

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST

A Nonprofit Corporation

Kaiser Permanente Individuals and Families KP WA Traditional 80 Adult Dental Plan Evidence of Coverage Face Sheet

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

MONTHLY PREMIUM

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

For renewing Members, the Premium amount you pay is based on each Member’s age as of January 1, 2020. For new Members, the Premium amount you pay is based on each Member’s age on the effective date of their enrollment in 2020.

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

Premium

Member Age	Premium
19	[\$]
20-24	[\$]
25-29	[\$]
30-34	[\$]
35-39	[\$]
40-44	[\$]
45-49	[\$]
50-54	[\$]
55-59	[\$]
60-64	[\$]
65+	[\$]

EFFECTIVE DATE: January 1, 2020 through December 31, 2020

Kaiser Foundation Health Plan of the Northwest

Ruth Williams Brinkley, FACHE
President, Northwest Region
Kaiser Foundation Health Plan & Hospitals



Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation
Portland, Oregon

Kaiser Permanente Individuals and Families Adult Dental Plan Evidence of Coverage

Group Number: 20103

This *Evidence of Coverage* is effective January 1, 2020 through December 31, 2020.

Printed:

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

10-DAY CANCELLATION POLICY:

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

Member Services

Monday through Friday (except holidays)

8 a.m. to 6 p.m.

Portland area503-813-2000

All other areas 1-800-813-2000

Dental Appointment Center

All areas 1-800-813-2000

TTY

All areas 711

Language interpretation services

All areas 1-800-324-8010

kp.org/dental/nw

KP WA DENTAL 80 ADULT TRADITIONAL 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 benefits. This summary does not fully describe benefits, limitations, or exclusions. To see complete explanations of what is covered for each benefit (including exclusions and limitations), and for additional benefits that are not included in this summary, please refer to the “Benefits,” “Exclusions and Limitations,” and “Reductions” sections of this *EOC*. All Services are subject to the applicable Deductible, Copayment, or Coinsurance, unless otherwise noted.

Dental Services described in this “Benefit Summary” are only covered for Members age 19 years and older.

Benefit Maximum	
Per Member per Year	None
Deductible	
For one Member per Year	\$100
For an entire Family per Year	\$300
Benefits	You Pay
Preventive and Diagnostic Services (not subject to the Deductible)	
Oral exam, including evaluations and diagnostic exams	20% Coinsurance
Fluoride treatments	20% Coinsurance
Teeth cleaning	20% Coinsurance
Space maintainers	20% Coinsurance
X-rays	20% Coinsurance
Minor Restorative Services	
Routine fillings	50% Coinsurance after Deductible
Simple extractions	50% Coinsurance after Deductible
Restorations (composite/acrylic and steel)	50% Coinsurance after Deductible
Oral Surgery Services	
Major oral surgery	50% Coinsurance after Deductible
Surgical tooth extractions	50% Coinsurance after Deductible
Periodontic Services	
Scaling and root planing	50% Coinsurance after Deductible
Periodontal Surgery	50% Coinsurance after Deductible
Treatment of gum disease	50% Coinsurance after Deductible
Endodontic Services	
Root canal and related therapy	
Anterior Tooth	50% Coinsurance after Deductible
Bicuspid Tooth	50% Coinsurance after Deductible
Molar Tooth	50% Coinsurance after Deductible
Major Restorative Services	
Bridge abutments	50% Coinsurance after Deductible
Noble metal gold or porcelain crowns	50% Coinsurance after Deductible
Inlays	50% Coinsurance after Deductible
Pontics	50% Coinsurance after Deductible
Removable Prosthetic Services	
Full upper and lower dentures	50% Coinsurance after Deductible

Benefits	You Pay
Partial dentures	50% Coinsurance after Deductible
Rebases	50% Coinsurance after Deductible
Relines	50% Coinsurance after Deductible
Emergency Dental Care	You Pay
From Participating Providers	\$25 plus Deductible, Copayment, or Coinsurance that normally apply for non-emergency dental care Services
From Non-Participating Providers outside the Service Area	Any Charges that normally apply plus amounts that exceed Usual and Customary Charges for qualifying claims
Other Dental Services (not subject to or counted toward the Deductible or Benefit Maximum)	You Pay
Nightguards	10% Coinsurance
Nitrous oxide	\$25
Dependent Limiting Age	Limiting Age
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INTRODUCTION

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

The provider network for this Adult Dental Plan is the Dental network. Permanente Dental Associates, PC, is included in the Dental 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* and the “Benefit Summary” completely, so that you can take full advantage of your plan benefits. Also, if you have special dental care needs, carefully read the sections applicable to you.

Term of this EOC and Renewal

Term of this EOC

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

Renewal

This *EOC* does not automatically renew. If you comply with all of the terms of this *EOC*, Company will offer to renew this *EOC* and will send Subscriber a new evidence of coverage to become effective immediately after termination of this *EOC* or will extend the term of this *EOC*. The new evidence of coverage will include a new term of coverage and other changes. If Subscriber does not renew this *EOC*, Subscriber must give Company written notice as described under “How You May Terminate Your Membership” in the “Termination of Membership” section.

This *EOC* will not be terminated, except as described in the “Termination of Membership” section.

About Kaiser Permanente

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

We provide covered Services using Participating Providers and Participating Dental Offices located in our Service Area except as described under “In a Dental Emergency” in the “Emergency and Urgent Dental Care” section and under “Emergency Dental Care and Urgent Dental Care” in the “Benefits” section.

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

DEFINITIONS

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

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

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

Charges. The term “Charges” is used to describe the following:

- For Services provided by Permanente Dental Associates, PC, the charges in Company’s schedule of charges for Services provided to Members.
- For Services for which a provider (other than Permanente Dental Associates, PC) is compensated on a capitation basis, the charges in the schedule of charges that Company negotiates with the capitated provider.
- For items obtained at a pharmacy owned and operated by Company, the amount the pharmacy would charge a Member for the item if a Member’s benefit plan did not cover the item. (This amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing pharmacy Services to Members, and the pharmacy program’s contribution to the net revenue requirements of Company.)
- For all other Services, the payment that Company makes for the Services (or, if Company subtracts a 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 Charges that you must pay when you receive a covered Service as described in the “What You Pay” section.

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

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

Deductible. The amount you must pay in a Year for certain Services before we will cover those Services at the Copayment or Coinsurance in that Year.

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

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

Dental Specialist. A Participating Provider who is an endodontist, oral pathologist, oral radiologist, oral surgeon, orthodontist, pediatric dentist, periodontist or prosthodontist. A referral by a Participating Dentist is required in order to receive covered Services from a Dental Specialist.

Dentally Necessary. A Service that, in the judgment of a Participating Dentist, is required to prevent, diagnose, or treat a dental condition. A Service is Dentally Necessary only if a Participating Dentist determines that its omission would adversely affect your dental health and its provision constitutes a dentally appropriate course of treatment for you in accord with generally accepted professional standards of practice that are consistent with a standard of care in the dental community and in accordance with applicable law. Unless otherwise required by law, we decide if a service is Dentally Necessary. You may appeal our decision as set forth in the “Grievances, Claims, and Appeals” section. The fact that a Participating Dentist has

prescribed, recommended, or approved an item or service does not, in itself, make such item or 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.

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.

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

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

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

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

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

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

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

Non-Participating Provider. A person who is either:

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

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

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

Participating 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, dentist, or pediatric dental assistant, and who is an employee or agent of a Participating Dentist.

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

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

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

Services. Dental care services, supplies, or items.

Spouse. The person to whom you are legally married under applicable law. For the purposes of this *EOC*, the term “Spouse” includes a person legally recognized as your domestic partner in a valid Certificate of State Registered Domestic Partnership issued by the state of Washington or who is validly registered as your domestic partner under the laws of another state.

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, who is enrolled, and for whom we have received the applicable Premium.

Urgent Dental Care. Treatment for an Urgent Dental Condition.

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

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

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

PREMIUM, ELIGIBILITY, AND ENROLLMENT

Premium

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

Monthly Premium

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

Who Is Eligible

General

Enrollment in this plan is subject to our approval of your application for this Kaiser Permanente Individuals and Families Adult Dental Plan. In order to be eligible to enroll in this plan you must either:

- Elect to enroll under this plan at the time of enrollment onto one of Company's Kaiser Permanente Individuals and Families medical plans, or
- If you fail to elect to enroll under this plan at the time of enrollment onto one of Company's Kaiser Permanente Individuals and Families medical plans, or if you terminate coverage under this plan or any other Company Kaiser Permanente Individuals and Families dental plan after making the election, but prior to the next Annual Renewal Date, you may not enroll on this plan until the next Annual Renewal Date.

Subscriber

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

- On your membership effective date under this EOC, you must be enrolled as a Member in one of Company's Kaiser Permanente Individuals and Families medical plans.
- You must be age 19 years or older at your effective date.
- You must submit a completed application for this Kaiser Permanente Individuals and Families Adult Dental Plan.
- You must live in our Washington Service Area. For assistance about the Service Area or eligibility, please contact Member Services. The Subscriber's or the Subscriber's Spouse's otherwise eligible children are not ineligible solely because they live outside our Service Area or in another Kaiser Foundation Health Plan service area.

Dependents

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

- Your Spouse who is age 19 years or older.
- A person who is age 19 years or older and who is under the Dependent Limiting Age shown in the "Benefit Summary" and who is any of the following:
 - Your or your Spouse's child.
 - A child adopted by you or your Spouse.
 - Any other person for whom you or your Spouse is a court-appointed guardian.
- A person who is age 19 years or older 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 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.
 - Any other person for whom you or your Spouse is a court-appointed guardian and was a court-appointed guardian prior to the person reaching the Dependent Limiting Age shown in the "Benefit Summary."

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

When You Can Enroll and When Coverage Begins

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

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

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

Annual Open Enrollment Period

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

Special Enrollment

A special enrollment period is open to individuals who experience a qualifying event, as defined in applicable state and federal law. We will administer special enrollment rights consistent with applicable state and federal law.

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

- Loss of minimum essential coverage for any reason other than nonpayment of Premium, rescission of coverage, misrepresentation, fraud or voluntary termination of coverage.
- Gaining a Dependent through marriage or entering into a domestic partnership.
- 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.

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

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

Adding New Dependents to an Existing Account

To enroll a Dependent (such as a new Spouse) who becomes eligible to enroll after you became a Subscriber, you must submit an enrollment application within 60 days after the qualifying event. Enrollment in this Plan is subject to our verification of your eligibility.

Selecting and Switching Your Benefit Plan

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

When Coverage Begins

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

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

HOW TO OBTAIN SERVICES

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

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

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 Care Dentist

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

The online *Dental Provider Directory* provides the names and locations of Participating Dentists. Before receiving Services, you should confirm your Dentist has continued as a Participating Dentist. The information in the *Dental Provider Directory* is updated monthly, however, for the most up-to-date information, contact Member Services or go to kp.org/dental/nw/directory. Participating Dentists include both general Dentists and Dental Specialists.

Referrals

Referrals to Participating Providers

When you need Services, you should talk with your personal care Participating Dentist about your dental needs or your request for Services. Your Participating Dentist and other Participating Providers provide covered Services that are Dentally Necessary. Participating Dentists will use their judgment to determine if Services are Dentally Necessary. If you seek a specific Service, you should talk with your personal care Participating Dentist, who will discuss your needs and recommend an appropriate course of treatment. When appropriate, your Participating Dentist will refer you to a Participating Provider who is a Dental Specialist.

Referrals to Non-Participating Providers

If your Participating Dentist decides that you require Dentally Necessary Services that are not available from Participating Providers, and we determine that the Services are covered Services, your Participating Dentist will refer you to a Non-Participating Provider. The Deductible, Copayment, or Coinsurance for these authorized referral Services are the same as those required for Services provided by a Participating Provider and are subject to any benefit limitations and exclusions applicable to the Services.

Appointments for Routine Services

If you need to make a routine dental care appointment, please contact Member Services. Routine appointments are for dental needs that are not urgent such as checkups, teeth cleanings, and follow-up visits that can wait more than a day or two. Try to make your routine care appointments as far in advance as possible. For information about getting other types of care, refer to “Emergency and Urgent Dental Care” in this “How to Obtain Services” section.

Getting Assistance

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

Most Participating Dental Offices have an administrative office staffed with representatives who can provide assistance if you need help obtaining Services. Member Services representatives are also available to assist you Monday through Friday (except holidays), from 8 a.m. to 6 p.m.

Portland area 503-813-2000

All other areas 1-800-813-2000

TTY for the hearing and speech impaired 711

Language interpretation services 1-800-324-8010

You may also e-mail us by registering on our website at kp.org/dental/nw.

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

Participating Providers and Participating Dental Office Compensation

Participating Providers and Participating Dental Offices may be paid in various ways, including salary, per diem rates, fee-for-service, incentive payments, and capitation payments. Capitation payments are based on a total number of Members (on a per-Member, per-month basis), regardless of the amount of Services

provided. Company may directly or indirectly make capitation payments to Participating Providers and Participating Dental Offices only for the professional Services they deliver, and not for Services provided by other providers, dental offices, or facilities. Please call Member Services if you would like to learn more about the ways Participating Providers and Participating Dental Offices are paid to provide or arrange Services for Members.

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

Hold Harmless

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

Emergency and Urgent Dental Care

In a Dental Emergency

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

Obtaining Urgent Dental Care

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

Dental Appointment Center

All areas 1-800-813-2000

TTY 711

POST-SERVICE CLAIMS – SERVICES ALREADY RECEIVED

In general, if you have a dental bill from a Non-Participating Provider or Non-Participating Dental Office, our Dental Claims department will handle the claim. Member Services can assist you with questions about specific claims or about the claim procedures in general.

If you receive Services from a Non-Participating Provider following a referral from a Participating Provider, the Non-Participating Provider will send the bill to Dental Claims directly. You are not required to file a claim.

However, if you receive Services from a Non-Participating Provider or Non-Participating Dental Office without a referral and you believe Company should cover the Services, you need to send a completed dental claim form and the itemized bill to:

Kaiser Permanente
Dental Claims 16th Floor
500 NE Multnomah Street
Portland, OR 97232
Fax: 971-285-9031

You can request a claim form from Member Services. When you submit the claim, please include a copy of your dental records from the Non-Participating Provider or Non-Participating Dental Office if you have them.

Company accepts American Dental Association (ADA) Dental claim forms, CMS 1500 claim forms for professional services and UB-04 forms for hospital claims. Even if the provider bills Company directly, you still need to submit the claim form.

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

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

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

If you have questions or concerns about a bill from Company, 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

Deductible

In any Year, we will not cover Services that are subject to the Deductible until you meet the Member Deductible or the Family Deductible as shown in the “Benefit Summary” during that Year. The only payments that count toward the Deductible are those you make for covered Services that are subject to the Deductible under this *EOC*. The “Benefit Summary” indicates which Services are subject to the Deductible.

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

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

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.

Benefit Maximum

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

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 age 19 years or older at the time Services are provided.
- A Participating Dentist determines that the Services are Dentally Necessary.
- The Services are provided, prescribed, authorized, and/or directed by a Participating Dentist or Participating Provider, except where specifically noted to the contrary in this *EOC*.
- You receive the Services inside our Service Area from a Participating Provider, except where specifically noted to the contrary in this *EOC*.
- The Services are provided in a Participating Dental Office, except where specifically noted to the contrary in this *EOC*.

Coverage is based on the least costly treatment alternative. If you request a Service that is a more costly treatment alternative from that recommended by your Participating Dentist, but that accomplishes the same goal, we will 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, and the 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

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

Inside our Service Area

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

Outside our Service Area

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

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

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

An Emergency Dental Care office visit Copayment may apply when you receive Emergency Dental Care or an Urgent Dental Care appointment from a Participating Provider.

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

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

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

Other Dental Services

We cover other dental Services as follows:

- Medically Necessary general anesthesia and covered dental Services in conjunction with Medically Necessary anesthesia. We cover Medically Necessary general anesthesia services when provided in conjunction with the dental Services described in the “Benefits” section, if the general anesthesia services are Medically Necessary because the Member is physically or mentally disabled. We cover the dental Services described in the “Benefits” section when provided in a hospital or ambulatory surgical center, if the Services are performed at that location in order to obtain Medically Necessary general anesthesia for a Member who is physically or mentally disabled, along with the Medically Necessary general anesthesia.

- Nightguards. We cover removable dental appliances designed to minimize the effects of bruxism (teeth grinding) and other occlusal factors.
- Nitrous oxide, once per day. We cover use of nitrous oxide during Dentally Necessary treatment as deemed appropriate by the Participating 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 implants, including bone augmentation and fixed or removable prosthetic devices attached to or covering the implants; all related Services, including diagnostic consultations, impressions, oral surgery, placement, removal, and cleaning when provided in conjunction with dental implants; and Services associated with postoperative conditions and complications arising from implants.
- Dental Services not listed in the “Benefits” section 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 United States 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.
- Government agency responsibility; 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. However, this exclusion does not apply to Medicaid.
- Maxillofacial surgery.
- Medical or Hospital Services, unless otherwise specified in the *EOC*.
- Myofunctional therapy.

- Non-orthodontic recording of jaw movements or positions.
- Orthodontic Services.
- 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) disorder; treatment of problems of the jaw joint, including temporomandibular joint (TMJ) syndrome and craniomandibular disorders; and treatment of conditions of the joint linking the jaw bone and skull and of the complex of muscles, nerves, and other tissues related to that joint.
- Treatment of cleft palate.
- Treatment of macroglossia.
- Treatment of micrognathia.
- Treatment to restore tooth structure lost due to attrition, erosion, or abrasion.
- Use of alternative materials for removal and replacement of clinically acceptable material or restorations for any reason, except the pathological condition of the tooth (or teeth).

Limitations

- Dentures, bridges, crowns (per tooth), and replacement needed due to normal wear and tear of permanent fixed or removable prosthetic devices are limited to once every five years (except resin-based partial dentures which are replaceable once every three years).
- Examination and prophylaxis (routine preventive teeth cleaning), including scaling and polishing, is limited to two visits per Calendar Year as Dentally Necessary.
- Extraction of asymptomatic or nonpathologic third molars (wisdom teeth) are not covered unless performed in conjunction with orthodontic or periodontal treatment and prescribed by an orthodontist or periodontist.
- Full mouth gross debridement is limited to a frequency of once every 36 months.
- “Hospital call fees,” “call fees” or similar Charges associated with Dentally Necessary Services that are performed at ambulatory surgical centers or hospitals, unless the Services are provided in that setting in order to obtain Medically Necessary general anesthesia for a Member who is physically or mentally disabled.
- Repair or replacement needed due to normal wear and tear of interim fixed and removable prosthetic devices are limited to once every 12 months.
- Repair or replacement needed due to normal wear and tear of permanent fixed and removable prosthetic devices are limited to once every five years.

- Sedation and general anesthesia (including, but not limited to, intramuscular IV sedation, non-IV sedation, and inhalation sedation) are not covered, except when pursuant to the “nitrous oxide” provision described in the “Other Dental Services” section, and when Medically Necessary for members who are developmentally disabled or physically handicapped, pursuant to the “Medically Necessary general anesthesia and covered dental Services in conjunction with Medically Necessary anesthesia” provision as described in the “Other Dental Services” section.

REDUCTIONS

Injuries or Illnesses Alleged to be Caused by Third Parties or Covered by No-fault Insurance

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

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

If you obtain a settlement or judgment from or on behalf of a third party, or a payment under a no-fault insurance provision, you must ensure we are reimbursed for covered Services that you receive for the injury or illness, except that we will not collect to the extent that the payment would leave you less than fully compensated for your injury or illness. This “Injuries or Illnesses Alleged to be Caused by Third Parties or Covered by No-fault Insurance” 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 third party or no-fault insurance, 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 a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by any third party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney, but we will be subrogated only to the extent of the total Charges for the relevant covered Services.

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

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

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

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

You must provide us written notice before you settle a claim or obtain a judgment, or if it appears you will make a recovery of any kind. If you recover any amounts from any third party or any insurer based on your injury or illness, you must pay us after you are reimbursed the total amount of the actual losses and damages you incurred, or place the funds in a specifically identifiable account and retain control over the recovered amounts to which we may assert a right.

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

Workers' Compensation or Employer's Liability

If you suffer from an injury or illness that is compensable under a workers' compensation or employer's liability law, we will provide Services subject to your obligation to reimburse us to the extent of a payment or any other benefit, including any amount received as a settlement that you receive under such law.

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

GRIEVANCES, CLAIMS, AND APPEALS

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

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

A claim is a request for us to:

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

An adverse benefit determination includes:

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

An internal 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.

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 seek assistance from the Office of the Insurance Commissioner. Contact them by mail, telephone, or online at:

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

Reviewing Information Regarding Your Claim

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

Providing Additional Information Regarding Your Claim

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

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.

In addition, there is a separate appeals procedure for adverse benefit determinations due to a retroactive termination of membership (rescission).

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 pre-service claim, a non-urgent pre-service appeal, and an urgent pre-service appeal.

Pre-service Claim

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

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 N.E. Multnomah St., Suite 100
Portland, OR 97232-2099
Phone: 1-800-813-2000
Fax: 1-855-347-7239

- 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 not later than five calendar days after we receive your claim.

If we tell you we need more information, we will ask you for the information before the initial decision period ends, and we will give you five calendar days to send the information.

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

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

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

- 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 not later than two calendar days after we receive your claim. Within one calendar day after we receive your claim, we may ask you for more information. If we tell you we need more information, we will give you two calendar days to send the information. We will notify you of our decision within two calendar days of receiving the first piece of requested information or by the deadline for receiving the information, whichever is sooner. If we notify you of our decision orally, we will send you written confirmation within three days after the oral notification.
- If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

Non-Urgent Pre-service Appeal

- Within 180 days after you receive our adverse benefit determination notice, you must tell us by mail, fax, or orally that you want to appeal our denial of your pre-service claim. Please include the following:
 - (1) Your name and health record number;
 - (2) Your dental condition or relevant symptoms;
 - (3) The specific Service that you are requesting;
 - (4) All of the reasons why you disagree with our adverse benefit determination; and
 - (5) All supporting documents.

Your request and the supporting documents constitute your appeal. You must mail, fax, or call 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 acknowledge your appeal within seventy-two hours after we receive it.

- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and send you a written decision within 14 days after we receive your appeal, unless you are notified that additional time is needed to complete the review. The extension will not delay the decision beyond 30 days without your consent.
- If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal.

Urgent Pre-service Appeal

- Tell us that you want to urgently appeal our adverse benefit determination regarding your pre-service claim. Please include the following:
 - (1) Your name and health record number;
 - (2) Your dental condition or relevant symptoms;
 - (3) The specific Service that you are requesting;
 - (4) All of the reasons why you disagree with our adverse benefit determination; and
 - (5) All supporting documents.

Your request and the supporting documents constitute your appeal. You must mail, fax, or call 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 not later than 72 hours after we receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within 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 concurrent care claim, a non-urgent concurrent care appeal, and an urgent concurrent care appeal:

Concurrent Care Claim

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

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

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

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

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

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

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

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

- We will send written notice of our decision to you and, if applicable, to your provider.
- If we consider your concurrent care claim on an urgent basis, we will notify you of our decision orally

or in writing as soon as your clinical condition requires, but not later than 24 hours after we received your claim. If we notify you of our decision orally, we will send you written confirmation within three days after the oral notification.

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

Non-Urgent Concurrent Care Appeal

- Within 180 days after you receive our adverse benefit determination notice, you must tell us by mail, fax, or orally that you want to appeal our adverse benefit determination. Please include the following:
 - (1) Your name and health record number;
 - (2) Your dental condition or relevant symptoms;
 - (3) The ongoing course of covered treatment that you want to continue or extend;
 - (4) All of the reasons why you disagree with our adverse benefit determination; and
 - (5) All supporting documents.

Your request and all supporting documents constitute your appeal. You must mail, fax, or call 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 acknowledge your appeal within seventy-two hours after we receive it.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and send you a written decision as soon as possible if your care has not ended but not later than 14 days after we receive your appeal. We may extend the time for making a decision on your appeal for up to an additional 16 days if there is good cause.
- If we deny your appeal, our adverse benefit determination decision will tell you why we denied your appeal.

Urgent Concurrent Care Appeal

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

Your request and the supporting documents constitute your appeal. You must mail, fax, or call 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 us a letter explaining the Services for which you are requesting payment. Provide us with the following:
 - (1) The date you received the Services;
 - (2) Where you received them;
 - (3) Who provided them;
 - (4) Why you think we should pay for the Services; and
 - (5) A copy of the bill and any supporting documents, including dental records.

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

Kaiser Permanente
National Claims Administration - Northwest
P.O. Box 370050
Denver, CO 80237-9998

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

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

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

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

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

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

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

Post-service Appeal

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

Your request and the supporting documents constitute your appeal. You must mail, fax, or call 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 acknowledge your appeal within seventy-two hours after we receive it.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and send you a written decision within 14 days after we receive your appeal. We may extend the time for making a decision on your appeal for up to an additional 16 days if there is good cause.
- If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal.

Appeals of Retroactive Membership Termination (Rescission)

We may terminate your membership retroactively (see “Rescission of Membership” in the “Termination of Membership” section). We will send you written notice at least 30 days prior to the termination. If you have general questions about retroactive membership terminations or appeals, please call Member Relations at 1-800-813-2000.

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

Appeal of Retroactive Membership Termination

- Within 180 days after you receive our adverse benefit determination that your membership will be terminated retroactively, you must tell us, in writing, that you want to appeal our termination of your membership retroactively. Please include the following:
 - (1) Your name and health record number;
 - (2) All of the reasons why you disagree with our retroactive membership termination; and
 - (3) All supporting documents.

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

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Phone: 1-800-813-2000
Fax: 1-855-347-7239

- We will fully and fairly review all available information relevant to your request without deferring to prior decisions.
- We will review your appeal and send you a written decision within 14 days after we receive your appeal. We may extend the time for making a decision on your appeal for up to an additional 16 days if there is good cause.
- If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal.

Experimental or Investigational Determination and Appeal

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

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

Grievance Procedure

We want you to be satisfied with the Services you receive from Kaiser Permanente. We encourage you to discuss any questions or concerns about your care with your Participating Provider or another member of your dental care team. If you are not satisfied with your Participating Provider, you may request another. Contact Member Services for assistance. You always have the right to a second opinion from a qualified Participating Provider at the applicable Deductible, Copayment, or Coinsurance.

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

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

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

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

All complaints are handled in a confidential manner.

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

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

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

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

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

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

TERMINATION OF MEMBERSHIP

Membership continues from month to month subject to payment of applicable Premium. If your membership terminates, all rights to benefits end at 11:59 p.m. 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 termination date, except as provided under "Payments after Termination" in this "Termination of Membership" section.

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

Termination Due to Loss of Eligibility

You must immediately report to us any changes that affect eligibility status, such as moving out of our Service Area, a Spouse's loss of eligibility due to divorce, or a Dependent child who has reached the Dependent Limiting Age. If you meet the eligibility requirements under "Who Is Eligible" in the "Premium, Eligibility, and Enrollment" section on the first day of a month, but later in that month you no longer meet those eligibility requirements, your membership will end at 11:59 p.m. on the last day of that month. For example, if you first became ineligible on January 5, your termination date would be January 31, and your last minute of coverage would be 11:59 p.m. on January 31.

If your membership ends because you are no longer eligible to be a Dependent, but you continue to meet all other eligibility requirements, you will be able to enroll as a Subscriber under the identical Kaiser Permanente Individuals and Families dental plan if you request enrollment within 30 days after your membership termination date. However, you are not eligible if we terminate your membership under "Termination for Cause" in this "Termination of Membership" section. If we approve your application and you pay the required Premium, your membership as a Subscriber will begin when your membership under this *EOC* ends. Your Premium may differ from that under this *EOC*. For information about becoming a Subscriber, call Member Services.

Termination for Cause

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

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

Examples. We would consider the following acts as fraudulent:

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

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

Termination for Nonpayment of Premium

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

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

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

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

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

Payments after Termination

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

- Refund any amounts we owe the Subscriber for Premium paid for the period after the termination date.
- Pay you any amounts we have determined that we owe you for claims during your membership.
- Deduct any amounts you owe Company, Participating Providers, or Participating Dental Offices from any payment we make.

Rescission of Membership

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

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

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

Termination of a Plan

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

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

MISCELLANEOUS PROVISIONS

Administration of *EOC*

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

Applications and Statements

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

Assignment

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

Attorney Fees and Expenses

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

EOC Binding on Members

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

Exercise of Conscience

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

Governing Law

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

Litigation Venue

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

No Waiver

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

Nondiscrimination

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

Notices

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

Overpayment Recovery

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

Privacy Practices

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

copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

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

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

Unusual Circumstances

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 facilities, 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 <http://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 ሊያግዙዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ **1-800-813-2000** (TTY: **711**)።

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

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 **(711 :TTY) 1-800-813-2000** 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 ដោយមិនគិតលុយ គឺអាចមានសរាប់បំរើអ្នក។ 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) ໂປດຄຳບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ **1-800-813-2000** (TTY: **711**).

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódíłnih **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**).