GUIDE TO YOUR BENEFITS AND SERVICES

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SAIF Corporation

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation
Portland, Oregon

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

Group Name: SAIF Corporation
Group Number: 1816 - 023-025

This *EOC* is effective 1/1/2021 through 12/31/2021.

Printed: December 23, 2020

Member 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

SKYGEN USA

5 a.m. to 5 p.m. 1-844-621-4577

Dental Appointment Center

All areas 1-800-813-2000

TTY

Kaiser Permanente 711
SKYGEN USA..... 1-855-934-9817

Language interpretation services

All areas 1-800-324-8010

kp.org/dental/nw

DENTAL CHOICE PREFERRED PROVIDER ORGANIZATION DENTAL PLAN 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 your benefits. This summary does not fully describe benefits, limitations, or exclusions. To see complete explanations of what is covered for each benefit (including exclusions and limitations), and for additional benefits that are not included in this summary, please refer to the "Benefits," "Exclusions and Limitations," and "Reductions" sections of this *EOC*. All Services are subject to the Deductible, Copayment, or Coinsurance, unless otherwise noted.

Covered Services that are subject to either Benefit Maximum and that are received in the same Year will count toward both the in-network and out-of-network Benefit Maximums.

For the Services that are subject to a Benefit Maximum, it is your responsibility to pay the full amount of any Charges incurred above the applicable Benefit Maximum.

	In-network benefit (reimbursement is based on MAC)	**Out-of-network benefit** (reimbursement is based on MAC)
Benefit Maximum		
Per Member per Year	$2,000	$2,000
Deductible	**You Pay**	
For one Member per Year	$25	
For an entire Family per Year	$75	
Preventive and Diagnostic Services (Not subject to the Deductible)	**You Pay**	
Oral exam, including evaluations and diagnostic exams	$0	$0
Fluoride treatments	$0	$0
Teeth cleaning	$0	$0
Sealants	$0	$0
Space maintainers	$0	$0
X-rays	$0	$0
Minor Restorative Services	**You Pay**	
Routine fillings	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Simple extractions	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Restorations (composite/acrylic and steel)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Oral Surgery Services	**You Pay**	
Major oral surgery	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Surgical tooth extractions	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Periodontic Services	**You Pay**	
Scaling and root planing	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Treatment of gum disease	20% Coinsurance after Deductible	20% Coinsurance after Deductible

	In-network benefit (reimbursement is based on MAC)	**Out-of-network benefit** (reimbursement is based on MAC)
Endodontic Services	**You Pay**	
Root canal and related therapy	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Major Restorative Services	**You Pay**	
Bridge abutments	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Noble metal gold or porcelain crowns	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Inlays	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Pontics	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Removable Prosthetic Services	**You Pay**	
Full upper and lower dentures	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Partial dentures	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Rebases	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Relines	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Emergency Dental Care	**You Pay**	
Emergency Dental Care or Urgent Dental Care	$25 plus Deductible, Copayment, or Coinsurance that normally apply for non-emergency dental care Services	Deductible, Copayment, or Coinsurance that normally apply for non-emergency dental care Services
Other Dental Services (Not subject to or counted toward the Deductible or Benefit Maximum)	**You Pay**	
Nightguards	10% Coinsurance	10% Coinsurance
Nitrous oxide		
Members age 13 years and older	$25	$25
Members age 12 years and younger	$0	$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 Dental Choice Preferred Provider Organization (PPO) Dental Plan provided under the *Group Agreement (Agreement)* between Kaiser Foundation Health Plan of the Northwest and your Group. For benefits provided under any other plan, refer to that plan's evidence of coverage.

The provider network for this PPO Dental Plan is the Dental Choice network. Permanente Dental Associates, PC, is included in the Dental Choice network. In this *EOC*, Kaiser Foundation Health Plan of the Northwest is sometimes referred to as "Company," "we," "our," or "us." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this *EOC*; please see the "Definitions" section for terms you should know. The benefits under this plan are not subject to a pre-existing condition waiting period.

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

Term of this *EOC*

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

About Kaiser Permanente

Kaiser Permanente provides or arranges for Services to be provided to you and your Dependents using Participating Providers and Participating Dental Offices, which are described online at **kaiserpermanentedentalnw.org/choose/dental-choice-ppo-member**. You may also receive Services from Non-Participating Providers and Non-Participating Dental Offices.

For more information, see "How to Obtain Services" in this *EOC*, contact SKYGEN, or check our website at **kaiserpermanentedentalnw.org/choose/dental-choice-ppo-member**.

DEFINITIONS

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

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.

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

- For Services provided by Permanente Dental Associates, PC, the charges in Company's schedule of charges for Services provided to Members.
- For Services for which a provider (other than Permanente Dental Associates, PC) is compensated on a capitation basis, the charges in the schedule of charges that Company negotiates with the capitated provider.

- For items obtained at a pharmacy owned and operated by Company, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item. (This amount is an estimate of the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Company.)
- For all other Services, the payment that Company makes for the Services (or, if Company subtracts a Deductible, Copayment, or Coinsurance from its payment, the amount Company would have paid if it did not subtract the Deductible, Copayment, or Coinsurance).

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

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

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

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

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

Dental Facility Directory. The *Dental Facility Directory* includes addresses, maps, and telephone numbers for Participating Dental Offices and provides general information about getting dental care at Kaiser Permanente.

Dental Provider Directory. The *Dental Provider Directory* lists Participating Providers, includes addresses for Participating Dental Offices, and provides general information about each Participating Provider such as gender, specialty, and language spoken.

Dental Specialist. A Participating Provider who is an endodontist, oral pathologist, oral radiologist, oral surgeon, orthodontist, pediatric dentist, periodontist or prosthodontist.

Dentally Necessary. A Service that, in the judgment of a Dentist, is required to prevent, diagnose, or treat a dental condition. A Service is Dentally Necessary and appropriate only if we determine that its omission would adversely affect your dental health and its provision constitutes a dentally appropriate course of treatment for you in accord with generally accepted professional standards of practice that are consistent with a standard of care in the dental community and in accordance with applicable law. Unless otherwise required by law, we decide if a Service is Dentally Necessary. You may appeal our decision as set forth in the "Grievances, Claims, and Appeals" section. The fact that a Dentist has prescribed, recommended, or approved a Service does not, in itself, make such Service Dentally Necessary and, therefore, a covered Service.

Dentist. Any licensed doctor of dental science (DDS) or doctor of medical dentistry (DMD).

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

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

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

Emergency Dental Condition. A dental condition, or exacerbation of an existing dental condition, occurring suddenly and unexpectedly, involving injury, swelling, bleeding, or extreme pain in or around the teeth and gums 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 an *Agreement* that includes this *EOC*.

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

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

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

Medically Necessary. Our determination that the Service is all of the following: (i) medically required to prevent, diagnose or treat your condition or clinical symptoms; (ii) in accordance with generally accepted standards of medical practice; (iii) not solely for the convenience of you, your family and/or your provider; and, (iv) the most appropriate level of Service which can safely be provided to you. For purposes of this definition, "generally accepted standards of medical practice" means (a) standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; (b) physician specialty society recommendations; (c) the view of physicians practicing in the relevant clinical area or areas within Kaiser Permanente locally or nationally; and/or (d) any other relevant factors reasonably determined by us. Unless otherwise required by law, we decide if a Service is Medically Necessary. You may appeal our decision as set forth in the "Grievances, Claims, and Appeals" section. The fact that a provider has prescribed, recommended, or approved a Service does not, in itself, make such Service Medically Necessary and, therefore, a covered Service.

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

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

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

Non-Participating Provider. A person who is either:

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

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

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

Participating Provider. A person who, under a contract directly or indirectly with Company, has agreed to provide covered Services to Members with an expectation of receiving payment, other than Deductible, Copayment, or Coinsurance, from Company rather than from the Member, and is either:

- A Participating Dentist, or
- A person who is regulated under state law to practice dental or dental-related Services or otherwise practicing dental care Services consistent with state law, including an expanded practice dental hygienist, denturist, or pediatric dental assistant, and who is an employee or agent of a Participating Dentist.

Percentage Payable. The percentage we pay toward Maximum Allowable Charges or Usual and Customary Charges after any applicable Deductible has been met.

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

Premium. Monthly membership charges paid by Group.

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

Services. Dental care services, supplies, or items.

SKYGEN USA, LLC, formerly known as Scion Dental, Inc. ("SKYGEN"). The third-party administrator (TPA) that manages Prior Authorization, billing, claims and grievances for the Services covered under this *EOC*.

Spouse. The person to whom you are legally married under applicable law. For the purposes of this *EOC*, the term "Spouse" includes a person who is legally recognized as your domestic partner in a valid Certificate of Registered Domestic Partnership issued by the state of Oregon, validly registered as your domestic partner under the laws of another state, or otherwise recognized as your domestic partner under criteria agreed upon, in writing, by Kaiser Foundation Health Plan of the Northwest and your Group.

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

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

PREMIUM, ELIGIBILITY, AND ENROLLMENT

Premium

Your Group will tell you the Premium amount that you pay and how to pay your Premium.

Who Is Eligible

General

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

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

Subscriber

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

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

Dependents

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

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

  Students who suffer a severe illness or injury that causes them to lose full-time student status will continue to be considered full-time students for eligibility purposes, provided that within 31 days after the loss of full-time student status, we receive written certification from the child's treating physician that the child is suffering from a serious illness or injury and that the leave of absence or other change of enrollment is Medically Necessary. Eligibility as a full-time student under this provision may then continue for up to 12 months from the date that your child's medical leave of absence began, or until your child reaches the student Dependent Limiting Age shown in the "Benefit Summary," whichever comes first.
- A person who is of any age and who is primarily dependent upon you or your Spouse for support and maintenance if the person is incapable of self-sustaining employment by reason of 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 general Dependent Limiting Age shown in the "Benefit Summary" established by the Group.

We may request proof of incapacity and dependency annually.

Children born to a Dependent other than your Spouse (for example, your grandchildren) are not eligible for coverage beyond the first 31 days of life, including the date of birth, unless: (a) you or your Spouse adopts them or assumes a legal obligation in anticipation of adoption; (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 (d) the mother of the child used drugs containing diethylstilbestrol prior to the child's birth. Also, Company does not discriminate between married and unmarried persons, or between children of married or unmarried persons.

When You Can Enroll and When Coverage Begins

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

New Employees and Their Dependents

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

Open Enrollment

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

Special Enrollment

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

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

- Loss of coverage for any reason other than nonpayment of Premium, rescission of coverage, misrepresentation, fraud or voluntary termination of coverage.
- Gaining a Dependent through marriage or entering into a domestic partnership, birth, adoption or placement for adoption, or through a child support order or other court order.

- Loss of a Dependent through divorce or legal separation, or if the enrollee, or his or her Dependent dies.

Note: If the individual is enrolling as a Subscriber along with at least one eligible Dependent, only one enrollee must meet one of the requirements for a qualifying event.

The individual must notify the Group within 30 days of a qualifying event, 60 days if they are requesting enrollment due to a change in eligibility for Medicaid or Child Health Insurance Program (CHIP) coverage. The Group will determine if the individual is eligible to select or change coverage. Contact the Group for further instructions on how to enroll.

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

Adding New Dependents to an Existing Account

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

Newborns, newly adopted children, or children newly placed for adoption are covered for the first 31 days after birth, adoption, or placement for adoption. In order for coverage to continue beyond this 31-day period, you must submit an enrollment application to your Group within 31 days after the date of birth, adoption, or placement for adoption if additional Premium is required to add the Dependent. If additional Premium is not required, the application requirement is waived; however, please notify your Group and Member Services to add the child to your plan.

To add all other newly eligible Dependents (such as a new Spouse), you must submit an enrollment application to your Group within 30 days after the qualifying event.

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

When Coverage Begins

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

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

HOW TO OBTAIN SERVICES

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

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

As a Member, you may receive covered Services from any Participating Provider or Non-Participating Provider inside the United States.

All benefits will be paid, subject to the Copayment or Coinsurance, after the Member satisfies any applicable Deductible, up to the Benefit Maximum.

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

Using Your Identification Card

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

Your ID card is for identification only and it does not entitle you to Services. To receive covered Services, you must be a current Member. Anyone who is not a Member will be billed as a non-member for any Services 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.

Choosing a Personal Dentist

We encourage you and your Dependents to choose a personal Dentist. The online search tool at **kaiserpermanentedentalnw.org/choose/dental-choice-ppo-member** provides the names, locations, and telephone numbers of Participating Providers. Before receiving Services, you should confirm your Dentist has continued as a Participating Provider. You may call SKYGEN or check the website at **kaiserpermanentedentalnw.org/choose/dental-choice-ppo-member** for the most up-to-date provider information. Participating Providers include both general Dentists and Dental Specialists.

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 the provider who is treating you. Most Participating Dental Offices have an administrative office staffed with representatives who can provide assistance if you need help obtaining Services. SKYGEN representatives are also available to assist you Monday through Friday (except holidays), from 5:00 a.m. to 5:00 p.m. Pacific Standard Time. Call 1-844-621-4577, or TTY 1-855-934-9817 for the hearing and speech impaired. For language interpretation services, call 1-800-324-8010.

SKYGEN representatives can answer any questions you have about your benefits, available Services, and the Participating Dental Offices where you can receive Services. For example, they can explain your dental benefits, how to make your first dental appointment, and how to replace your ID card. These representatives can also provide you with forms and instructions that will help you file a complaint, grievance, or appeal as described in the "Grievances, Claims, and Appeals" section of this *EOC*. Upon request, SKYGEN can also provide you with written materials about your coverage.

Prior Authorization

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

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

You are responsible for getting Prior Authorization, though Participating Providers and Non-Participating Providers may request Prior Authorization on your behalf. To request Prior Authorization, you or your

provider must call SKYGEN or mail material to the address on the back of the ID card. Providers may also request Prior Authorization electronically. SKYGEN will send a response within two business days after they receive the request.

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

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

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

Obtaining Emergency and Urgent Dental Care

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 at 1-800-813-2000 or TTY 711, and a representative will assist you or arrange for you to be seen for an Emergency Dental Condition. SKYGEN representatives are also available to assist you Monday through Friday (except holidays), from 5:00 a.m. to 5:00 p.m. Pacific Standard Time. Call 1-844-621-4577, or TTY 1-855-934-9817 for the hearing and speech impaired. For language interpretation services, call 1-800-324-8010. After regular hours, SKYGEN has an answering service that can assist you in the event of an Emergency Dental Condition.

If you need Urgent Dental Care, call the Dental Appointment Center or SKYGEN and a representative will assist you.

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

POST-SERVICE CLAIMS—SERVICES ALREADY RECEIVED

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

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

SKYGEN accepts American Dental Association (ADA) Dental claim forms. If the Non-Participating Provider bills SKYGEN directly, you will not need to submit the claim form.

You must submit a claim for a Service within 12 months after receiving that Service. If it is not reasonably possible to submit a claim within 12 months, then you must submit a claim as soon as reasonably possible, but in no case more than 15 months after receiving the Service, except in the absence of legal capacity.

SKYGEN will reach a decision on the claim and pay those covered Charges within 30 calendar days from receipt unless additional information, not related to coordination of benefits, is required to make a decision. If the 30-day period must be extended, you will be notified in writing with an explanation about why. This written notice will explain how long the time period may be extended depending on the requirements of applicable state and federal laws, including ERISA.

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

If you have questions or concerns about a bill from SKYGEN, you may contact Member Services for an explanation. If you believe the Charges are not appropriate, Member Services will advise you on how to proceed.

WHAT YOU PAY

You are covered for the Services described in this *EOC* when you receive Services from a Participating Provider or Non-Participating Provider. The amounts you pay for covered Services will vary based on whether you choose a Participating Provider or a Non-Participating Provider.

Your dental "Benefit Summary" describes your benefits and lists your Deductible, Copayment, or Coinsurance amount and Benefit Maximum. You may be required to pay your Copayment or Coinsurance amount at the time of Service, if applicable. You are responsible for payment of Charges incurred, but not paid, by your Dependents.

SKYGEN will pay covered Maximum Allowable Charges or Usual and Customary Charges as applicable (less Deductible, Copayment, or Coinsurance) after a claim has been submitted. Participating Providers will not balance bill for amounts over and above the Maximum Allowable Charges. Your "Benefit Summary" indicates whether the percentage you pay for covered Services is based on the Maximum Allowable Charge or the Usual and Customary Charge. After you reach the Benefit Maximum, you pay 100 percent of Charges for Services incurred during the balance of the Year.

You are responsible to pay your Copayment or Coinsurance to the Non-Participating Provider and any amounts in excess of the Maximum Allowable Charges or Usual and Customary Charges, as applicable.

Benefit Maximum

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

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

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

For plans with a different in-network and out-of-network Benefit Maximum, the amounts we pay for covered Services you receive from a Participating Provider count toward the in-network Benefit Maximum, and the

amounts we pay for covered Services you receive from a Non-Participating Provider count toward the out-of-network Benefit Maximum. The Benefit Maximums cross accumulate. This means that the amounts we pay for covered Services that count toward the in-network Benefit Maximum also count toward the out-of-network Benefit Maximum, and the amounts we pay for covered Services that count toward the out-of-network Benefit Maximum also count toward the in-network Benefit Maximum. If the out-of-network Benefit Maximum is lower than the in-network Benefit Maximum and you have reached the out-of-network Benefit Maximum, you may continue to use your in-network benefits until you reach the in-network Benefit Maximum. Check your "Benefit Summary" to learn if these Services have a different in-network and out-of-network Benefit Maximum.

When you receive Services from a Participating Provider or a Non-Participating Provider, you are required to pay the Copayment or Coinsurance amount at the time of Service. It is your responsibility to pay the full amount of any Maximum Allowable Charges or Usual and Customary Charges incurred above the applicable Benefit Maximum.

Deductible

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

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

After you meet the Deductible, you pay the applicable Copayment or Coinsurance for covered Services for the remainder of the Year.

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

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

In-Network Benefits

The provider network for dental Services is the Dental Choice network. For Services provided by a Participating Provider, you must pay a percentage of the Maximum Allowable Charge as shown in the "Benefit Summary."

We will pay a percentage of the Maximum Allowable Charge for each covered Service. The Percentage Payable is shown in the "Benefit Summary." For example, if the Plan pays 80 percent for a covered Service, (after Deductible, if applicable), the Member pays the remaining balance of 20 percent of the Participating Provider's negotiated fee for that covered Service. The Member may be required to remit payment at the time of Service. Billing arrangements are between the Member and the Participating Provider. Participating Providers are set forth in the online search tool at **kaiserpermanentedentalnw.org/choose/dental-choice-ppo-member**. Members should confirm continued participation of a Participating Provider before receiving Services.

Out-of-Network Benefits

You may obtain Services from a Non-Participating Provider that is not part of the Dental Choice network.

The "Benefit Summary" indicates whether the amount that you pay (after Deductible, if applicable) for covered Services from Non-Participating Providers is based on the Maximum Allowable Charge or the Usual and Customary Charge. You are responsible for paying the Copayment or Coinsurance, if applicable.

You or the Non-Participating Provider can submit a claim to us for payment of the out-of-network benefits. See the "Claims and Appeals" section under the "Grievances, Claims, and Appeals" section.

Non-Participating Providers have not negotiated their fees with us. The Non-Participating Provider may require you to remit payment at the time of Service. In addition to any applicable Deductible, Copayment, or Coinsurance, you are responsible for paying any remaining balance above the Maximum Allowable Charge or the Usual and Customary Charge to the Non-Participating Provider. Billing arrangements are between you and the Non-Participating Provider.

BENEFITS

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

- You are a current Member at the time Services are provided.
- The Services are Dentally Necessary.
- The covered Services are provided, prescribed, authorized, or directed by a Dentist.

Coverage is based on the least costly treatment alternative. If you request a Service that is a more costly treatment alternative from that recommended by your Dentist, but that accomplishes the same goal, we will cover the Services up to the benefit level of the least costly treatment alternative. You will be responsible for any additional Charges.

Your "Benefit Summary" lists your Deductible, Copayment, or Coinsurance for each covered Service. The Services covered by this plan are described below. All benefits are subject to the "Exclusions and Limitations" and "Reductions" sections of this *EOC*.

Preventive and Diagnostic Services

We cover the following preventive and diagnostic Services:

- Evaluations and diagnostic exams to determine Dentally Necessary treatment.
- Examination of your mouth (oral examination) to determine the condition of your teeth and gums.

- Fluoride treatments.
- Routine preventive teeth cleaning (prophylaxis).
- Sealants.
- Space maintainers (appliances used to maintain spacing after removal of a tooth or teeth).
- X-rays to check for cavities and to determine the condition of your teeth and gums.

Minor Restorative Services

We cover the following minor restorative dental Services:

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

Oral Surgery Services

We cover the following oral surgery Services:

- Major oral surgery.
- Surgical tooth extractions.

Periodontic Services

We cover the following periodontic Services:

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

Endodontic Services

We cover the following endodontic Services:

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

Major Restorative Services

We cover the following major restorative Services:

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

Removable Prosthetic Services

We cover the following removable prosthetic Services:

- Full upper and lower dentures.
- Partial upper and lower dentures.

- Maintenance prosthodontics:
  - Adjustments.
  - Rebase and reline.
  - Repairs.

Emergency Dental Care and Urgent Dental Care

We cover Emergency Dental Care, including local anesthesia and medication when used prior to dental treatment to avoid any delay in dental treatment, and Urgent Dental Care, only if the Services would have been covered under other headings of this "Benefits" section (subject to the "Exclusions and Limitations" section) if they were not Emergency Dental Care or Urgent Dental Care.

You pay the amount(s) shown in the "Benefit Summary." An Emergency Dental Care office visit Copayment may apply in addition to any other applicable Copayments or Coinsurance when you receive Emergency Dental Care or an Urgent Dental Care appointment from a Participating Provider.

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

Other Dental Services

We cover other dental Services as follows:

- Dental Services in conjunction with Medically Necessary general anesthesia or a medical emergency (subject to the "Exclusions and Limitations" section). We cover the dental Services described in the "Benefits" section when provided in a hospital or ambulatory surgical center, if the Services are performed at that location in order to obtain Medically Necessary general anesthesia for a Member or in a hospital's emergency department in order to provide dental Services in conjunction with a medical emergency. We do not cover general anesthesia Services.
- Nightguards. We cover removable dental appliances designed to minimize the effects of bruxism (teeth grinding) and other occlusal factors.
- Nitrous oxide. We cover use of nitrous oxide during Dentally Necessary treatment as deemed appropriate by your provider.

EXCLUSIONS AND LIMITATIONS

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

Exclusions

- Additional fees a Non-Participating Provider may charge for an Emergency Dental Care or Urgent Dental Care visit after our payment for covered Services.
- Continuation of Services performed or started prior to your coverage becoming effective.
- Continuation of Services performed or started after your membership terminates.
- Cosmetic Services, supplies, or prescription drugs that are intended primarily to improve appearance, repair, and/or replace cosmetic dental restorations.
- Dental conditions for which Service or reimbursement is required by law to be provided at or by a government agency. We do not reimburse the government agency for any Services that the law requires

be provided only by or received only from a government agency. When we cover any of these Services, we may recover the Charges for the Services from the government agency. This exclusion does not apply to Medicaid.

- Dental implants, including bone augmentation and fixed or removable prosthetic devices attached to or covering the implants; all related Services, including diagnostic consultations, impressions, oral surgery, placement, removal, and cleaning when provided in conjunction with dental implants; and Services associated with postoperative conditions and complications arising from implants, unless your Group has purchased coverage for dental implants as an additional benefit.
- Dental Services not listed in the "Benefits" section of this *EOC*.
- Drugs obtainable with or without a prescription. These may be covered under your medical benefits.
- Experimental or investigational treatments, procedures, and other Services that are not commonly considered standard dental practice or that require U.S. Food and Drug Administration (FDA) approval. A Service is experimental or investigational if:
  - the Service is not recognized in accordance with generally accepted dental standards as safe and effective for use in treating the condition in question, whether or not the Service is authorized by law for use in testing, or other studies on human patients: or
  - the Service requires approval by FDA authority prior to use and such approval has not been granted when the Service is to be rendered.
- Fees a provider may charge for a missed appointment.
- Full mouth reconstruction, including, but not limited to, occlusal rehabilitation, appliances, restorations, and procedures needed to alter vertical dimension, occlusion, or correct attrition or abrasion.
- Genetic testing.
- "Hospital call fees," "call fees" or similar Charges associated with Dentally Necessary Services that are performed at ambulatory surgical centers or hospitals.
- Maxillofacial surgery.
- Medical or Hospital Services, unless otherwise specified in the *EOC*.
- Myofunctional therapy.
- Non-orthodontic recording of jaw movements or positions.
- Orthodontic Services, unless your Group has purchased orthodontic coverage as an additional benefit.
- Orthodontic treatment of primary/transitional dentition.
- Orthognathic surgery.
- Procedures, appliances, or fixed crowns and bridges for periodontal splinting of teeth.
- Prosthetic devices following extraction of a tooth (or of teeth) for nonclinical reasons or when a tooth is restorable.
- Replacement of lost or damaged space maintainers.
- Replacement of prefabricated, noncast crowns, including noncast stainless steel crowns, except when the Member has five or more years of continuous dental coverage with Company.
- Services performed by someone other than a Participating Provider or Non-Participating Provider.
- Speech aid prosthetic devices and follow up modifications.

- Surgery to correct malocclusion or temporomandibular joint (TMJ) disorders; treatment for problems of the jaw joint, including temporomandibular joint (TMJ) syndrome and craniomandibular disorders; and treatment of conditions of the joint linking the jaw bone and skull and of the complex of muscles, nerves, and other tissues related to that joint.
- Treatment of cleft palate.
- Treatment of macroglossia.
- Treatment of micrognathia.
- Treatment to restore tooth structure lost due to attrition, erosion, or abrasion.
- Use of alternative materials for the removal and replacement of clinically acceptable material or restorations is not covered for any reason, except when the pathological condition of the tooth (or teeth) warrants replacement.

Limitations

- Amalgam, silicate, acrylic, or composite restorations are limited to once every 36 months for the same tooth.
- Benefits for prophylaxis will not be covered if performed on the same date of Service with periodontal cleaning treatment.
- Dentures, bridges, crowns (per tooth), and replacement needed due to normal wear and tear of permanent fixed or removable prosthetic devices are limited to once every five years (except resin-based partial dentures which are replaceable once every three years).
- Examination and prophylaxis (routine preventive teeth cleaning), including scaling and polishing, is limited to two visits per Year as Dentally Necessary.
- Extraction of asymptomatic or nonpathologic third molars (wisdom teeth) is not covered unless performed in conjunction with orthodontic or periodontal treatment and prescribed by an orthodontist or periodontist.
- Full mouth gross debridement is limited to a frequency of once every 36 months. Subsequent debridement within this period will require Prior Authorization.
- Periodontal scaling and root planing is limited to once per quadrant every 24 months and requires Prior Authorization before the initiation of Services. Prior Authorization submitted by the provider must include a copy of the periodontal chart with documented periodontal disease which must include at least four teeth per quadrant with four millimeters or greater periodontal pockets.
- Relines and rebases of complete or partial dentures are limited to once every 36 months, if performed at least six months from the seat date.
- Repair or replacement needed due to normal wear and tear of interim fixed and removable prosthetic devices is limited to once every 12 months.
- Repair or replacement needed due to normal wear and tear of permanent fixed and removable prosthetic devices is limited to once every five years.
- Root canals are limited to once per tooth per lifetime and re-treatment of root canal is limited to not more than once in 24 months for the same tooth.
- Routine fillings are limited to amalgam (silver) or glass ionomer fillings on posterior teeth and composite (tooth-colored) fillings on anterior and bicuspid teeth.
- Sealants are limited to once every three years for treatment of the occlusal surfaces of permanent molars for persons 15 years and younger.

- Sedation and general anesthesia (including, but not limited to, intramuscular IV sedation, non-IV sedation, and inhalation sedation) are not covered, except nitrous oxide when pursuant to the "nitrous oxide" provision described in the "Other Dental Services" section.
- X-rays are limited to one full mouth set of X-rays every three years, one bite wing series per year, and those that are necessary to document the need for oral surgery.

REDUCTIONS

Coordination of Benefits

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

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

Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Order of Benefit Determination Rules

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

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

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

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

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

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

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

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

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

- 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 dental care expenses or dental care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Plan years commencing after the Plan is given notice of the court decree;

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

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

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

The Plan covering the Custodial Parent;

The Plan covering the spouse of the Custodial Parent;

The Plan covering the non-Custodial Parent; and then

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

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

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

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

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

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

Effect on the Benefits of This Plan

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

Questions About Coordination of Benefits?
Contact Your State Insurance Department

Injuries or Illnesses Alleged to be Caused by Other Parties

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

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

If you obtain a settlement, award, or judgment from or on behalf of another party or insurer, you must ensure we are reimbursed for covered Services that you receive for the injury or illness, except that:

- for injuries caused by a motor vehicle accident, we will not collect to the extent that the payment would leave you less than fully compensated for your injury or illness; and
- for injuries or illnesses that are not caused by a motor vehicle accident, we will not collect more than the amount you receive from or on behalf of the other party.

This "Injuries or Illnesses Alleged to be Caused by Other Parties" section does not affect your obligation to make any applicable Deductible, Copayment, or Coinsurance payments for these covered Services.

If you do not recover anything from or on behalf of the other party, then you are responsible only for any applicable Deductible, Copayment, or 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 another party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by another party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney, but we will be subrogated only to the extent of the total Charges for the relevant covered Services.

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

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

SKYGEN
Attn: Claims Processing
P.O. Box 714
Milwaukee, WI 53201

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 responsible party, and the responsible party's 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 Other Parties" section pending final resolution of the claims. You must provide us with written notice before you settle a claim or obtain a judgment or award against any other 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 – 742.544, Oregon Revised Statutes.

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

Workers' Compensation or Employer's Liability

We will not reimburse for Services for any illness, injury, or condition to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any workers' compensation or employer's liability law. We will provide Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover Charges for any of these Services from the following sources:

- Any source providing a Financial Benefit or from whom a Financial Benefit is due.
- You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

GRIEVANCES, CLAIMS, AND APPEALS

The following terms have the following meanings when used in this "Grievances, Claims, and Appeals" section:

A claim is a request for us to:

- Provide or pay for a Service that you have not received (pre-service claim);
- Continue to provide or pay for a Service that you are currently receiving (concurrent care claim); or
- Pay for a Service that you have already received (post-service claim).

An adverse benefit determination is our decision to deny, reduce or terminate a Service, or failure or refusal to provide or to make a payment in whole or in part for a Service that is based on:

- Denial or termination of enrollment of an individual in a dental benefit plan;
- Rescission or cancellation of a policy;
- Imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered Services;
- Determination that a Service is experimental or investigational or not Dentally Necessary or appropriate; or
- Determination that a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care.

A grievance is communication expressing dissatisfaction with an adverse benefit determination, without specifically declining any right to appeal or review, that is:

- In writing, for an internal appeal;
- In writing or orally for an expedited response; or
- A written complaint regarding the:
  - Availability, delivery, or quality of a Service;
  - Claims payment, handling or reimbursement for Services and, unless a request for an internal appeal has not been submitted, the complaint is not disputing an adverse benefit determination; or
  - Matters pertaining to the contractual relationship between the Member and Company.

An appeal is a request for us to review our initial adverse benefit determination.

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

Member Satisfaction Procedure

Kaiser Permanente is committed to providing quality care and a timely response to your concerns. We encourage you to discuss any questions or concerns about your care with your provider or another member of your dental care team. If you are not satisfied with your provider, you may request another. Contact Member Services for assistance. You always have the right to a second opinion from a qualified provider at the applicable Deductible, Copayment, or Coinsurance.

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

- Contact the administrative office in the dental office where you are having the problem.
- Call Member Services; or
- Send your written complaint to Member Relations at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 NE Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 1-855-347-7239

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

All complaints are handled in a confidential manner.

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

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

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

Language and Translation Assistance

If we send you an adverse benefit determination, we will include a notice of language assistance (oral translation). You may request language assistance with your claim and/or appeal by calling 1-800-813-2000. The notice of language assistance "Help in Your Language" is also included in this *EOC*.

Appointing a Representative

If you would like someone to act on your behalf regarding your claim, you may appoint an authorized representative, an individual who by law or by your consent may act on your behalf. You must make this appointment in writing. Contact Member Services for information about how to appoint a representative. You must pay the cost of anyone you hire to represent or help you.

Help with Your Claim and/or Appeal

While you are encouraged to use our appeal procedures, you have the right to file a complaint or seek other assistance from the Consumer Advocacy Section of the Division of Financial Regulation.

Contact them by mail, email, telephone, fax, or online at:

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

Reviewing Information Regarding Your Claim

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

Providing Additional Information Regarding Your Claim

When you appeal, you may send us additional information including comments, documents, and additional dental records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal. Please 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: 1-855-347-7239

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

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 N.E. Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: 1-855-347-7239

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.

Sharing Additional Information That We Collect

If we believe that your appeal of our initial adverse benefit determination will be denied, then before we issue another adverse benefit determination, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the new or additional information and/or reasons and inform you how you can respond to the information in the letter if you choose to do so. If you do not respond before we must make our final decision, that decision will be based on the information already in your claim file.

Claims and Appeals Procedures

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

There are several types of claims, and each has a different procedure described below for sending your claim and appeal to us as described in this "Claims and Appeals Procedures" section:

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

When you file an appeal, we will review your claim without regard to our previous adverse benefit determination. The individual who reviews your appeal will not have participated in our original decision regarding your claim nor will he/she be the subordinate of someone who did participate in our original decision.

Pre-service Claims and Appeals

Pre-service claims are requests that we provide or pay for a Service that you have not yet received. Failure to receive authorization before receiving a Service that must be authorized in order to be a covered benefit may be the basis for our denial of your pre-service claim or a post-service claim for payment. If you receive any of the Services you are requesting before we make our decision, your pre-service claim or appeal will become a post-service claim or appeal with respect to those Services. If you have any general questions about pre-service claims or appeals, please contact Member Services.

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

Non-Urgent Pre-service Claim

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

SKYGEN
Attn: Appeals
P.O. Box 714
Milwaukee, WI 53201

- If you want us to consider your pre-service claim on an urgent basis, your request should tell us that. We will decide whether your claim is urgent or non-urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life or health or your ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of your dental condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting, or (c) your attending dental care provider requests that your claim be treated as urgent.
- We will review your claim and, if we have all the information we need, we will make a decision within a reasonable period of time, but no later than two business days after we receive your claim.

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

  If we tell you we need more information is needed to make a decision, we will ask you for the information in writing before the initial decision period ends, and we will give you 15 days to send the information.

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

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

  If we do not receive any of the requested information (including documents) within 15 days after we send our request, we will make a decision based on the information we have no later than 15 days following the date the additional information was requested.
- We will send written notice of our decision to you and, if applicable, to your provider.

Urgent Pre-service Claim

- If your pre-service claim was considered on an urgent basis, we will notify you of our decision orally or in writing within a timeframe appropriate to your clinical condition, but no later than two business days after we receive your claim.

  Within 24 hours after we receive your claim, we may ask you for more information.
- We will notify you of our decision within two business days 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 two business days after making our request.

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

Non-Urgent Pre-service Appeal

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

(1) Your name and health record number;

(2) Your dental condition or relevant symptoms;

(3) The specific Service that you are requesting;

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

(5) All supporting documents.

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

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 N.E. Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: 1-855-347-7239

- We will acknowledge your appeal in writing within five 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 mail, call, 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
  Phone: 503-813-4480
  Fax: 1-855-347-7239

- We will decide whether your appeal is urgent or non-urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life or health or your ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of your dental condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting, or (c) your attending dental care provider requests that your claim be treated as urgent.

- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and give you oral or written notice of our decision as soon as your clinical condition requires, but no later than 72 hours after we receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within three days after the oral notification.
- If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal.

Concurrent Care Claims and Appeals

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

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

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

Non-Urgent Concurrent Care Claim

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

  SKYGEN
  Attn: Appeals
  P.O. Box 714
  Milwaukee, WI 53201
- If you want SKYGEN to consider your claim on an urgent basis and you contact them at least 24 hours before your care ends, you may request that SKYGEN reviews your concurrent claim on an urgent basis. They will decide whether your claim is urgent or non-urgent. If they determine that your claim is not urgent, they will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life or health or your ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of your dental condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting, or (c) your attending dental care provider requests your claim be treated as urgent.
- SKYGEN will review your claim, and if they have all the information they need, they will make a decision within a reasonable period of time.

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

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

They may extend the time for making a decision for an additional 15 days if circumstances beyond their control delay the decision, if they send you notice before the initial decision period ends.

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

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

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

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

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

Urgent Concurrent Care Claim

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

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

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

Non-Urgent Concurrent Care Appeal

- Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing 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: 1-855-347-7239

- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.

- We will review your appeal and send you a written decision as soon as possible if your care has not ended but no 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 care claim. Please include the following:

  (1) Your name and health record number;

  (2) Your dental condition or relevant symptoms;

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

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

  (5) All supporting documents.

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

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 N.E. Multnomah St., Suite 100
Portland, OR 97232-2099
Phone: 503-813-4480
Fax: 1-855-347-7239

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

Post-service Claims and Appeals

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

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

Post-service Claim

- Within 12 months from the date you received the Services, mail a letter to SKYGEN explaining the Services for which you are requesting payment. Provide the following:

  (1) The date you received the Services;

  (2) Where you received them;

(3) Who provided them;

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

(5) A copy of the bill and any supporting documents.

Your letter and the related documents constitute your claim. You may contact Member Services to obtain a claim form. You must mail your claim to the Claims Department at:

SKYGEN
Attn: Claims Processing
P.O. Box 714
Milwaukee, WI 53201

- We will not accept or pay for claims received from you after 12 months from the date of Service, except in the absence of legal capacity.
- SKYGEN will review your claim, and if they have all the information they need, they will send you a written decision within 30 days after they receive your claim.

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

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

  SKYGEN will make a decision within 15 days after they receive the first piece of information (including documents) that were requested.

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

  If the requested information (including documents) is not received within 45 days after the request is sent, a decision based on the information they have will be made within 15 days following the end of the 45-day period.
- If SKYGEN denies your claim (does not pay for all the Services you requested), the adverse benefit determination notice will tell you why your claim was denied and how you can appeal.

Post-service Appeal

- Within 180 days after you receive our adverse benefit determination, tell us in writing 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: 1-855-347-7239

- We will acknowledge your appeal in writing within five 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 Subscriber's membership ends.

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

Termination Due to Loss of Eligibility

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

Termination for Cause

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

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

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

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

If we terminate your membership for cause we will:

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

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

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

Termination of Your Group's *Agreement* with Us

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

Termination of a Product or All Products

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

CONTINUATION OF MEMBERSHIP

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

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

Federal or State-Mandated Continuation of Coverage

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

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

MISCELLANEOUS PROVISIONS

Administration of *Agreement*

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

Agreement Binding on Members

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

Amendment of *Agreement*

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

Applications and Statements

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

Assignment

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

Attorney Fees and Expenses

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

Governing Law

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

Group and Members Not Company Agents

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

No Waiver

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

Nondiscrimination

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

Notices

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

Overpayment Recovery

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

Privacy Practices

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

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

This is only a brief summary of some of our key privacy practices. Our Notice of Privacy Practices, which provides additional information about our privacy practices and your rights regarding your PHI, is available and will be furnished to you upon request. To request a copy, call Member Services. You can also find the notice 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, complete or partial destruction of Participating Dental Office facilities, and labor disputes. However, in these circumstances, neither we, nor any Participating Dental Office 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.

NONDISCRIMINATION STATEMENT AND NOTICE OF LANGUAGE ASSISTANCE

Nondiscrimination Notice

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

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call 1-800-813-2000 (TTY: 711)

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at:

Member Relations Department
Attention: Kaiser Civil Rights Coordinator
500 NE Multnomah St. Ste 100
Portland, OR 97232-2099
Phone: 1-800-813-2000

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

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

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

Help in Your Language

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

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

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

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

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

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

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

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

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

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

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

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-813-2000** (TTY: **711**).

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

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

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

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

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

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

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

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

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

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST DENTAL IMPLANT 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 "Dental Implant Services Rider Benefit Summary," which becomes part of the *EOC* "Benefit Summary." This entire benefit rider is therefore subject to all the terms and provisions of the *EOC*.

All Services covered under this rider count toward your Benefit Maximum as shown in your *EOC* "Benefit Summary."

Definitions

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

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

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

General Benefit Requirements

We cover the Services described in the "Dental Implant Benefit" section only if you meet all of the following requirements:

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

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

Dental Implant Benefit

We cover the following Services:

- Surgical placement and removal of a Dental Implant once per tooth space per lifetime including the following Services when provided in relation to covered Dental Implants or removals: diagnostic consultations, occlusal analysis, bone augmentation and grafts, impressions, oral surgery, placement, removal, and cleaning; and Services associated with postoperative conditions and complications arising from Dental Implants or removals;
- The final crown and implant Abutment over a single implant;
- The final implant-supported bridge Abutment and implant Abutment; or
- An alternate benefit per arch of a full or partial denture for the final implant-supported full or partial denture prosthetic device when the implant is placed to support a prosthetic device.

  Note: A pontic used in an implant-supported bridge is not covered under this "Dental Implant Services Rider" (see the "Major Restorative Services" section of the *EOC).*

Exclusions

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

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

Limitations

- Implant maintenance procedures when prostheses are removed and reinserted, including cleaning of prosthesis and abutments, are limited to a Dental Implant placed by a Permanente Dental Associates, PC Participating Dentist.
- Repair of a Dental Implant is not covered, except when the Member has five or more years of continuous dental coverage under this or any other Company dental contract that includes coverage for Dental Implant Services. This limitation does not apply to Services associated with postoperative conditions or complications arising from Dental Implants or removals, or failure of a Dental Implant, if the Dental Implant was placed by a Participating Provider or Non-Participating Provider.
- These benefits or alternate benefits are not provided if the tooth, Dental Implant, or tooth space received a cast restoration or fixed or removable prosthodontic benefit, including a Pontic, within the previous five years.

Dental Implant Services Rider Benefit Summary

Dental Implants	**In-network benefit**	**Out-of-network benefit**
Dental Implant benefit maximum	Implant Services Charges count toward your Benefit Maximum as shown in your *EOC* "Benefit Summary."	
	You Pay	
Dental Implant Services	50% Coinsurance after Deductible	50% Coinsurance

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 Benefit Summary," which becomes part of the *EOC* "Benefit Summary." This entire benefit rider is therefore subject to all the terms and provisions of the *EOC*.

Definitions

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

General Benefit Requirements

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

- You allow no significant lapse in the continuous orthodontic treatment process.
- You maintain continuous eligibility under this or any other Company dental contract that includes coverage for Orthodontic Services.
- You make timely payment of amounts due.
- Treatment must be started prior to a Member becoming 18 years of age.

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

Exclusions and Limitations

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

- Maxillofacial surgery.
- Myofunctional therapy.
- Replacement of broken orthodontic appliances.
- Re-treatment of orthodontic cases.
- Treatment of cleft palate.
- Treatment of macroglossia.
- Treatment of micrognathia.
- Treatment of primary/transitional dentition.

Orthodontic Services Rider Benefit Summary

Orthodontics	In-network benefit	Out-of-network benefit
	You Pay	
Members age 17 years and younger	50% Coinsurance	50% Coinsurance, plus any remaining balance above MAC or UCC
Members age 18 years and older	No coverage	No coverage