GROUP AGREEMENT

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Lewis & Clark College

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

April 5, 2013

Kris Codron
Lewis & Clark College
0615 S.W. Palatine Hill Road

Portland, OR 97219

Group number: 1495-006, 007

Dear Kris,

Enclosed is the Dental Plan Group Agreement effective April 1, 2013 through March 31, 2014 for Lewis & Clark College. There are two documents which serve as the entire contract. The Wrap (titled "Group Agreement") contains the group contract provisions, including rates. The Evidence of Coverage (EOC) is the member portion of the contract. The EOC contains benefit descriptions, limitations, exclusions, and instructions which assist the member in obtaining care. Wraps and EOCs are subgroup specific and it is possible to have multiple Wraps associated with the same EOC. Please review the list of contract changes including those things that may have been updated since the renewal notice was released.

We know you have a choice of health plans and we appreciate your business. If you have any questions about this Agreement or your health plan, please contact R Elisa Silva at (503) 813-2448.

Thank you for partnering with us to keep your employees healthy and productive.

Sincerely,

Kaiser Permanente Sales Team
Enclosures

/sm

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

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2013 *Group Agreement* and *Evidence of Coverage* Summary of Changes and Clarifications for Oregon Large Employer Groups

This is a summary of changes and clarifications that we have made to your *Group Agreement*. The *Group Agreement* includes the *Evidence of Coverage* (*EOC*), "Benefit Summary," riders, and any applicable endorsement documents. This summary does not include minor changes and clarifications we are making to improve the readability and accuracy of the *Group Agreement* and any changes we have made at your Group's request. Additional administrative changes may occur throughout the remainder of the year. Other Group-specific or product-specific plan design changes may apply, such as moving to standard benefits. Refer to the benefits shown on the rate and benefit summary pages in the Group's renewal packet for information about these types of changes.

To the extent that this summary of changes and clarifications conflicts with, modifies or supplements the information contained in your *Group Agreement*, the information contained in the *Group Agreement* shall supersede what is set forth below. Unless another date is listed, the changes in this document are effective when your Group renews in 2013. The products named below are offered and underwritten by Kaiser Foundation Health Plan of the Northwest.

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

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

Benefit changes

- The "Limited Outpatient Prescription Drugs, Supplies, and Supplements" *EOC* section has been modified. The medical plan now includes a cost share for outpatient administered medications. This change is also reflected on the *EOC* "Benefit Summary" under "Outpatient Services." This change brings our plans into better alignment with the industry.
- For Traditional Plans, Coinsurance for covered Outpatient Durable Medical Equipment (DME), External Prosthetic Devices, and Orthotic Devices now counts toward the Out-of-Pocket Maximum. For Added Choice Plans, this change applies to the Tier 1 benefit. Previously, Outpatient DME, External Prosthetic Devices, and Orthotic Devices counted toward the Out-of-Pocket Maximum in Tier 2 and Tier 3 only. This change brings our plans into better alignment with the industry and provides catastrophic out-of-pocket protection to our Members.
- For Deductible Plans, Coinsurance for covered Outpatient DME, External Prosthetic Devices, and Orthotic Devices now counts toward the Deductible and Out-of-Pocket Maximum. For Deductible Added Choice Plans, this change applies to the Tier 1 benefit. Previously, Outpatient DME, External Prosthetic Devices, and Orthotic Devices counted toward the Deductible and Out-of-Pocket Maximum in Tier 2 and Tier 3 only. This change brings our plans into better alignment with the industry and provides catastrophic out-of-pocket protection to our Members.
- Coinsurance for Ambulance Services now counts toward the Deductible and Out-of-Pocket Maximum for Deductible Plans. For Deductible Added Choice Plans, this change applies to Tier 1. Previously, Ambulance Services counted toward the Deductible and Out-of-Pocket Maximum in Tier 2 and Tier 3 only. This change brings our plans into better alignment with the industry and provides catastrophic out-of-pocket protection to our Members.

- Special diagnostic procedures (CT, MRI, and PET scans) are now subject to an increased Copayment. The change is reflected under "Outpatient Laboratory, X-rays, Imaging, and Special Diagnostic Procedures" in the *EOC* "Benefit Summary." This applies to Traditional Plans, Deductible Plans, and Added Choice Plans in Tier 1 and brings these plans into better alignment with the industry.
- The dollar allowance explanation for the state-mandated hearing aid benefit for Members under age 18 and any child Dependents has been modified in the "Hearing Services" *EOC* section. The statement that the dollar allowance can be used only at the initial point of sale has been deleted.
- The hearing aid annual allowance for the state-mandated hearing aid benefit for Members under age 18 and any child Dependents has been increased based on the Consumer Price Index for medical care. This change is reflected on the *EOC* "Benefit Summary" under "Hearing Services."
- Specialty care visits are now subject to a Copayment that is $10 higher than primary care visits on Traditional Plans as shown on the *EOC* "Benefit Summary." This change brings the plans into better alignment with the industry.
- The "Outpatient Durable Medical Equipment (DME), External Prosthetic Devices, and Orthotic Devices" *EOC* section has been modified. In the bullet describing coverage for external prostheses after a Medically Necessary mastectomy, coverage has increased from three brassieres required to hold a prosthesis to four brassieres every 12 months.
- The "Mental Health Services Exclusions and Limitations" *EOC* section has been modified. We no longer exclude mental health Services for gender-identity disorders in adults.
- For medical plans that include the Affordable Care Act (ACA) preventive care Services coverage with no Member cost share, the August 1, 2012 women's preventive care Services change has now been incorporated into your *EOC*. As a reminder, women's preventive care Services specified in the Health Resources and Services Administration (HRSA) guidelines are covered at no charge, not subject to any Deductible. Certain religious employer groups may be exempt from providing contraceptive coverage.

Benefit clarifications

- The definition of Out-of-Pocket Maximum in the "Definitions" *EOC* section has been modified. We have reworded the definition to reference Copayments and Coinsurance, instead of Charges, for clarification.
- The "Definitions" *EOC* section has been modified to align with provider and facility references in our *Medical Directory* and *Added Choice Medical Directory*.
- Several *EOC* sections have been updated to clarify the referral and prior authorization requirements for specialty Services and for Services from Non-Participating Providers and Non-Participating Facilities.
- The "Preventive Care Services" *EOC* section has been modified. We have provided website links to the U.S. Preventive Services Task Force and U.S. Department of Health and Human Services for Member reference.
- The "Outpatient Durable Medical Equipment (DME), External Prosthetics, and Orthotics" *EOC* section has been modified. We have clarified that we cover standard glucose blood monitors, but not continuous-type monitoring devices.
- Exclusions have been clarified to explain we do not cover Services provided by unlicensed people, or items and Services that are not health care items or health care Services.

- The exclusion for Dental Services has been modified. We have added language clarifying that coverage for Medically Necessary general anesthesia in conjunction with non-covered dental Services is subject to Utilization Review.
- The Experimental or Investigational Services exclusion has been modified. We have clarified that we cover routine care for Members enrolled in and participating in qualifying clinical trials if such care would have been covered by Company under this *EOC* absent a clinical trial.
- The exclusion for Sexual Reassignment Surgery has been deleted to comply with the Oregon Equality Act.

Administrative changes or clarifications

- The "Monthly Premium Amounts" provision in the "Premium" section of the *Group Agreement* has been modified. We have clarified that Group pays the applicable Premium for Members who do not enroll in Kaiser Permanente Senior Advantage (HMO) but who meet the requirements listed in the "Medicare as Primary Payer" section.
- A "Premium Rebates" provision has been added to the "Miscellaneous Provisions" section of the *Group Agreement*, in accordance with the ACA. The provision clarifies the roles and responsibilities of Company and of Group in the event that a Premium rebate is required.
- The "Reporting Membership Changes and Retroactivity" provision under the "Miscellaneous Provisions" section of the *Group Agreement* has been modified. We have clarified that membership forms must be approved by Company.
- A "Summary of Benefits and Coverage" provision has been added to the "Miscellaneous Provisions" section of the *Group Agreement*, explaining when Group and Company are required to provide summaries of benefits and coverage.
- The "Medicare" section of the *Group Agreement* that was previously titled "Medicare Eligible and Members Age 65 or Over" has been modified. We have consolidated the bulleted lists for improved readability, and added text to explain that Group must pay the applicable Premiums listed in the "Monthly Premium Amounts" section for certain Medicare-eligible Members who do not enroll in Kaiser Permanente Senior Advantage (HMO). We have clarified when Medicare is primary payer.
- The definition of "Dependent Limiting Age" has been clarified to explain that Spouses are not subject to the Dependent Limiting Age.
- The "Grievances, Claims, Appeals, and External Review" *EOC* section has been changed in accordance with the ACA and state requirements and per the 2012 endorsement to your *EOC*.
- The "Termination Due to Loss of Eligibility" *EOC* section has been modified in the Traditional, Deductible, and High Deductible *EOCs* only. We have deleted the text that stated we terminate the memberships of COBRA Members who permanently reside outside our Service Area and do not work for any employer at least 50 percent of the time within our Service Area. The text did not reflect administrative practices, as COBRA coverage is not terminated for Members who reside outside of our Service Area.
- The "State Continuation Coverage for Non-COBRA Groups" *EOC* section has been modified to comply with state law. A description of qualifying events and how to request continuation coverage under this provision has been added.

- The "HIPAA and Other Individual Plans" provision in the "Conversion to an Individual Plan" *EOC* section has been removed. The provision is redundant, as the eligibility requirements for portability coverage are described in the "Portability Plans" section.
- The "Miscellaneous Provisions" *EOC* section has been modified. We have added a new "Annual Summaries and Additional Information" provision that describes information Members can request from the Oregon Department of Consumer and Business Services.
- The "Claims Review Authority" paragraph in the "Miscellaneous Provisions" *EOC* section has been deleted. The text did not reflect our administrative practices.

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

Benefit changes

- The definition of "Usual and Customary Fee" in the *EOC* "Definitions" section has been changed to "Allowed Amount." The definition applies to Tier 3 only. Allowed Amount is based on billed Charges or 160 percent of the Medicare rate, whichever is lower. This change is also reflected on the *EOC* "Benefit Summary," where we have clarified that in Tier 3, the Member is responsible for paying any provider or facility fees in excess of the Allowed Amount.
- The "Services Subject to Permanente Advantage Prior Authorization Review under Tier 2 and Tier 3" and "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures" *EOC* sections have been modified. Bone density/DXA scans covered under Tier 2 or Tier 3 now require prior authorization by Permanente Advantage.

Benefit clarifications

- The "When Referrals are Required under Tier 2 and Tier 3" *EOC* section has been clarified. Provider referrals are not limited to physician referrals.
- The *EOC* has been modified to clarify that we have the right to determine medical necessity.
- Several sections of the *EOC* have been modified to clarify that when a Select Physician refers a Member to any hospital or other facility, that hospital or facility is covered under the Tier 1 benefit.
- The "Post-Stabilization Care" *EOC* provision has been modified. We have clarified that if the Member is clinically stable and declines special transportation to a Select Provider or Select Facility (or other designated provider or facility), Post-Stabilization Care Services will be covered under Tier 2 (for Services provided by a PPO Facility or a PPO Provider) or Tier 3 (for Services provided by a Non-Participating Facility or a Non-Participating Provider).

Administrative changes or clarifications

- The term "Allied Health Professional" has been removed from the "Definitions" *EOC* section because the term is not used elsewhere in the document.
- The "What You Pay" *EOC* section has been modified to include consistent language when describing deductible carry-over and deductible take-over provisions. The definition of Deductible in the "Definitions" *EOC* section has also been updated for consistency.

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Changes and clarifications that apply to medical benefit riders

Benefit changes

- The "Outpatient Prescription Drug Riders" have been changed in accordance with the Affordable Care Act. We have eliminated the Deductible (if applicable), Copayments and Coinsurance for FDA-approved contraceptive drugs and devices included on our drug formulary. Certain religious employer groups may be exempt from providing contraceptive coverage.
- The "Outpatient Prescription Drug Rider" available with Traditional, Deductible, and High Deductible Health Plans that includes a higher cost share for Approved Non-Formulary Drugs has been modified. We have decreased the Member cost share for Approved Non-Formulary Generic Drugs. The Member pays the Generic Drug cost share for both the Generic Formulary and Generic Approved Non-Formulary Drug.
- The dollar allowance explanation for vision hardware and adult hearing aids has been changed in the respective "Vision Hardware and Optical Services Rider" and "Hearing Aid Rider." The statement that the dollar allowance can be used only at the initial point of sale has been deleted.
- Language has been changed in certain "Vision Hardware and Optical Services Riders." The provision that allowed for replacement eyeglass lenses or contact lenses within 12 months was erroneous for 12-month benefit allowance plans. The provision is applicable only to "Vision Hardware and Optical Services Riders" with a 24-month benefit allowance period.

Benefit clarifications

- The "Outpatient Prescription Drug Rider Benefit Summary" Mail Delivery Pharmacy rows have been removed. The information has been incorporated into the Participating Pharmacy rows since the Member cost share for drugs, supplies, or supplements obtained from a Participating Pharmacy and from a Mail Delivery Pharmacy are the same. Note this change does not apply to maintenance drugs.
- The Added Choice "Outpatient Prescription Drug Rider" that covers Brand-Name and Generic Drugs only if obtained at Select Pharmacies has been modified. The definitions of "Preferred Brand-Name Drug" and "Non-Preferred Brand-Name Drug" have been deleted because the terms are not used elsewhere in the rider.
- The Added Choice "Outpatient Prescription Drug Rider" that includes the MedImpact pharmacy network option has been modified. The definition of "Approved Non-Formulary Brand-Name or Generic Drug" has been added. Cost-share tiers are now included in the "Outpatient Prescription Drug Rider Benefit Summary" for "Formulary Brand-Name Drugs" and "Approved Non-Formulary Brand-Name Drugs." These cost-share tiers apply to drugs obtained from Select pharmacies.
- The "Hearing Aid Rider" has been modified. We have added a bullet under the "Hearing Aid Exclusions" section to clarify that cleaners, moisture guards, and assistive listening devices are not covered.
- The "Vision Hardware and Optical Services Rider" has been modified. We have clarified that nonprescription lenses and contacts, including sunglasses, are not covered.
- The exclusion for physical examinations in the "Chiropractic Services Rider" has been clarified. The exclusion has been reworded to explain what types of physical examinations are excluded. Also, for ease of reference, the treatment of workers' compensation illnesses and vocational rehabilitation are now listed as two separate exclusions.

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Changes and clarifications that apply to dental plans

Benefit changes

- In the Dental Choice PPO Plan, the "Limitations" *EOC* section has been modified. The age limit for sealant coverage has been increased to persons aged 15 years. Previously, the limit applied to persons aged 14 years.

Benefit clarifications

- In the Dental Choice PPO Plan, the "Benefits," "Exclusions," and "Limitations" *EOC* sections have been updated for clarification and standardization.
- In the Dental Choice PPO Plan, the "DenteMax" definition has been deleted and "Participating Provider" definition has been revised. Dental Choice Participating Providers are not limited to DenteMax providers.
- In the Dental Choice PPO Plan, the "Prior Authorization" *EOC* section has been modified. We have clarified our prior authorization procedures.
- An exclusion has been added in the "Exclusions and Limitations" *EOC* section to clarify that fees a provider may charge for Emergency Dental Care or Urgent Dental Care visits are not covered. These provider fees are not Copayments or Coinsurance for covered Services.
- In the Dental Deductible Plan, Emergency Dental Care Services have been clarified in the *EOC* "Benefit Summary." The Member pays Copayments or Coinsurance that normally apply to non-emergency dental care Services. The fee for Emergency or Urgent Dental Care visits has been deleted, since provider fees are not Copayments or Coinsurance for covered Services.

Administrative changes or clarifications

- The "Reporting Membership Changes and Retroactivity" provision under the "Miscellaneous Provisions" section of the *Group Agreement* has been modified. We have clarified that membership forms must be approved by Company.
- The definition of "Dependent Limiting Age" has been clarified to explain that Spouses are not subject to the Dependent Limiting Age.
- The "Grievances, Claims, and Appeals" *EOC* section is updated to provide a more detailed and accurate description of the grievances and appeals process.
- In the Deductible Dental Plan, the "Termination Due to Loss of Eligibility" *EOC* section has been modified. We have deleted the text that stated we terminate the memberships of COBRA Members who permanently reside outside our Service Area and do not work for any employer at least 50 percent of the time within our Service Area. The text did not reflect administrative practices, as COBRA coverage is not terminated for Members who reside outside of our Service Area.
- The "Claims Review Authority" paragraph in the "Miscellaneous Provisions" *EOC* section has been deleted. The text did not reflect our administrative practices.

Changes and clarifications that apply to dental benefit riders

- The "Orthodontic Services Rider" has been modified. We have clarified that we do not count orthodontic benefits paid under a different insurer to the lifetime benefit maximum accumulation for orthodontic benefits under this *EOC*.

Changes and clarifications that apply to all Senior Advantage plans

The following changes take effect as Groups renew in 2013 unless otherwise noted.

These preliminary changes and clarifications do not include changes that may occur throughout the remainder of the year, including, but not limited to, mandated federal and state changes.

Benefit changes or clarifications

- Additional preventive services have been added to the CMS, zero cost-share list. Additional preventive CMS services may be added to the list throughout the 2013 plan year. All Medicare-covered preventive services will continue to be provided at no cost.

Administrative changes or clarifications

- The "Contribution and Participation Requirements" section in the *Group Agreement* has been modified. We have clarified that Group must ensure that any Subscribers who are active employees work on a regularly scheduled basis.
- The "Medicare as Secondary Payer" section of the *Group Agreement* that was previously titled "Medicare Eligible and Members Age 65 or Over" has been modified. We have clarified when Medicare is secondary payer.

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Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation
Portland, Oregon

Large Group Dental Plan
Group Agreement

Group Name: Lewis & Clark College

Group Number: 1495 Subgroup: 006, 007

Term of Agreement

April 1, 2013 through March 31, 2014

Anniversary date

April 1

Authorized representative

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST

A Nonprofit Corporation

Group *Agreement*

INTRODUCTION

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

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

PREMIUM

Group will pay to Company, for each Subscriber and his or her Dependents, the amount(s) specified for each month on or before the due date. The payment due date for each bill group associated with Group will be reflected on the monthly membership invoice if applicable to Group (if not applicable, then as specified in writing by Company). If Group fails to make payments when due, upon renewal, the new Premium may include an additional charge.

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

Monthly Premium Amounts

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

Subscriber only: $55.81

Subscriber with one Family Dependent: $111.63

Subscriber with two or more Family Dependents: $156.27

NOTICES

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

Notices from Company to Group will be sent to:

Group Contact…….Kris Codron
Group Name……Lewis & Clark College

Group Address…….0615 S.W. Palatine Hill Road
Group Address…….Portland, OR 97219
Producer Contact…….Rico Bocala
Producer Name……USI Northwest
Producer Address…….700 NE Multnomah St. #1300
Producer Address…….Portland, OR 97232
Note: When Company sends Group a new (or renewed) group agreement, Company will enclose a summary that discusses the changes Company has made to this *Agreement*. Groups that want information about changes before receiving the new group agreement may request advance information from Group's Company account manager. Also, if Group designates in writing a third party such as a "Producer of Record," Company may send the advance information to the third party rather than to Group (unless Group requests a copy also).

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

Kaiser Foundation Health Plan of the Northwest
P.O. Box 203012
Denver, CO 80220-9012

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

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

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

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

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

Term of *Agreement*

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

Acceptance of *Agreement*

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

Group may not change this *Agreement* by adding or deleting words, and any such addition or deletion is void. If Group wishes to change anything in this *Agreement*, Group must contact its Company account manager. Company might not respond to any changes or comments that Group may submit. Group may not construe Company's lack of response to any submitted changes or comments to imply acceptance. Company will issue a new agreement or amendment if Company and Group agree on any changes.

Renewal

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

AMENDMENT OF *AGREEMENT*

Amendments Effective on Anniversary Date

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

Amendment due to Tax or Other Charges

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

Other Amendments

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

TERMINATION OF *AGREEMENT*

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

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

Termination on Notice

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

Termination due to Nonacceptance of Amendments

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

Termination for Nonpayment

Company will allow a grace period until the end of the month for which Premium is due. If Company has not received Premium 10 days before the end of the month for which Premium is due, Company may send Group notice of the past-due amount.

If Group fails to make past-due payment within 10 days after Company's initial written notice to Group of the past-due amount, Company may terminate this *Agreement* immediately by giving written notice to Group, and Group will be liable for all unpaid Premium through the termination date.

Termination for Fraud

Company may terminate this *Agreement* by giving at least 31 days advance written notice to Group, if Group commits fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan. For example, an intentional misrepresentation of material fact occurs if Group intentionally furnishes incorrect or incomplete material information to Company or is aware that incorrect or incomplete material information has been provided to Company on enrollment or other Company forms.

Termination for Violation of Contribution or Participation Requirements

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

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

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

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

Company may terminate this *Agreement* if it elects not to offer or renew, or offer and renew, this type of Plan in Oregon or within a specific service area within Oregon. Except as provided below regarding failure to reach agreement with providers, in order to discontinue a product, Company must: (a) cease to offer and/or cease to renew this Plan for all groups; (b) offer (in writing) to each

group covered by this Plan, enrollment in any other Plan offered by Company in the group market, not less than 90 days prior to discontinuance; and (c) act uniformly without regard to claims experience of affected groups or the health status of any current or prospective Member.

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

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

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

CONTRIBUTION AND PARTICIPATION REQUIREMENTS

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

Group must:

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

MISCELLANEOUS PROVISIONS

Administration of *Agreement*

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

Assignment

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

Attorney Fees and Costs

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

Governing Law

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

Litigation Venue

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

No Waiver

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

Reporting Membership Changes and Retroactivity

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

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation
Portland, Oregon

Large Group Deductible Dental Plan Evidence of Coverage

Group Name: Lewis & Clark College
Group Number: 1495-006, 007

This *EOC* is effective April 1, 2013, through March 31, 2014.

Printed: April 5, 2013

Membership Services

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

Portland area..... 503-813-2000
All other areas 1-800-813-2000

Dental Appointment Center

From Portland..... 503-286-6868
From Vancouver..... 360-254-9158
From Salem..... 503-370-4311
From Longview..... 360-575-4800

TTY

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

Language interpretation services

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

kp.org/dental/nw

BENEFIT SUMMARY

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

The Deductible does not apply to preventive, diagnostic, or orthodontic Services.

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

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

Major Restoration Services	**You Pay**
Gold or porcelain crowns	20% Coinsurance
Inlays	20% Coinsurance
Bridge abutments	20% Coinsurance
Pontics	20% Coinsurance
Removable Prosthetic Services	**You Pay**
Full and partial dentures	20% Coinsurance
Relines	20% Coinsurance
Rebases	20% Coinsurance
Emergency Dental Care	**You Pay**
From Participating Providers	Copayments or Coinsurance that normally apply for non-emergency dental care Services.
From Non-Participating Providers outside the Service Area (coverage is limited to $100 per incident)	All Charges over $100
Other Benefits	**You Pay**
Nightguards	10% of the full price
Nitrous oxide	
Adults and children age 13 years and older	$15
Children age 12 years and younger	$0
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INTRODUCTION

This *Evidence of Coverage* (*EOC*), including the "Benefit Summary" and any benefit riders attached to this *EOC,* describes the dental care coverage of the Large Group Deductible Dental Plan provided under the *Group Agreement (Agreement)* between Kaiser Foundation Health Plan of the Northwest and your Group. For benefits provided under any other plan, refer to that plan's evidence of coverage. In this *EOC*, Kaiser Foundation Health Plan of the Northwest is sometimes referred to as "Company," "we," "our," or "us." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this *EOC*; please see the "Definitions" section for terms you should know. The benefits under this plan are not subject to a pre-existing waiting period.

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

Term of this *EOC*

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

About Kaiser Permanente

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

For more information about your benefits, our Services, or other products, please call Membership Services at 503-813-2000, outside the Portland area at 1-800-813-2000, and TTY at 1-800-735-2900, or you may e-mail us by registering at **kp.org/dental/nw**.

DEFINITIONS

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

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

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

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

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

- For Services provided by Dental Group, the charges in Company's schedule of Dental Group charges for Services provided to Member.
- For Services for which a provider (other than Dental Group) is compensated on a capitation basis, the charges in the schedule of charges that Company negotiates with the capitated provider.
- For items obtained at a pharmacy owned and operated by 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 Deductible, Copayment, or Coinsurance from its payment, the amount it would have paid if it did not subtract the Deductible, Copayment, or Coinsurance).

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

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

Dental Directory. The *Dental Directory* lists Participating Providers, includes addresses, maps, and telephone numbers for Participating Dental Offices, and provides general information about getting dental care at Kaiser Permanente. After you enroll, you will receive a flyer that explains how you may either download an electronic copy of the *Dental Directory* or request that the *Dental Directory* be mailed to you.

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

Dentally Necessary. A Service that, in the judgment of a Participating Dentist, is required to prevent, diagnose, or treat a dental condition. A Service is Dentally Necessary only if a Participating Dentist determines that its omission would adversely affect your dental health and its provision constitutes a dentally appropriate course of treatment for you in accord with generally accepted professional standards of practice that are consistent with a standard of care in the dental community and in accordance with applicable law.

Dental Office Visit Charge. The amount you pay for Participating Dental Office visits with Dental Group Participating Dentists, hygienists, or denturists.

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

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

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

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

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

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

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

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

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

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

Non-Participating Dental Office. Any dental office or other dental facility that is not a Participating Dental Office.

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

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

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

Participating Dentist. Any licensed doctor of dental science (DDS) or doctor of medical dentistry (DMD) who is an employee of Dental Group, or any licensed 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, Coinsurance, or Deductibles, from Company rather than from the Member.

Participating Provider. (a) A person regulated under state law to practice dental or dental-related Services or to otherwise practice dental care Services consistent with state law; or (b) an employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment either of whom, under a contract directly or indirectly with Company, has agreed to provide covered Services to Members with an expectation of receiving payment, other than Copayments, Coinsurance, or Deductibles, from Company rather than from the Member.

Premium. Monthly membership charges paid by Group.

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

Services. Dental care services, supplies, or items.

Spouse. Your legal husband or wife. For the purposes of this *EOC,* the term "Spouse" includes a person legally recognized as your domestic partner in a valid Certificate of Registered Domestic Partnership issued by the state of Oregon or who is otherwise recognized as your domestic partner under criteria agreed upon, in writing, by Kaiser Foundation Health Plan of the Northwest and your Group.

Subscriber. A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber (Subscriber eligibility requirements are described under "Who is Eligible" in the "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. With respect to any one Service or supply:

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

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

Works-in-Progress. The following Services and related materials: a) a prosthetic or other appliance, or modification of one, where an impression was made before your coverage became effective; b) a crown, bridge, or gold restoration for which a tooth was prepared before your coverage became effective; or c) any other dental procedure or procedures started prior to your coverage becoming effective under this *EOC*, are considered Works-in-Progress. A tooth extraction performed before your coverage became effective under this *EOC* will not be considered a Work-in-Progress if on-going treatment has not progressed to include the Services listed in this definition.

PREMIUM, ELIGIBILITY, AND ENROLLMENT

Premium

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

Who is Eligible

General

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

- You must meet your Group's eligibility requirements that we have approved. (Your Group is required to inform Subscribers of its eligibility requirements.)
- You must meet one of the Subscriber or Dependent eligibility requirements described below, unless your Group has different eligibility requirements that we have approved.
- You must live or physically work inside our Service Area at least 50 percent of the time. Our Service Area is described in the "Definitions" section of this *EOC*. For assistance about the Service Area or eligibility, please contact Membership Services. The Subscriber's or the Subscriber's Spouse's otherwise eligible children are not ineligible solely because they live outside our Service Area if: (i) they are attending an accredited college or accredited vocational school; or (ii) if otherwise required by law.

Subscribers

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

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

Dependents

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

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

- Any other person for whom you or your Spouse is a court-appointed guardian.

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

You may be asked to provide proof of dependency annually until the Dependent reaches the student Dependent Limiting Age shown in the "Benefit Summary" and his/her coverage ends.

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

- A person of any age who is chiefly dependent upon you or your Spouse for support and maintenance if the person is incapable of self-sustaining employment by reason of developmental disability or physical handicap which occurred prior to his or her reaching the general Dependent Limiting Age shown in the "Benefit Summary," if the person is any of the following:
  - Your or your Spouse's child.
  - A child adopted by you or your Spouse, or for whom you or your Spouse have assumed legal obligation in anticipation of adoption.
  - Any other person for whom you or your Spouse is a court-appointed guardian and was a court-appointed guardian prior to the person reaching the Dependent Limiting Age shown in the "Benefit Summary" established by the Group.

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

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

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

When You Can Enroll and When Your Coverage Begins

Your Group is required to inform you about when you are eligible to enroll and your effective date of coverage. Your effective date of coverage will depend upon how and when you enroll. If you are eligible to enroll, enrollment is permitted as described below.

New Employees and Their Dependents

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

Adding New Dependents to an Existing Account

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

- **Newborn child.** Newborns are covered from the moment of birth for the first 31 days of life. In order for coverage to continue beyond this 31-day period you must submit an enrollment application to your Group within 60 days after the child's birth if additional Premium is required to add the Dependent. If additional Premium is not required, the application requirement is waived; however, please notify Membership Services of the birth so that we may update our records for more efficient provision of covered Services.
- **Newly adopted child.** Newly adopted children or children for whom you or your Spouse have newly assumed a legal obligation in anticipation of adoption are covered for 31 days following the date of adoption or the date you or your Spouse assume legal obligation. In order for coverage to continue beyond this 31-day period, you must submit an enrollment application to your Group within 60 days after the date of adoption or the date you or your Spouse assumed legal obligation if additional Premium is required. If additional Premium is not required, the application requirement is waived; however, please notify Membership Services of the adoption so that we may update our records for more efficient provision of covered Services. Assumption of legal obligation means when the adopting parent assumes and retains the legal obligation for the child in anticipation of the adoption of the child. Placement terminates upon termination of the legal obligations.

Open Enrollment

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

Special Enrollment

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during open enrollment unless one of the following is true:

- You become eligible as described in this "Special Enrollment" section.
- You did not enroll when you were first eligible and your Group provided to us a written statement that verifies you signed a document that explained restrictions about enrolling in the future, but only if your Group required you to sign such a document. The effective date of an enrollment resulting from this provision is no later than the first day of the month following the date your Group receives a Company approved enrollment or change of enrollment application from the Subscriber.

Special Enrollment due to New Dependents

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Company-approved enrollment application to your Group within 31 days after a Dependent becomes newly eligible.

The effective date of an enrollment resulting from marriage is no later than the first day of the month following the date your Group receives an enrollment application from the Subscriber. Enrollments due to birth, adoption, or placement for adoption are effective on the date of birth, adoption, or placement for adoption. If additional Premium is not required, the application requirement is waived; however, please notify Membership Services so that we may update our records for more efficient provision of covered Services.

Special Enrollment due to Loss of Other Coverage

You may enroll as a Subscriber (along with any eligible Dependents) if you or your Dependents were not previously enrolled and existing Subscribers may add eligible Dependents not previously enrolled if all of the following are true:

- You did not enroll when you were first eligible and your Group provided to us a written statement that verifies you signed a document that explained restrictions about enrolling in the future, but only if your Group required you sign such a document.
- You or at least one of your eligible Dependents had other coverage when you or the eligible Dependent previously declined Company coverage (some groups require you to have stated in writing when declining Company coverage was the reason).
- The loss of the other coverage is due to one of the following:
  - Exhaustion of COBRA coverage.
  - Termination of employer contributions for non-COBRA coverage.
  - Loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (nongroup) plan for nonpayment. For example, this loss of eligibility may be due to legal separation or divorce, reaching the age limit for dependent children, or the Subscriber's death, termination of employment, or reduction in hours of employment, or as a result of moving out of the Service Area.
  - Loss of eligibility for Medicaid coverage or Child Health Insurance Program coverage, but not termination for cause.

Note: If you are enrolling as a Subscriber along with at least one eligible Dependent, only one of you must meet the requirements stated above.

To request enrollment, the Subscriber must submit a Company-approved enrollment or change of enrollment application to your Group within 30 days after loss of other coverage, except that the timeframe for submitting the application is 60 days if you are requesting enrollment due to loss of eligibility for Medicaid or Child Health Insurance Program coverage. The effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives the enrollment or change of enrollment application from the Subscriber.

Special Enrollment due to Eligibility for Premium Assistance under Medicaid or CHIP

You may enroll as a Subscriber (along with any or all eligible Dependents), and existing Subscribers may add any or all eligible Dependents, if the Subscriber or at least one of the enrolling Dependents becomes eligible to receive premium assistance under Medicaid or CHIP. To request enrollment, the Subscriber must submit a Company-approved enrollment or change of enrollment application to your Group within 60 days after the Subscriber or Dependent is determined eligible for premium assistance. The effective date of an enrollment resulting from eligibility for the premium assistance under Medicaid or CHIP is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

Note: If you are enrolling yourself as a Subscriber along with at least one eligible Dependent, only one of you must meet the requirements stated above.

Special Enrollment due to Court or Administrative Order

A court or administrative agency may require a Subscriber to provide health care coverage for a Spouse or child who meets the eligibility requirements to be added as a Dependent. You may add the Spouse or child as a Dependent by submitting to your Group a Company-approved enrollment application within 31 days of the court or administrative order. Your Group will let us know who to enroll under the order and the effective date of the enrollment. The effective date cannot be earlier than the date of the order and cannot be later than the first day of the month following the date of the order.

Special Enrollment due to Re-employment after Military Service

If you terminated your health care coverage because you were called to active duty in the military service, you may be able to be re-enrolled in your Group's health plan if required by state or federal law. Ask your Group for more information.

HOW TO OBTAIN SERVICES

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

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

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

The online dental directory provides the names, locations, and telephone numbers of Participating Dentists. Before receiving Services, you should confirm your dentist has continued as a Participating Dentist. To do so, you may call Membership Services at 503-813-2000 from within Portland, 1-800-813-2000 from outside the Portland area, via TTY at 1-800-735-2900, or you may email us by registering at **kp.org/dental/nw** for the most up-to-date provider information. Participating Dentists include both general dentists and Specialists.

Choosing a Personal Care Dentist

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

Using Your Identification Card

We provide each Member with a Company Identification (ID) card that contains the Member health record number. Please 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, please let us know by calling Membership Services. If you need to replace your ID card, please call Membership Services.

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

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

Getting Assistance

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

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

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

Emergency and Urgent Dental Care

In a Dental Emergency

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

Obtaining Urgent Dental Care

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

Dental Appointment Center

From Portland 503-286-6868

From Vancouver 360-254-9158

From Salem 503-370-4311

From Longview 360-575-4800

TTY 1-800-735-2900

WHAT YOU PAY

Deductible

Note: check the "Benefit Summary" to determine what your Deductible is, if any.

In any Calendar Year, we will not cover Services that are subject to the Deductible until you meet the Member Deductible or the Family Deductible shown in the "Benefit Summary" during that Calendar Year. The only payments that count toward the Deductible are those you make for covered Services that are subject to the Deductible under this *EOC* (and any Deductible take-over amounts as described below).

Preventive and diagnostic Services are not subject to the Deductible and any payments that you make for these Services do not count toward the Deductible. (The preventive and diagnostic Services covered by this plan are described in "Preventive and Diagnostic Services" in the "Benefits" section.) Any other covered Services you receive are subject to the Deductible and payments that you make for these Services count toward the Deductible.

For Services that are subject to the Deductible, you must pay 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 meet the Member Deductible, or your Family must meet the Family Deductible. Each Member Deductible amount counts toward the Family Deductible amount. Once the Family Deductible is satisfied, no further Member Deductible 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 Services for the remainder of the Calendar Year.

For each Calendar Year, only the following payments count toward your Deductible:

- Charges you pay for covered Services you receive in that Calendar 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 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 Dental Group had provided or authorized them during the term of this *EOC*.

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service (after you meet any applicable Deductible) is shown in the "Benefit Summary." Copayments or Coinsurance are due when you receive the Service. If we must bill you, an accounting fee of $10 or more will be added to offset handling costs.

Benefit Maximum

Note: Check the "Benefit Summary" to determine if the preventive and diagnostic services Charges count toward your "Benefit Maximum."

Your dental plan may be subject to a Benefit Maximum selected by your Group. If your plan includes a Benefit Maximum, your benefit is limited during each Calendar Year to the amount shown in the "Benefit Summary." Charges for Services we cover (other than Dental Office Visit Charges and for preventive and diagnostic Services in some plans), less Deductibles, Copayments or Coinsurance you pay, count toward the

Benefit Maximum. After you reach the Benefit Maximum, you pay 100 percent of Charges for Services incurred during the balance of the Calendar Year.

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

Dental Office Visits

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

BENEFITS

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

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

Your "Benefit Summary" lists your Deductible, and the Copayment or Coinsurance for each covered Service. The Services covered by this plan are described below.

Preventive and Diagnostic Services

We cover the following preventive and diagnostic Services:

- Examination of your mouth (oral examination) to determine the condition of your teeth and gums.
- X-rays to check for cavities and to determine the condition of your teeth and gums.
- Routine preventive teeth cleaning (prophylaxis). You are covered for no more than two visits for oral prophylaxis treatments in any 12-consecutive-month period, except when you are receiving periodontal treatment.
- Fluoride treatments.
- Space maintainers (appliances used to maintain spacing after removal of a tooth or teeth).

Basic Restoration Services

Basic restoration Services. We cover routine fillings and stainless steel and plastic/acrylic crowns. Synthetic (plastic, resin, and glass ionomer) restorations are covered in all primary teeth, anterior teeth, and one-surface restorations of posterior permanent teeth.

Simple extractions. We cover simple tooth extractions.

Oral Surgery Services

Oral surgery Services. We cover surgical tooth extractions, including diagnosis and evaluation.

Periodontics

Periodontics (gum treatment). We cover diagnosis, evaluation, and treatment of gum disease, including scaling and root planing.

Endodontics

Endodontics (root canal therapy). We cover diagnosis, evaluation, and treatment of the root canal or tooth pulp, including root canal and related therapy.

Major Restoration Services

Major restoration Services. We cover gold and porcelain crowns, inlays, bridge abutments and pontics, and other cast metal restorations. Repair or replacement of prosthetic devices that are less than five years old is not covered.

Pontic. We cover an artificial tooth on a fixed partial denture (a bridge).

Removable Prosthetic Services

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

Prosthetic device. We cover artificial teeth including dentures or bridges.

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

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

Emergency Dental Care and Urgent Dental Care

Emergency Dental Care. We cover Emergency Dental Care, including local anesthesia and premedication, 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 services.

Inside our Service Area

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

Outside our Service Area

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

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

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

There may be an additional fee added to any other applicable Copayments or Coinsurance when you receive Emergency Dental Care or an Urgent Dental Care appointment from a Participating Provider by the next business day after you contact us.

If you require Emergency Dental Care from Non-Participating Providers when you are outside the Service Area, you are provided limited coverage for Services, including local anesthesia and premedication. We will not cover more than the amount shown in the "Benefit Summary" for each incident.

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

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

Other Benefits

Dental Services in conjunction with medically necessary general anesthesia or a medical emergency. We cover the dental Services described in the "Benefits" section when provided in a hospital or ambulatory surgical center, if the Services are performed at that location in order to obtain medically necessary general anesthesia for a member or in a hospital's emergency department in order to provide dental Services in conjunction with a medical emergency. We do not cover general anesthesia services.

Nightguard. We cover a removable dental appliance designed to minimize the effects of grinding and other occlusal factors.

Nitrous oxide. We cover nitrous oxide for adults and children when administered by a pediatric dentist, oral surgeon, or periodontist.

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

- Dental conditions for which Service or reimbursement is required by law to be provided at or by a government agency.
- Cosmetic Services, supplies, or prescription drugs that are intended primarily to improve appearance, repair, and/or replace cosmetic dental restorations.
- Dental implants, including bone augmentation and fixed or removable prosthetic devices attached to or covering the implants; all related Services, including diagnostic consultations, impressions, oral surgery, placement, removal, and cleaning when provided in conjunction with dental implants; and Services

associated with postoperative conditions and complications arising from implants, unless your Group has purchased coverage for dental implants as an additional benefit.

- 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 governmental approval.
- Fees a provider may charge for an Emergency Dental Care or Urgent Dental Care visit.
- Full mouth reconstruction and occlusal rehabilitation, including appliances, restorations, and procedures needed to alter vertical dimension, occlusion, or correct attrition or abrasion.
- Genetic testing.
- "Hospital call fees," "call fees" or similar Charges associated with Dentally Necessary Services that are performed at ambulatory surgical centers or hospitals.
- Medical or Hospital Services, unless otherwise specified in the *EOC*.
- Missed appointment fees a provider may charge for a missed appointment.
- Orthodontic Services, unless your Group has purchased orthodontic coverage as an additional benefit.
- Prosthetic devices following your decision to have a tooth (or teeth) extracted for nonclinical reasons or when a tooth is restorable.
- Replacement of prefabricated, noncast crowns, including noncast stainless steel crowns that were not placed by a Participating Provider.
- Services for conditions that are covered by workers' compensation or that are the employer's responsibility.
- Services furnished by a family member.
- Services provided or arranged by criminal justice institutions for Members confined therein, unless care would be covered as Emergency Dental Care.
- Speech aid prosthetic devices and follow up modifications.
- Surgery to correct malocclusion or temporomandibular joint disorders; treatment for problems of the jaw joint, including temporomandibular joint syndrome and craniomandibular disorders; and treatment of conditions of the joint linking the jaw bone and skull and of the complex of muscles, nerves, and other tissues related to that joint.
- Treatment to restore tooth structure lost due to attrition, erosion, or abrasion.

Limitations

- Repair or replacement needed due to normal wear and tear of fixed and removable prosthetic devices that are less than five years old.
- Sedation and general anesthesia (including, but not limited to, intramuscular IV sedation, non-IV sedation, and inhalation sedation) are not covered, except when administered by an oral surgeon, periodontist, or pediatric dentist pursuant to the "Nitrous Oxide" provision as described in the "Other Benefits" section.
- Works-in-Progress started prior to your effective date are not covered and are the liability of the Member, or a prior dental insurance carrier. The only exception is a root canal in which the pulpal debridement has been completed. Dental Services to complete the root canal following pulpal debridement will be covered at 50 percent of the Usual and Customary Charges, subject to Deductibles and Benefit Maximum as shown in the "Benefit Summary."

REDUCTIONS

Coordination of Benefits

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

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

Definitions

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

   (1) Plan includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel Plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental Plan, as permitted by law.

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

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

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

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

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

D. Allowable expense is a health 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 a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

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

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

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

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

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

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

Order of Benefit Determination Rules

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

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

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. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel Plan to provide out-of-network benefits.

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

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

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary

and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is the Secondary Plan and the other Plan is the Primary plan.

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

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

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

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

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

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

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

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

The Plan covering the Custodial parent;

The Plan covering the spouse of the Custodial parent;

The Plan covering the non-custodial parent; and then

The Plan covering the spouse of the non-custodial parent.

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

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

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

state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

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

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

Effect on the Benefits of this Plan

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

Questions About Coordination of Benefits?
Contact Your State Insurance Department

Injuries or Illnesses Alleged to be Caused by Third Parties

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

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

If you obtain a settlement or judgment from or on behalf of a third party, you must pay us Charges for covered Services that you receive for the injury or illness, except that you do not have to pay us more than the amount you receive from or on behalf of the third party. This "Injuries or Illnesses Alleged to be Caused by Third Parties" section does not affect your obligation to make any applicable Deductible, Copayment, and Coinsurance payments for these covered Services, but we will credit any such payments toward the amount you must pay us under this paragraph.

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

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

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

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

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

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

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

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

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

GRIEVANCES, CLAIMS, AND APPEALS

We want you to be satisfied with the Services you receive from Kaiser Permanente. If you have questions about your Services or your coverage please contact Membership Services. You may contact Membership Services at 503-813-2000 in Portland, all other areas 1-800-324-2000. Membership Services hours of operation are Monday through Friday 8 a.m. to 6 p.m.

We encourage you to discuss any questions or concerns about your care with your Participating Provider or another member of your health care team. If you are not satisfied with your Participating Provider, you may request another. Contact Membership Services for assistance. You always have the right to a second opinion from a qualified Participating Provider at the applicable Deductible (if any), Copayment or Coinsurance.

If you feel that additional assistance is needed, complaint and grievance procedures are available to help. All complaints and grievances are handled in a confidential manner.

Complaints

If you want to talk to someone because you are dissatisfied with the availability, delivery, or quality of our Participating Provider Services, benefits, or administrative matters, you can make an oral complaint. Examples include appointment delays or the manner of communication by staff members.

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

If you have a concern involving a denial of future care, refer to "Claims and Appeals Procedures." If your concern involves a claim denial for Services you already received, refer to "Grievances" in this section.

Grievances

A grievance is a written or oral complaint submitted by or on behalf of a Member.

You can file a grievance regarding the availability, delivery, or quality of Participating Provider Services, including a complaint regarding an adverse benefit determination, claims payment handling, reimbursement for dental care Services, or administrative matters. Examples include delays in hearing back from your Participating Provider's office; not receiving an appointment in a timely manner; or a disagreement with a bill from Kaiser Permanente; or disagreement with our denial of your claim for Services that you received from a Non-Participating Provider or Facility.

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

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 N.E. Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: 503-813-3985

Written grievances will be acknowledged in writing within seven days of receipt.

If you need assistance filing a grievance, call Membership Services at 1-800-813-2000 or if your grievance is urgent call Member Relations at 503-813-4480.

Company will forward your grievance to the appropriate manager or department for resolution. An independent review will be conducted and we will provide you with a written decision within 30 days except as follows: if you fail to provide information necessary for us to make a determination on a grievance that is an initial claim, we will allow you 50 days from the date on our written notification to submit the information.

We will make a decision within 15 days after receiving the information or within 15 days after the end of the 50-day period if we do not receive the information.

If your grievance included a specific request and we deny that request, our decision letter will include detailed information about the basis of the decision, how to appeal the decision, and how to file a complaint with the Oregon Department of Consumer and Business Services (DCBS).

While we encourage you to use our complaint and grievance procedures, you have the right to seek assistance from the Consumer Protection Unit at the Oregon Insurance Division. Contact them by mail, telephone, over the internet, or by email:

Oregon Division of Insurance
Consumer Advocacy Unit
P.O. Box 14480
Salem, OR 97309-0405
503-947-7984 or 1-888-877-4894
www.insurance.oregon.gov/consumer/consumer.html
cp.ins@state.or.us

Claims and Appeals Procedures

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

The following terms have the following meanings when used in this "Claims and Appeals Procedures" 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 **appeal** is a request for us to review our initial adverse benefit determination.

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 of eligibility for or termination of enrollment in a dental benefit plan;
- Imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or Services;
- Determination that a Service is experimental or investigational or not Dentally Necessary, effective or appropriate; or
- Determination that a course or plan of treatment is not eligible for continuity of care when a provider's contract has terminated.

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

Language and Translation Assistance

If we send you an adverse benefit determination at an address in a county where a federally mandated threshold language applies, then your notice of adverse benefit determination will include a notice of language assistance (oral translation) in that threshold language. A threshold language applies to a county if at least 10 percent of the population is literate only in the same federally mandated non-English language. You may request language assistance with your claim and/or appeal by calling 1-800-324-8010.

If we send you an adverse benefit determination at an address in a county where a federally mandated threshold language applies, then you may request translation of that notice into the applicable threshold language. A threshold language applies to a county if at least 10 percent of the population is literate only in the same federally mandated non-English language. You may request translation of the notice by calling 1-800-324-8010.

Appointing a Representative

If you would like someone to act on your behalf regarding your claim or appeal, you may appoint an authorized representative. You must make this appointment in writing. Contact Membership Services at 1-800-813-2000 to request the necessary forms.

You must pay the cost of anyone you hire to represent or help you.

Help with Your Claim and/or Appeal

While you are encouraged to use our appeal procedures, you have the right to seek assistance from the Consumer Protection Unit at the Oregon Insurance Division. Contact them by mail, telephone, or online at:

Oregon Division of Insurance
Consumer Advocacy Unit
P.O. Box 14480
Salem, OR 97309-0405
503-947-7984 or 1-888-877-4894
www.insurance.oregon.gov/consumer/consumer.html
cp.ins@state.or.us

Reviewing Information Regarding Your Claim and/or Appeal

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 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 Membership Services at 1-800-813-2000.

Providing Additional Information Regarding Your Claim and/or Appeal

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

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 N.E. Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: 503-813-3985

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

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 N.E. Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: 503-813-3985

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

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

Utilization Review

When you need Services, you should talk with your Participating Provider about your dental needs or your request for Services. Your Participating Provider provides covered Services that are Dentally Necessary. Participating Providers will use their judgment to determine if Services are Dentally Necessary. If you seek a specific Service, you should talk with your Participating Provider. Your Participating Provider will discuss your needs and recommend an appropriate course of treatment.

If you request Services that the Participating Provider believes are not Dentally Necessary, you may ask for a second opinion from another Participating Provider. You should contact the manager in the area where the Participating Provider is located. Membership Services can connect you with the correct manager, who will listen to your issues and discuss the request with the Participating Provider.

Claims and Appeals

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" section:

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

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 or precertified 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 Membership Services at 1-800-813-2000.

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

Pre-service claim

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

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 N.E. Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 503-813-3985

  - 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 unless your attending dental care provider tells us your claim is 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.

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

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

  If we tell you we need more information, we will ask you for the information within the initial 15-day decision period, and we will give you 45 days to send the information.

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

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

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

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

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

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

Non-urgent pre-service appeal

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

  (1) Your name and health record number;

  (2) Your dental condition or relevant symptoms;

  (3) The specific Service that you are requesting;

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

  (5) All supporting documents.

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

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 N.E. Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 503-813-3985

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

Urgent pre-service appeal

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

  (1) Your name and health record number;

  (2) Your dental condition or relevant symptoms;

  (3) The specific Service that you are requesting;

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

  (5) All supporting documents.

  Your request and the supporting documents constitute your appeal. You must submit your appeal by mailing, faxing, or calling us at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 N.E. Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 503-813-3985
  Phone: 503-813-4480

- We will decide whether your appeal is urgent or non-urgent unless your attending dental care provider tells us your appeal is 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 claims or appeals (a) could seriously jeopardize your life or health (or the life or health of a fetus), 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.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and give you oral or written notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within 72 hours after our 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 Membership Services at 1-800-813-2000.

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

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

Concurrent care claim

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

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 N.E. Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 503-813-3985
  Phone: 1-800-813-2000

  If you want us to consider your claim on an urgent basis and you contact us at least 24 hours before your care ends, you may request that we review your concurrent claim on an urgent basis. We will decide whether your claim is urgent or non-urgent unless your attending dental care provider tells us your claim is 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 extending your course of covered treatment.

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

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

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

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

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

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

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

If we do not receive any of the requested information (including documents) within the stated timeframe after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 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.
- If we consider your concurrent claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but not later than 24 hours after we received your claim. If we notify you of our decision orally, we will send you written confirmation within 72 hours after our oral notification.
- If we deny your claim (if we do not agree to provide or pay for extending the ongoing course of treatment), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

Non-urgent concurrent care appeal

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

  (1) Your name and health record number;

  (2) Your dental condition or relevant symptoms;

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

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

  (5) All supporting documents.

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

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 N.E. Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 503-813-3985

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

Urgent concurrent care appeal

- Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent 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 submit your appeal by mailing, faxing, or calling us at:

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 N.E. Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: 503-813-3985
Phone: 503-813-4480

- We will decide whether your appeal is urgent or non-urgent unless your attending dental care provider tells us your appeal is 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 continuing your course of covered treatment.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and notify you of our decision orally or in writing as soon as your clinical condition requires, but no later than 72 hours after we receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within 72 hours after our 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. If you have any general questions about post-service claims or appeals, please call Membership Services at 1-800-813-2000.

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

Post-service claim

- If you have questions or concerns about a bill from Company, you may contact Membership Services for an explanation. If you believe the charges are not appropriate, Membership Services will advise you on how to proceed.
- Company accepts American Dental Association (ADA) Dental claim forms, CMS 1500 claim forms for professional services and UB-04 forms for hospital claims. Even if the provider or facility bills Company directly, you should mail us a letter or submit a Non-Plan Care Information form.
- Within 90 days after the date you received or paid for the Services, mail us a letter or submit a Non-Plan Care Information form 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; and

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

You must include a copy of the bill and any supporting documents, including medical records. Your letter and the related documents constitute your claim. You must mail your claim to:

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

- You can request a Non-Plan Care Information form from Membership Services or download it from **kp.org**. When you submit the claim, please include a copy of your dental records from the Non-Participating Provider or Non-Participating Facility if you have them.
- If it is not reasonably possible to submit a claim within 90 days, 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 review your claim, and if we have all the information we need we will send you a written decision within 30 days after we receive your claim.

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

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

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

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

  If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.
- If we deny your claim (if we do not pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

Post-service appeal

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

  (1) Your name and health record number;

  (2) Your dental condition or relevant symptoms;

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

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

  (5) All supporting documents.

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

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 N.E. Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: 503-813-3985

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

Additional Review

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

TERMINATION OF MEMBERSHIP

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

You will be billed as a non-member for any Services you receive after your membership terminates. 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 divorce or a Dependent's reaching 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 to the Subscriber at least 31 days before the membership termination date:

- You abuse or threaten the safety of Company personnel or of any person or property at a Participating Dental Office;
- 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 you or a Dependent.

- Presenting an invalid prescription or dental order.
- Misusing an ID card (or letting someone else use it).
- Giving us incorrect or incomplete material information.
- Failing to notify us of changes in Family status or Medicare coverage that may affect your eligibility or benefits.

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

If we terminate your membership for cause we will:

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

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

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

Termination of *Group Agreement*

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

Termination of a Product or All Products

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

CONTINUATION OF MEMBERSHIP

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

You may be able to continue your coverage under this *EOC* for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. COBRA applies to most employees (and most of their covered Dependents) of most employers with 20 or more employees. Please contact your Group for details about COBRA continuation coverage, such as how to elect coverage and how much you must pay your Group for the coverage.

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

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

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

- You are the Subscriber's Spouse.
- You are age 55 or older.

- The Subscriber died, or you divorced or are legally separated from the Subscriber.
- You are not eligible for Medicare.

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

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

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

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

MISCELLANEOUS PROVISIONS

Administration of *Agreement*

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

Agreement Binding on Members

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

Amendment of *Agreement*

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

Applications and Statements

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

Assignment

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

Attorney Fees and Expenses

In any dispute between a Member and Company, Dental Group, Participating Providers, or Participating Dental Offices, each party will bear its own attorneys' fees and other expenses.

Governing Law

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

Group and Members not Company's Agents

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

Litigation Venue

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

No Waiver

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

Nondiscrimination

We do not discriminate in our employment practices or in the delivery of Services on the basis of age, race, color, national origin, religion, sex, sexual orientation, or physical or mental disability.

Notices

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

Overpayment Recovery

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

Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require contracting providers 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 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 Membership Services. You can also find the notice at your local Participating Facility or on our website at **kp.org/dental/nw**.

Unusual Circumstances

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

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST ORTHODONTIC SERVICES RIDER

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

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

Orthodontics. Orthodontic treatment for abnormally aligned or positioned teeth.

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

- Allow no significant lapse in the continuous orthodontic treatment process.
- Maintain continuous eligibility under this or any other Company dental contract containing an orthodontic benefit.
- Make timely payment of amounts due.

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

Exclusions and Limitations

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

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

Orthodontic Services Rider Plan E Benefit Summary

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

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