you turn 19 years of age. 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 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, please note that these Services may not count toward the plan Benefit Maximum. Your orthodontic coverage may 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.

Deductible

In any Year, we will not cover Services that are subject to the Deductible until you meet the Member Deductible or the Family Deductible as shown on the "Benefit Summary" during that Year. The only payments that count toward the Deductible are those you make for covered Services that are subject to the Deductible under this *EOC* (and any Deductible take-over amounts as described below). The "Benefit Summary" indicates which Services are subject to the Deductible. Payments you make for amounts in excess of the Maximum Allowable Charge (MAC) or the Usual and Customary Charge (UCC) do not count toward the Deductible.

For Services that are subject to the Deductible, you must pay all Charges for the Services when you receive them, until you meet your Deductible.

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

After you meet the Deductible, you pay the applicable Copayment or Coinsurance for covered Services for the remainder of the Year, until you meet your Out-of-Pocket Maximum (see Out-of-Pocket Maximum" in this 'What You Pay" section). You will also be responsible for paying any amount over the Maximum Allowable Charge (MAC) or Usual and Customary Charge (UCC) for Services you receive from Non-Participating Providers.

For each Year, the following amounts count toward your Deductible:

- Charges you pay for covered Services you receive in that Year and that are subject to the Deductible.
- Deductible take-over. If this *EOC* replaces prior group dental coverage with us or with another carrier, amounts that were applied toward a deductible under the prior coverage will be credited toward the Deductible under this *EOC* if you provide documentation demonstrating that:
    - The Services were received between January 1 and the effective date of coverage of this *EOC*, not to exceed a 12-month period.
    - The Services would have been covered and subject to the Deductible under this *EOC* if you had received them, or if a Participating Provider had provided them, or if we had authorized them during the term of this *EOC*.

Copayments and Coinsurance

When you receive covered Services, you are responsible for Copayments and Coinsurance, after you meet any applicable Deductible, 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.

Out-of-Pocket Maximum

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

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

together meet the Family Out-of-Pocket Maximum, whichever amount occurs first. Each Member Out-of-Pocket Maximum amount counts toward the Family Out-of-Pocket Maximum amount.

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

Note: There is no Out-of-Pocket Maximum for Services you receive from Non-Participating Providers, and amounts you pay for those Services do not count toward the Out-of-Pocket Maximum for Services you receive from Participating Providers. Dental Choice Customer Service can provide you with the amount you have paid toward your Out-of-Pocket Maximum.

BENEFITS

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

- You are a Member on the date you receive the Services.
- The Services are Dentally Necessary.
- The covered Services are provided, prescribed, authorized, or directed by a Dentist.
- The Service is listed on the "Schedule of Covered Pediatric Dental Procedures" located at the back of this *EOC*.

Coverage is based on the least costly treatment alternative. If you request a Service that is a more costly treatment alternative from that recommended by your 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.
- 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.

Dental Implant Services

We cover the following Dental Implant Services, subject to the requirements described in this "Dental Implant Services" section for Members age 19 years and older:

- Surgical placement and removal of a Dental Implant once per tooth space per lifetime including diagnostic consultations, occlusal analysis, bone augmentation and grafts, impressions, oral surgery, placement, and Services associated with postoperative conditions and complications arising from Dental Implants or removals;

- The final crown and implant Abutment over a single implant;
- The final implant-supported bridge Abutment and implant Abutment; or
- An alternate benefit per arch of a full or partial denture for the final implant-supported full or partial denture prosthetic device when the implant is placed to support a prosthetic device.
- Cleaning of Dental Implant prosthesis and Abutments including scaling debridement, and cleaning of implant surfaces performed as part of routine prophylaxis and periodontal maintenance or as Dentally Necessary.
- Dental Implant maintenance when the prosthesis is removed and reinserted, including cleaning of the prosthesis and Abutments.

Note: A Pontic used in an implant-supported bridge is not covered under this "Dental Implant Services" section. Refer instead to the "Major Restorative Services" section and Benefit Summary for coverage and Cost Share for Pontics).

We cover these Services only if you meet all of the following requirements:

- You receive all care and Services in the continuous implant treatment plan directed by your Participating Provider or Non-Participating Provider.
- You maintain continuous eligibility under this or any other Company dental contract that includes coverage for Dental Implant Services.
- You make timely payment of amounts due.

In all other cases, implant treatment may be completed at the full price for the Service.

Benefit Maximum

All Services covered in this "Dental Implant Services" section count toward your benefit maximum as shown in the "Benefit Summary."

Dental Implant Services Exclusions

- A Dental Implant, or any part of a dental implant, that has been surgically placed prior to your effective date of coverage.
- Eposteal and transosteal implants.
- Implant-supported bridges are not covered if one or more of the Abutments are supported by a natural tooth.
- Myofunctional therapy.
- Treatment of cleft palate.
- Treatment of macroglossia.
- Treatment of micrognathia.
- Treatment of primary/transitional dentition.

Dental Implant Services Limitations

- Routine scaling, debridement, and cleaning of Dental Implant surfaces, when performed as part of routine prophylaxis and periodontal maintenance, is limited to two visits per Year.
- Dental Implant maintenance when the prosthesis is removed and reinserted, including cleaning of the prosthesis and Abutments, is limited to once every two years.

- Repair of a Dental Implant is not covered, except when the Member has five or more years of continuous dental coverage under this or any other Company dental contract that includes coverage for Dental Implant Services. This limitation does not apply to Services associated with postoperative conditions or complications arising from Dental Implants or removals, or to Services associated with failure of a Dental Implant.
- These benefits or alternate benefits are not provided if the tooth, Dental Implant, or tooth space received a cast restoration or fixed or removable prosthodontic benefit, including a Pontic, within the previous five years.

Orthodontic Services

We cover Medically Necessary Orthodontic Services for Members with a diagnosis of cleft palate or cleft lip (subject to the "Exclusions and Limitations" section) until the end of the month in which the Member turns 19 years of age.

We also cover Orthodontic Services for abnormally aligned or positioned teeth (subject to the "Exclusions and Limitations" section).

In order to be covered for orthodontic Services you must meet the following conditions:

- You receive all care and Services in the continuous orthodontic treatment plan directed by your Participating Provider or Non-Participating Provider.
- You maintain continuous eligibility under this or any other Company dental contract that includes coverage for Orthodontic Services.
- You make timely payment of amounts due.

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

Benefit Maximum

Coverage of Orthodontic Services for abnormally aligned or positioned teeth has a Lifetime Benefit Maximum. For purposes of this section, a Lifetime Benefit Maximum means we will not cover more than the amount shown in the "Benefit Summary" for all covered Orthodontic Services during your lifetime. Your Lifetime Benefit Maximum is calculated by adding up the Charges for all Orthodontic Services we covered under this *EOC* or under any other *EOC* with the same group number printed on the *EOC* and subtracting any Cost Share you paid for those Services.

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.

Other Dental Services

We cover other dental Services as follows:

- Dental Services in conjunction with Medically Necessary general anesthesia or a medical emergency (subject to the "Exclusions and Limitations" section). We cover the dental Services described in the "Benefits" section when provided in a hospital or ambulatory surgical center if the Services are performed at that location in order to obtain Medically Necessary general anesthesia for a Member or in a hospital's emergency department in order to provide dental Services in conjunction with a medical emergency. .We

cover Medically Necessary general anesthesia or sedation until the end of the month in which the Member turns 19 years of age, and for any Member, regardless of age, who is physically or mentally disabled.

- 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.

Teledentistry Services

Teledentistry is a means of delivering oral health care Services using information and telecommunication technologies, to provide consultation and education, or to facilitate diagnosis, treatment, care management or self-management of your oral health. Technologies include, but are not limited to, real-time audio and/or video conferencing, secure web-based communication, and secure asynchronous information exchange to transmit dental information such as digital images and laboratory results.

We cover teledentistry Services at the applicable "Teledentistry Services" Cost Share shown in your "Benefit Summary" if:

- The Service is otherwise covered under this EOC if received in person;
- The Service is Dentally Necessary;
- The Service is determined to be safely and effectively provided using teledentistry, according to generally accepted dental care practices and standards; and
- The application and technology used to provide the Service meets all standards required by state and federal laws governing the privacy and security of protected health information.

For Services that can be appropriately provided using teledentistry, you may choose to receive the covered Service via teledentistry or in person. You are not required to have an established patient-provider relationship with the Participating Provider or Non-Participating Provider to receive teledentistry Services.

Telephone and Video Visits

If you have a dental condition that does not require an in-person exam, you have the option to schedule a telephone visit, just as you would with an in-person appointment. If you prefer to meet face-to-face with the provider online by computer, smartphone, or tablet, you may set up a video visit.

In a teledentistry visit, the Participating Provider or Non-Participating Provider will meet with you about your dental problem and concerns, may guide you through an exam of your mouth, provide instructions on how to treat the condition, prescribe medication if necessary, and determine if you need to schedule an in-person visit. If you have a cracked or chipped tooth, lesion or swelling on the gum, or dental pain, a teledentistry visit may be an option for you. Telephone and video visits are also appropriate for specialty care such as pre-op and post-op appointments.

To schedule a telephone visit or video visit with a Participating Provider, call Dental Choice Customer Service. To schedule a telephone visit or video visit with a Non-Participating Provider, contact that provider's office. Please note, not all dental conditions can be treated through teledentistry visits. The dental provider will identify any condition for which treatment by in-person visit is needed.

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.
- 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 Services not listed in the "Benefits" section or on the "Schedule of Covered Pediatric Dental Procedures" located at the back of this *EOC*.
- Drugs obtainable with or without a prescription. These may be covered under your medical benefits.
- Experimental or investigational treatments, procedures, and other Services that are not commonly considered standard dental practice or that require U.S. Food and Drug Administration (FDA) approval. A Service is experimental or investigational if:
    - the Service is not recognized in accordance with generally accepted dental standards as safe and effective for use in treating the condition in question, whether or not the Service is authorized by law for use in testing, or other studies on human patients; or
    - the Service requires approval by FDA authority prior to use and such approval has not been granted when the Service is to be rendered.
- Fees a provider may charge for a missed appointment.
- For Members age 19 years and older, replacement of prefabricated, noncast crowns, including noncast stainless steel crowns, except when the Member has five or more years of continuous dental coverage with Company.
- Full mouth reconstruction, including, but not limited to, the extensive restoration of the mouth with crowns, bridges, or implants; and occlusal rehabilitation, including crowns, bridges, or implants used for the purpose of splinting, altering vertical dimension, restoring occlusions, or correcting attrition, abrasion, or erosion.
- Genetic testing.
- Maxillofacial surgery.
- Medical or Hospital Services, unless otherwise specified in the *EOC*.
- Myofunctional therapy.
- Non-orthodontic recording of jaw movements or positions.
- Orthodontic treatment of primary/transitional dentition.
- Orthognathic surgery.
- Procedures, appliances, or fixed crowns and bridges for periodontal splinting of teeth.
- Prosthetic devices following extraction of a tooth (or of teeth) for nonclinical reasons or when a tooth is restorable.
- Replacement of broken orthodontic appliances.
- Replacement of lost or damaged space maintainers.

- Re-treatment of orthodontic Services cases.
- Services performed by someone other than a Participating Provider or Non-Participating Provider.
- Speech aid prosthetic devices and follow up modifications.
- Surgery to correct malocclusion or temporomandibular joint (TMJ) disorders; treatment for problems of the jaw joint, including temporomandibular joint (TMJ) syndrome and craniomandibular disorders; and treatment of conditions of the joint linking the jaw bone and skull and of the complex of muscles, nerves, and other tissues related to that joint.
- Treatment of cleft palate for Members age 19 years and older.
- Treatment of macroglossia.
- Treatment of micrognathia.
- Treatment to restore tooth structure lost due to attrition, erosion, or abrasion.
- Use of alternative materials for the removal and replacement of clinically acceptable material or restorations is not covered for any reason, except when the pathological condition of the tooth (or teeth) warrants replacement.

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 24 months. Subsequent debridement within this period will require Prior Authorization.
- Medically Necessary general anesthesia Services are covered only when provided in conjunction with the dental Services described in the "Benefits" section, if the general anesthesia or sedation Services are Medically Necessary because the Member is a child 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, or who is physically or mentally disabled, along with the Medically Necessary general anesthesia or sedation.
- 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.
- 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; or
  - 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

Coordination of Benefits

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

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

Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Order of Benefit Determination Rules

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

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

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

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

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

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

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

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

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

(i) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(ii) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

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

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

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

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

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

The Plan covering the Custodial Parent;

The Plan covering the spouse of the Custodial Parent;

The Plan covering the non-Custodial Parent; and then

The Plan covering the spouse of the non-Custodial Parent.

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

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

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

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

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

Effect on the Benefits of This Plan

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

Questions About Coordination of Benefits?
Contact Your State Insurance Department

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

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

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

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

Subject to applicable law, if you obtain a settlement, award, or judgment from or on behalf of another party or insurer, or a payment under a no-fault insurance provision, you must ensure we are reimbursed for covered Services that you receive for the injury or illness.

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

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

To the extent permitted by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against another party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by another party. We will be so subrogated as of the time we mail or deliver a written notice

of our exercise of this option to you or your attorney, but we will be subrogated only to the extent of the total Charges for the relevant covered Services.

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

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

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

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

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

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

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

In addition to the rights set forth above, we shall also be entitled to all of the remedies, benefits, and other rights of sections 742.520 – 742.544, Oregon Revised Statutes.

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

Workers' Compensation or Employer's Liability

If you suffer from an injury or illness that is compensable under a workers' compensation or employer's liability law, we will provide Services even if it is unclear whether you are entitled to a payment or settlement under the law. You have an obligation to reimburse us to the extent of a payment or any other benefit, including any amount you receive as a settlement under the law.

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

GRIEVANCES, CLAIMS, AND APPEALS

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

Member Satisfaction Procedure

We want you to be satisfied with the Services you receive from Kaiser Permanente. We encourage you to discuss any questions or concerns about your care with your Dentist or another member of your dental care

team. If you are not satisfied with your Dentist, you may request another. Contact Dental Choice Customer Service for assistance. You always have the right to a second opinion from a qualified Dentist at the applicable Cost Share.

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

- Call 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

All complaints are handled in a confidential manner.

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

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

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

Language and Translation Assistance

If we send you a grievance or adverse benefit determination correspondence, we will include a notice of language assistance (oral translation). You may request language assistance with your claim and/or appeal by calling 1-800-324-8010. The notice of language assistance "Help in Your Language" is also included in this *EOC*.

Appointing a Representative

If you would like someone to act on your behalf regarding your claim, you may appoint an authorized representative, an individual who by law or by your consent may act on your behalf. You must make this appointment in writing. Contact 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 file a complaint or seek other assistance from the Consumer Advocacy Section of the Division of Financial Regulation. Contact them by mail, email, telephone, fax, or online at:

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

Reviewing Information Regarding Your Claim

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

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.

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 that you want to make a claim for us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your claim. You must mail or fax your claim to us at:

  Kaiser Foundation Health Plan of the Northwest
  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 two business days after we receive your claim.

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

If more information is needed to make a decision, we will ask you for the information in writing within two business days after we receive your claim, and we will give you 15 calendar days to send the information.

We will make a decision and send notification within two business days after we receive the first piece of information (including documents) we requested.

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

If we do not receive any of the requested information (including documents) within 15 calendar days after we send our request, we will make a decision based on the information we have no later than 15 calendar days following the date the additional information was requested.

If we notify you of our decision orally, we will send you written confirmation no later than two business days after the oral notification.

- 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 business days after we receive your claim.
- We may extend the time for making a decision for an additional 15 calendar days if circumstances beyond our control delay our decision, if we notify you prior to the expiration of the initial decision period.
- If more information is needed to make a decision, we will ask you for the information in writing within 2 business days after we receive your claim, and we will give you 15 calendar days to send the information.
- We will make a decision and send notification within two business days after we receive the first piece of information (including documents) we requested.
- We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision.
- If we do not receive any of the requested information (including documents) within 15 calendar days after we send our request, we will make a decision based on the information we have no later than 15 calendar days following the date the additional information was requested.

  If we notify you of our decision orally, we will send you written confirmation no later than two business days after the oral notification.
- If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

Non-Urgent Pre-service Appeal

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

  (1) Your name and health record number;

  (2) Your dental condition or relevant symptoms;

  (3) The specific Service that you are requesting;

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

(5) All supporting documents.

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

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 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 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 calendar 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 us in detail of the reasons that your authorized ongoing care should be continued or extended. Your request and any related documents you give us constitute your claim. You must mail or fax your claim 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

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

- We will review your claim, and if we have all the information we need, we will make a decision within a reasonable period of time.

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

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

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

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

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

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

If we do not receive any of the requested information (including documents) within 45 calendar days after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 calendar days following the end of the timeframe we gave you for sending the additional information.

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

Urgent Concurrent Care Claim

- If we consider your concurrent care claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but no later than 24 hours after we received your claim. If we notify you of our decision orally, we will send you written confirmation within three calendar days after the oral notification.
- If more information is needed to make a decision, we will give you seven calendar days to send the information.
- 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 notify you of our decision within 48 hours of receiving the first piece of requested information or by the deadline for receiving the information, whichever is sooner.
- If we deny your claim (if we do not agree to provide or pay for extending the ongoing course of treatment), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

Non-Urgent Concurrent Care Appeal

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

  (1) Your name and health record number;

  (2) Your dental condition or relevant symptoms;

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

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

  (5) All supporting documents.

  Your request and all supporting documents constitute your appeal. You must mail 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 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 30 calendar days after we receive your appeal.

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

Urgent Concurrent Care Appeal

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

  (1) Your name and health record number;

  (2) Your dental condition or relevant symptoms;

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

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

  (5) All supporting documents.

  Your request and the supporting documents constitute your appeal. You must mail 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 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 calendar 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 us a letter explaining the Services for which you are requesting payment. Provide us with the following:

  (1) The date you received the Services;

  (2) Where you received them;

(3) Who provided them;

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

(5) A copy of the bill and any supporting documents, including dental records.

Your letter and the related documents constitute your claim. You may contact 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, we will send you a written decision within 30 calendar days after we receive your claim.

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

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

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

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

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

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

Post-service Appeal

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

  (1) Your name and health record number;

  (2) Your dental condition or relevant symptoms;

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

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

  (5) All supporting documents.

Your request and the supporting documents constitute your appeal. You must mail 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 five calendar days after we receive it.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and send you a written decision within 30 calendar days after we receive your appeal.
- If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal.

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 Subscriber's membership ends.

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

Termination Due to Loss of Eligibility

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

Termination for Cause

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

- You knowingly commit fraud and intentional misrepresentation in connection with membership, Company, or a Participating Provider. Some examples of fraud include:
  - Misrepresenting eligibility information about yourself or a Dependent.
  - Presenting an invalid prescription or dental order.

- Intentionally misusing a Company ID card (or letting someone else use your ID card to obtain Services while pretending to be you).
- Giving us incorrect or incomplete material information.
- Failing to notify us of changes in Family status or Medicare coverage that may affect your eligibility or benefits.

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

If we terminate your membership for cause we will:

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

We may deduct any amounts you owe Company 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 the *Agreement* with us terminates.

Termination of a Product or All Products

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

CONTINUATION OF MEMBERSHIP

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

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

Federal or State-Mandated Continuation of Coverage

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

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

MISCELLANEOUS PROVISIONS

Administration of *Agreement*

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

Agreement Binding on Members

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

Amendment of *Agreement*

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

Applications and Statements

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

Assignment

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

Attorney Fees and Expenses

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

Governing Law

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

Group and Members Not Company Agents

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

No Waiver

Our failure to enforce any provision of this *EOC* will not constitute a waiver of that or any other provision, nor will it impair our right thereafter to require your strict performance of any provision.

Nondiscrimination

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

Notices

We will send our notices to you to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change of address. Subscribers who move should call 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.

SCHEDULE OF COVERED PEDIATRIC DENTAL PROCEDURES

Code	Description
D0120	Periodic oral exam
D0140	Limited oral evaluation – problem focused
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver
D0150	Comprehensive oral evaluation – new or established patient

Code	Description
D0160	Detailed and extensive oral evaluation, problem focused – by report
D0170	Re-evaluation – limited, problem focused (established patient, not post-operative visit)
D0180	Comprehensive periodontal evaluation
D0190	Screening of patient
D0191	Assessment of patient
D0210	Intraoral – complete series of radiographic images
D0220	Intraoral – periapical, first radiographic image
D0230	Intraoral – periapical, each additional radiographic image
D0240	Intraoral – occlusal radiographic image
D0250	Extraoral – 2D projection radiographic image created using a stationary radiation source and detector
D0251	Extraoral posterior dental radiographic image
D0270	Bitewing – single radiographic image
D0272	Bitewings – two radiographic images
D0273	Bitewings – three radiographic images
D0274	Bitewings – four radiographic images
D0277	Vertical bitewings – 7 to 8 radiographic images
D0330	Panoramic radiographic image
D0340	2D cephalometric radiographic image – acquisition, measurement, and analysis
D0350	Oral/facial photographic images
D0364	Cone beam CT capture and interpretation, limited field of view, less than one whole jaw
D0365	Cone beam CT capture and interpretation, view of one full dental arch – mandible
D0366	Cone beam CT capture and interpretation, view of one full dental arch – maxilla
D0367	Cone beam CT capture and interpretation, view of both jaws
D0368	Cone beam CT capture and interpretation, for TMJ series
D0380	Cone beam CT image capture, limited field of view, less than one whole jaw
D0381	Cone beam CT image capture, view of one full dental arch – mandible
D0382	Cone beam CT image capture, view of one full dental arch – maxilla
D0383	Cone beam CT image capture, view of both jaws
D0384	Cone beam CT image capture, for TMJ series including 2 or more exposures
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report
D0460	Pulp vitality tests
D0470	Diagnostic casts
D0601	Caries risk assessment and documentation, with a finding of low risk

Code	Description
D0602	Caries risk assessment and documentation, with a finding of moderate risk
D0603	Caries risk assessment and documentation, with a finding of high risk
D0604	Antigen testing for a public health related pathogen including coronavirus
D0701	Panoramic radiographic image – image capture only
D0702	2D cephalometric radiographic image – image capture only
D0703	2D cephalometric radiographic image obtained intra-orally or extra-orally – image capture only
D0705	Extra-oral posterior dental radiographic image – image capture only
D0706	Intraoral occlusal radiographic image – image capture only
D0707	Intraoral periapical radiographic image – image capture only
D0708	Intraoral bitewing radiographic image – image capture only
D0709	Intraoral complete series of radiographic images – image capture only
D0801	3D dental surface scan – direct
D0802	3D dental surface scan – indirect; surface scan of a diagnostic cast
D0803	3D facial surface scan – direct
D0804	3D facial surface scan – indirect; surface scan of constructed facial features
D1110	Prophylaxis – adult
D1120	Prophylaxis – child
D1206	Topical application of fluoride varnish
D1208	Topical application of fluoride
D1310	Nutritional counseling for control of dental disease
D1320	Tobacco counseling for the control and prevention of oral disease
D1321	Counseling for the control & prevention of adverse oral, behavioral & systemic health effects associated with high-risk substance use
D1330	Oral hygiene instruction
D1351	Sealant – per tooth
D1352	Preventive resin restoration in a moderate to high caries risk patient, permanent tooth
D1353	Sealant repair – per tooth
D1354	Interim caries arresting medicament application
D1355	Caries preventive medicament application, per tooth
D1510	Space maintainer – fixed unilateral
D1516	Space maintainer – fixed bilateral – maxillary
D1517	Space maintainer – fixed bilateral – mandibular
D1520	Space maintainer – removable unilateral
D1526	Space maintainer – removable bilateral – maxillary

Code	Description
D1527	Space maintainer – removable bilateral – mandibular
D1551	Re-cement or re-bond bilateral space maintainer – maxillary
D1552	Re-cement or re-bond bilateral space maintainer – mandibular
D1553	Re-cement or re-bond bilateral space maintainer – per quadrant
D1556	Removal of fixed unilateral space maintainer – per quadrant
D1557	Removal of fixed bilateral space maintainer – maxillary
D1558	Removal of fixed bilateral space maintainer – mandibular
D1575	Distal shoe space maintainer – fixed-unilateral
D2140	Amalgam – one surface, primary or permanent
D2150	Amalgam – two surfaces, primary or permanent
D2160	Amalgam – three surfaces, primary or permanent
D2161	Amalgam – four or more surfaces, primary or permanent
D2330	Resin-based composite – one surface, anterior
D2331	Resin-based composite – two surfaces, anterior
D2332	Resin-based composite – three surfaces, anterior
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)
D2390	Resin-based composite crown, anterior
D2391	Resin-based composite – one surface, posterior
D2392	Resin-based composite – two surfaces, posterior
D2393	Resin-based composite – three surfaces, posterior
D2394	Resin-based composite – four or more surfaces, posterior
D2510	Inlay – metallic, one surface
D2520	Inlay – metallic, two surfaces
D2530	Inlay – metallic, three or more surfaces
D2542	Onlay – metallic, two surfaces
D2543	Onlay – metallic, three surfaces
D2544	Onlay – metallic, four or more surfaces
D2610	Inlay – porcelain/ceramic, one surface
D2620	Inlay – porcelain/ceramic, two surfaces
D2630	Inlay – porcelain/ceramic, three or more surfaces
D2642	Onlay – porcelain/ceramic, two surfaces
D2643	Onlay – porcelain/ceramic, three surfaces
D2644	Onlay – porcelain/ceramic, four or more surfaces

Code	Description
D2650	Inlay – resin-based composite, one surface
D2651	Inlay – resin-based composite, two surfaces
D2652	Inlay – resin-based composite, three or more surfaces
D2662	Onlay – resin-based composite, two surfaces
D2663	Onlay – resin-based composite, three surfaces
D2664	Onlay – resin-based composite, four or more surfaces
D2710	Crown – resin-based composite (indirect)
D2712	Crown – ¾ resin-based composite (indirect)
D2720	Crown – resin with high noble metal
D2721	Crown – resin with predominantly base metal
D2722	Crown – resin with noble metal
D2740	Crown – porcelain/ceramic substrate
D2750	Crown – porcelain fused to high noble metal
D2751	Crown – porcelain fused to predominantly base metal
D2752	Crown – porcelain fused to noble metal
D2753	Crown – porcelain fused to titanium and titanium alloys
D2780	Crown – ¾ cast to high noble metal
D2781	Crown – ¾ cast to predominantly base metal
D2782	Crown – ¾ cast noble metal
D2783	Crown – ¾ porcelain/ceramic (does not include facial veneers)
D2790	Crown – full cast high noble metal
D2791	Crown – full cast predominantly base metal
D2792	Crown – full cast noble metal
D2794	Crown – titanium
D2799	Provisional crown (not a temporary crown)
D2910	Recement inlay, onlay, or partial coverage restoration
D2915	Recement cast or prefabricated post and core
D2920	Recement crown
D2921	Reattachment of tooth fragment, incisal edge or cusp
D2928	Prefabricated porcelain/ceramic crown – permanent tooth
D2929	Prefabricated porcelain/ceramic crown – primary tooth
D2930	Prefabricated stainless steel crown – primary tooth
D2931	Prefabricated stainless steel crown – permanent tooth

Code	Description
D2932	Prefabricated resin crown
D2933	Prefabricated stainless steel crown with resin window
D2934	Prefabricated aesthetic coated stainless steel crown – primary
D2940	Protective restoration
D2941	Interim therapeutic restoration – primary dentition
D2949	Restorative foundation for an indirect restoration
D2950	Core build-up, including any pins
D2951	Pin retention/tooth, in addition to restoration
D2952	Cast post and core in addition to crown, indirectly fabricated
D2953	Each additional indirectly fabricated cast post – same tooth
D2954	Prefabricated post and core in addition to crown
D2955	Post removal
D2957	Each additional prefabricated post – same tooth
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework. This procedure is in addition to the separate crown procedure documented with its own code.
D2975	Coping
D2980	Crown repair necessitated by restorative material failure
D2981	Inlay repair necessitated by restorative material failure
D2982	Onlay repair necessitated by restorative material failure
D2990	Resin infiltration of incipient smooth surface lesions
D3110	Pulp cap – direct (excluding final restoration)
D3120	Pulp cap – indirect (excluding final restoration)
D3220	Therapeutic pulpotomy (excluding final restoration)
D3221	Gross pulpal debridement
D3222	Partial pulpotomy for apexogenesis
D3230	Pulpal therapy resorbable filling – anterior primary tooth (excluding final restoration)
D3240	Pulpal therapy resorbable filling – posterior primary tooth (excluding final restoration)
D3310	Root canal – anterior (excluding final restoration)
D3320	Root canal – bicuspid (excluding final restoration)
D3330	Root canal – molar (excluding final restoration)
D3331	Treatment of root canal obstruction – non-surgical access
D3332	Incomplete root canal therapy – inoperable, unrestorable, or fractured tooth
D3333	Internal root repair of perforation defects
D3346	Re-treatment previous root canal therapy – anterior

Code	Description
D3347	Re-treatment previous root canal therapy – bicuspid
D3348	Re-treatment previous root canal therapy – molar
D3351	Apexification/recalcification – initial visit
D3352	Apexification/recalcification – interim medication replacement
D3353	Apexification/recalcification – final visit
D3355	Pulpal regeneration – initial visit
D3356	Pulpal regeneration – interim medication replacement
D3357	Pulpal regeneration – completion of treatment
D3410	Apicoectomy – anterior
D3421	Apicoectomy – bicuspid (first root)
D3425	Apicoectomy – molar (first root)
D3426	Apicoectomy (each additional root)
D3428	Bone graft in conjunction with periradicular surgery – per tooth, single site
D3429	Bone graft in conjunction with periradicular surgery – each additional contiguous tooth in same surgical site
D3430	Retrograde filling – per root
D3431	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery
D3432	Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery
D3450	Root amputation – per root
D3470	Intentional reimplantation (including necessary splinting)
D3471	Surgical repair of root resorption – anterior
D3472	Surgical repair of root resorption – premolar
D3473	Surgical repair of root resorption – molar
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar
D3910	Surgical procedure for isolation of tooth with rubber dam
D3911	Intraorifice barrier
D3920	Hemisection – including root removal, not including root canal
D3921	Decoronation or submergence of an erupted tooth
D3950	Canal preparation and fitting of preformed dowel or post
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant

Code	Description
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant
D4245	Apically positioned flap
D4249	Clinical crown lengthening – hard tissue
D4260	Osseous surgery (including flap entry/closure) – four or more contiguous teeth or tooth bounded spaces per quadrant
D4261	Osseous surgery (including flap entry/closure) – one to three contiguous teeth or tooth bounded spaces per quadrant
D4263	Bone replacement graft – first site in quadrant
D4264	Bone replacement graft – each additional site in quadrant
D4266	Guided tissue regeneration – resorbable barrier per site
D4267	Guided tissue regeneration – nonresorbable barrier per site (includes membrane removal)
D4268	Surgical revision procedure, per tooth
D4270	Pedicle soft tissue graft procedure
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)
D4275	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) first tooth, implant, or edentulous tooth position in graft
D4276	Combined connective tissue and pedicle graft, per tooth
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth or edentulous tooth position in graft
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth or edentulous tooth position in same graft site
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites), each additional contiguous tooth, implant or edentulous tooth position in same graft site
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material), each additional contiguous tooth, implant or edentulous tooth position in same graft site
D4341	Periodontal scaling and root planing – four or more teeth per quadrant
D4342	Periodontal scaling & root planing – one to three teeth per quadrant
D4346	Scaling moderate or severe gingival inflammation – full mouth, after oral evaluation

Code	Description
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth
D4910	Periodontal maintenance (following active therapy)
D4920	Unscheduled dressing change (not by treating dentist)
D4921	Gingival irrigation – per quadrant
D5110	Complete denture – maxillary
D5120	Complete denture – mandibular
D5130	Immediate denture – maxillary
D5140	Immediate denture – mandibular
D5211	Maxillary partial denture – resin base (including any clasps, rests, and teeth)
D5212	Mandibular partial denture – resin base (including any clasps, rests, and teeth)
D5213	Maxillary partial denture – metal frame with resin base (including any clasps, rests, and teeth)
D5214	Mandibular partial denture – metal frame with resin base (including any clasps, rests, and teeth)
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)
D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5225	Maxillary partial denture – flexible base (including any clasps, rests, and teeth)
D5226	Mandibular partial denture – flexible base (including any clasps, rests, and teeth)
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)
D5410	Adjust complete denture – maxillary
D5411	Adjust complete denture – mandibular
D5421	Adjust partial denture – maxillary
D5422	Adjust partial denture – mandibular
D5511	Repair broken complete denture base – mandibular
D5512	Repair broken complete denture base – maxillary
D5520	Replace miss/broken teeth – complete denture (each tooth)
D5611	Repair resin partial denture base – mandibular
D5612	Repair resin partial denture base – maxillary
D5621	Repair cast partial framework – mandibular

Code	Description
D5622	Repair cast partial framework – maxillary
D5630	Repair or replace broken clasp, per tooth
D5640	Replace broken teeth – per tooth, partial denture
D5650	Add tooth to existing partial denture
D5660	Add clasp to existing partial denture, per tooth
D5670	Replace all teeth & acrylic – cast metal frame, maxillary
D5671	Replace all teeth & acrylic – cast metal frame, mandibular
D5710	Rebase complete maxillary denture
D5711	Rebase complete mandibular denture
D5720	Rebase maxillary partial denture
D5721	Rebase mandibular partial denture
D5725	Rebase hybrid prosthesis
D5730	Reline complete maxillary denture (chairside)
D5731	Reline complete mandibular denture (chairside)
D5740	Reline maxillary partial denture (chairside)
D5741	Reline mandibular partial denture (chairside)
D5750	Reline complete maxillary denture (laboratory)
D5751	Reline compete mandibular denture (laboratory)
D5760	Reline maxillary partial denture (laboratory)
D5761	Reline mandibular partial denture (laboratory)
D5765	Soft liner for complete or partial removable denture – indirect
D5810	Interim complete denture – maxillary
D5811	Interim complete denture – mandibular
D5820	Interim partial denture – maxillary
D5821	Interim partial denture – mandibular
D5850	Tissue conditioning – maxillary
D5851	Tissue conditioning – mandibular
D5863	Overdenture – complete maxillary
D5864	Overdenture – partial maxillary
D5865	Overdenture – complete mandibular
D5866	Overdenture – partial mandibular
D5875	Modification of removable prosthesis following implant surgery
D5876	Add metal substructure to acrylic full denture, per arch

Code	Description
D5899	Unspecified removable prosthetic procedure, by report
D5986	Fluoride gel carrier
D6205	Pontic – indirect resin based composite
D6210	Pontic – cast high noble metal
D6211	Pontic – cast predominantly base metal
D6212	Pontic – cast noble metal
D6214	Pontic – titanium
D6240	Pontic – porcelain fused to high noble metal
D6241	Pontic – porcelain fused to predominantly base metal
D6242	Pontic – porcelain fused to noble metal
D6243	Pontic – porcelain fused to titanium and titanium alloys
D6245	Pontic – porcelain/ceramic
D6250	Pontic – resin with high noble metal
D6251	Pontic – resin with predominantly base metal
D6252	Pontic – resin with noble metal
D6253	Provisional pontic (not temporary)
D6545	Retainer – cast metal for resin bonded fixed prosthesis
D6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis
D6549	Retainer – for resin bonded fixed prosthesis
D6600	Retainer inlay – porcelain/ceramic, two surfaces
D6601	Retainer inlay – porcelain/ceramic, three or more surfaces
D6602	Retainer inlay – cast high noble metal, two surfaces
D6603	Retainer inlay – cast high noble metal, three or more surfaces
D6604	Retainer inlay – cast predominantly base metal, two surfaces
D6605	Retainer inlay – cast predominantly base metal, three or more surfaces
D6606	Retainer inlay – cast noble metal, two surfaces
D6607	Retainer inlay – cast noble metal, three or more surfaces
D6608	Retainer onlay – porcelain/ceramic, two surfaces
D6609	Retainer onlay – porcelain/ceramic, three or more surfaces
D6610	Retainer onlay – cast high noble metal, two surfaces
D6611	Retainer onlay – cast high noble metal, three or more surfaces
D6612	Retainer onlay – cast predominantly base metal, two surfaces
D6613	Retainer onlay – cast predominantly base metal, three or more surfaces

Code	Description
D6614	Retainer onlay – cast noble metal, two surfaces
D6615	Retainer onlay – cast noble metal, three or more surfaces
D6624	Retainer inlay – titanium
D6634	Retainer onlay – titanium
D6710	Retainer crown – retainer – indirect resin based composite
D6720	Retainer crown – bridge retainer – resin with high noble metal
D6721	Retainer crown – bridge retainer – resin predominantly base metal
D6722	Retainer crown – resin with noble metal
D6740	Retainer crown – retainer – porcelain/ceramic
D6750	Retainer crown – retainer – porcelain fused to high noble metal
D6751	Retainer crown – retainer – porcelain fused to predominantly base metal
D6752	Retainer crown – retainer – porcelain fused to noble metal
D6753	Retainer crown – porcelain fused to titanium and titanium alloys
D6780	Retainer crown – retainer ¾ cast high noble metal
D6781	Retainer crown – retainer ¾ predominantly base metal
D6782	Retainer crown – retainer ¾ cast noble metal
D6783	Retainer crown – retainer ¾ porcelain/ceramic
D6784	Retainer crown ¾ – titanium and titanium alloys
D6790	Retainer crown – retainer – full cast high noble metal
D6791	Retainer crown – retainer – full cast predominantly base metal
D6792	Retainer crown – retainer – full cast noble metal
D6793	Provisional retainer crown (not temporary)
D6794	Retainer crown – retainer – titanium
D6920	Connector bar
D6930	Recement fixed partial denture
D6940	Stress breaker
D6950	Precision attachment
D6980	Fixed partial denture repair, necessitated by restorative material failure
D6985	Pediatric partial denture, fixed
D7111	Extraction, coronal remnants – deciduous tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Surgical removal of erupted tooth
D7220	Removal of impacted tooth – soft tissue

Code	Description
D7230	Removal of impacted tooth – partially bony
D7240	Removal of impacted tooth – completely bony
D7241	Removal of impacted tooth – completely bony with unusual complications
D7250	Surgical removal of residual tooth roots (cutting procedure)
D7251	Coronectomy – intentional partial tooth removal
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7270	Reimplantation or stabilization of accidentally evulsed or displaced tooth
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)
D7280	Surgical access of an unerupted tooth
D7282	Mobilization of erupted or malpositioned tooth to aid eruption; not in conjunction with extraction
D7283	Placement of device to facilitate eruption of impacted tooth
D7285	Biopsy of oral tissue – hard (bone, tooth)
D7286	Biopsy of oral tissue – soft
D7287	Exfoliative cytological sample collection
D7288	Brush biopsy – transepithelial sample collection
D7292	Placement of temporary anchorage device (screw retained plate) requiring flap
D7293	Placement of temporary anchorage device requiring flap
D7294	Placement of temporary anchorage device without flap
D7298	Removal of temporary anchorage device (screw retained plate), requiring flap
D7299	Removal of temporary anchorage device, requiring flap
D7300	Removal of temporary anchorage device without flap
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces per quadrant
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant
D7320	Alveoloplasty not in conjunction with extractions –four or more teeth or tooth spaces, per quadrant; no extractions performed in an edentulous area
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant; no extractions performed in an edentulous area
D7340	Vestibuloplasty – ridge extension (secondary epithelization)
D7350	Vestibuloplasty – ridge extension
D7410	Excision of benign tumor lesion up to 1.25 cm
D7411	Excision of benign lesion greater than 1.25 cm
D7412	Excision of benign lesion, complicated

Code	Description
D7413	Excision malignant lesion up to 1.25 cm
D7414	Excision malignant lesion greater than 1.25 cm
D7415	Excision malignant lesion, complicated
D7440	Excision malignant tumor – lesion up to 1.25 cm
D7441	Excision malignant tumor – lesion greater than 1.25 cm
D7450	Removal of odontogenic cyst/tumor/lesion up to 1.25 cm
D7451	Removal of odontogenic cyst/tumor/lesion greater than 1.25 cm
D7460	Removal of nonodontogenic cyst/tumor/lesion up to 1.25 cm
D7461	Removal of benign nonodontogenic cyst or tumor – lesion greater than 1.25 cm
D7465	Lesion destruction
D7471	Removal of lateral exostosis (maxilla or mandible)
D7472	Removal of torus palatinus
D7473	Removal of torus mandibularis
D7485	Surgical reduction of osseous tuberosity
D7490	Radical resection of maxilla or mandible
D7510	Incision and drainage abscess -intraoral soft tissue
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)
D7520	Incision and drainage of abscess – extraoral soft tissue
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)
D7530	Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
D7910	Suture of recent small wounds up to 5 cm
D7911	Complicated suture up to 5 cm, meticulous closure
D7912	Complicated suture greater than 5 cm, meticulous closure
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla
D7951	Sinus augmentation with bone or bone substitutes via lateral open approach
D7952	Sinus augmentation via vertical approach
D7953	Bone replacement graft for ridge preservation – per site
D7961	Buccal/labial frenectomy (frenulectomy)
D7962	Lingual frenectomy (frenulectomy)
D7963	Frenuloplasty

Code	Description
D7970	Excision of hyperplastic tissue – per arch
D7971	Excision of pericoronal gingiva
D7972	Surgical reduction of fibrous tuberosity
D8010	Limited orthodontic treatment – primary dentition
D8020	Limited orthodontic treatment – transitional dentition
D8030	Limited orthodontic treatment – adolescent dentition
D8040	Limited orthodontic treatment – adult dentition
D8070	Comprehensive orthodontic treatment of the transitional dentition
D8080	Comprehensive orthodontic treatment of the adolescent dentition
D8090	Comprehensive orthodontic treatment of the adult dentition
D8660	Pre-orthodontic treatment visit
D8681	Removable orthodontic retainer adjustment
D9110	Palliative (emergency) treatment of dental pain – minor procedure
D9120	Fixed partial denture sectioning
D9210	Local anesthesia not in conjunction with operative or surgical procedures
D9222	Deep sedation/general anesthesia – first 15 minute increment
D9223	Deep sedation/general anesthesia – each 15 minute increment
D9230	Nitrous oxide/analgesia, anxiolysis
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minute increment
D9243	Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment
D9248	Non-intravenous conscious sedation
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician
D9311	Treating dentist consultation with a medical health care professional
D9410	House/extended care facility call
D9420	Hospital or ambulatory surgical center call
D9430	Office visit for observation (regular hours) – no other services performed
D9440	Office visit – after regularly scheduled hours
D9450	Case presentation, detailed and extensive treatment planning established patient – not performed on the same day as evaluation
D9610	Therapeutic parenteral drug, single administration
D9612	Therapeutic parenteral drug, two or more administrations, different medications
D9630	Other drugs and/or medications, by report
D9910	Application of desensitizing medicament

Code	Description
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth
D9912	Pre-visit patient screening
D9920	Behavior management, by report
D9930	Treatment of complications (post-surgical) – unusual circumstances
D9932	Cleaning and inspection of removable complete denture, maxillary
D9933	Cleaning and inspection of removable complete denture, mandibular
D9934	Cleaning and inspection of removable partial denture, maxillary
D9935	Cleaning and inspection of removable partial denture, mandibular
D9942	Repair and/or reline of occlusal guard
D9943	Occlusal guard adjustment
D9951	Occlusal adjustment – limited
D9952	Occlusal adjustment – complete
D9970	Enamel microabrasion
D9971	Odontoplasty 1-2 teeth; includes removal of enamel projections
D9995	Teledentistry – synchronous; real-time encounter
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review
D9997	Dental case management – patients with special health care needs. special treatment considerations for patients/individuals with physical, medical, developmental or cognitive conditions resulting in substantial functional limitations or incapacitation, which require that modifications be made to delivery of treatment to provide customized or comprehensive oral health care services.
D9999	Unspecified adjunctive procedure, by report

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

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

NONDISCRIMINATION STATEMENT AND NOTICE OF LANGUAGE ASSISTANCE

Nondiscrimination Notice

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

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats

- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Member Services at **1-800-813-2000** (TTY: **711**).

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator, by mail, phone, or fax. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You may contact our Civil Rights Coordinator at:

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

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

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

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

Help in Your Language

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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