

BENEFIT SUMMARY

American Indian/ Alaskan Native

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, the 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 “Dental Benefits” section of this *EOC*. Exclusions and limitations that apply to all benefits are described in the “Benefit Exclusions” and “Benefit Limitations” sections of this *EOC*.

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

Calendar Year Benefit Maximum	\$1,750
Out-of-Pocket Maximum	
Individual	\$0
Multi-child	\$0
Dental Office Visit	You Pay
	\$0
Preventive and Diagnostic Services	You Pay
Oral exam	\$0
X-rays	\$0
Teeth cleaning	\$0
Fluoride treatments	\$0
Space maintainers	\$0
Basic Restorative Services	You Pay
Routine fillings	\$0
Crowns (plastic/acrylic and steel)	\$0
Simple extractions	\$0
Oral Surgery Services	You Pay
Surgical tooth extractions including diagnosis and evaluation	\$0
Major oral surgery	\$0
Orthodontic Services	You Pay
Orthodontic treatment only for persons with a diagnosis of cleft palate with cleft lip.	\$0 (No Benefit Maximum)
Periodontics	You Pay
Diagnosis and evaluation	\$0
Treatment of gum disease	\$0
Scaling and root planing	\$0
Endodontics	You Pay
Root canal, related therapy, including diagnosis and evaluation	\$0
Major Restoration Services	You Pay
Gold or porcelain crowns	\$0
Inlays	\$0
Bridge abutments	\$0
Pontics	\$0

Removable Prosthetic Services	You Pay
Full and partial dentures	\$0
Relines	\$0
Rebases	\$0
Emergency Dental Care	You Pay
From Participating Providers	\$0 for Emergency Dental Care and Urgent Dental Care visits on the same or next business day plus any other Charges that normally apply.
From Non-Participating Providers outside the Service Area	All Charges over \$100
Other Benefits	You Pay
Nightguards	\$0
Nitrous oxide	
Children age 13 years and older	\$0
Children age 12 years and younger	\$0

This is not a contract. This “Benefit Summary” does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. Members may not be enrolled in and receive benefits from other private, public, or government sponsored health insurance plans while receiving benefits from Healthy KidsConnect plans, although some exceptions may apply. For more details on your benefit coverage, please refer to your *Evidence of Coverage* or call Membership Services. In the case of conflict between this “Benefit Summary” and the *Evidence of Coverage*, the *Evidence of Coverage* will prevail.

Benefits are subject to approval by the Oregon Health Authority.

All plans are offered and underwritten by:
Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah Street, Suite 100
Portland, OR 97232-2009

State of Oregon



Healthy KidsConnect Plan

Dental Benefits Evidence of Coverage

This *Evidence of Coverage* is effective January 1, 2012 through December 31, 2012



Healthy KidsConnect
Office Of Private Health Partnerships (OPHP)
250 Church Street SE, Suite 200
Salem, OR 97301
Salem (503) 378-8631
Toll Free 1-888-260-4555

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INTRODUCTION

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

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

TERM OF THIS EOC

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

ABOUT KAISER PERMANENTE

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

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

DEFINITIONS

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

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

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

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

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

- For Services provided by Dental Group, the charges in Company’s schedule of Dental Group charges for Services provided to Member.
- For Services for which a provider or (other than Dental Group) is compensated on a capitation basis, the charges in the schedule of charges that Company negotiates with the capitated provider.
- For items obtained at a pharmacy owned and operated by Company, the amount the pharmacy would charge a Member for the item if a Member’s benefit plan did not cover the item. (This amount is an

estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Company.)

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

Coinsurance. A percentage of Charges that you must pay when you receive a covered Service.

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

Copayment. The defined dollar amount that you must pay when you receive a covered dental Service.

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

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

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

Eligibility. The requirements that you must meet in order to qualify for and remain in the Healthy KidsConnect Program. *See “When coverage begins” and “When coverage ends”.*

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.

Exclusions. Specified conditions or circumstances, listed in this Plan, for which we pay no benefits. Exclusions may apply to Services that are Dentally Necessary and Dentally Appropriate.

Group. The Healthy KidsConnect Program with which we have a *Group Agreement* that includes this *EOC*.

Healthy KidsConnect Program means the Healthy Kids Program of the Office of Private Health Partnerships (OPHP), 250 Church Street SE, Suite 200, Salem, OR 97301. Telephone Salem (503) 378-8631, Toll Free 1-888-260-4555.

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

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

Member. A person who is eligible and enrolled under this *EOC*. This *EOC* sometimes refers to a Member as “you.”

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

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

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

Out-of-Network. Covered Services that you receive from providers that have **NO** contract with us to serve the Healthy KidsConnect Program.

Out-of-Pocket Maximum. The maximum set amount that you will incur in a Calendar Year before we will begin paying 100% for covered dental expenses.

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

Participating Dentist. Any licensed doctor of dental science (DDS) or doctor of medical dentistry (DMD) who is an employee of Dental Group, or any licensed dentist who, under a contract directly or indirectly with Company, has agreed to provide covered Services to Members with an expectation of receiving payment, other than Copayments or Coinsurance from Company rather than from the Member.

Participating Provider. A Provider that has a contract with us to serve the Healthy KidsConnect Program.

Plan. Our Healthy KidsConnect *Medical Benefits Plan, Dental Benefits Plan, Vision Benefits Plan,* and administrative procedures (such as procedures for claims submission, grievances, appeals, external review, and third party liability), all as described in this *EOC*.

Preauthorization. A determination by us prior to provision of Services that we will provide coverage for the Service.

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

Services. Dental care diagnosis, treatments, procedures, equipment, medications, or devices. Services include supplies to support a Service.

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

Supplies. Consumable goods to support dental care Services.

Temporomandibular Joint Disorder. Services related to treatment of Temporomandibular Joint Disorder when received by a Provider.

Urgent Dental Care. Treatment for an Urgent Dental Condition. .

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

Usual and Customary Charge. With respect to any one Service or supply:

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

- The usual charge made by the Participating Provider for that treatment; or

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

We, us, or our, refers to Kaiser Foundation Health Plan of the Northwest.

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

When coverage begins means:

- The first of the month after we have received your completed enrollment materials from the Healthy KidsConnect Program.
- From birth or placement for adoption, in the case of a newborn or adoptee enrolled in accordance with the requirements of the Healthy KidsConnect Program.

When coverage ends is when you have:

- Become age 19.
- Become eligible or entitled to Medicare.
- Become eligible for Medicaid/Oregon Health Plan (OHP).
- Not paid your premium.
- Moved out of state.
- Moved out of our Service Area.
- Otherwise fail to satisfy the Eligibility requirements of the Healthy KidsConnect Program.

You or your. The person enrolled in Healthy KidsConnect. Also referred to as Member in this *EOC*.

HOW TO OBTAIN SERVICES

Using Your Identification Card

We provide each Member with a Company 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 Membership Services. If you need to replace your ID card, call Membership Services.

Your ID card is for identification only and it does not entitle you to Services. To receive covered Services, you must be a current Member. Anyone who is not a Member will be billed as a non-Member for any Services he or she receives. If you let someone else use your ID card, we may keep your card and terminate your membership (see the “Termination for Cause” section). We may request photo identification in conjunction with your ID card to verify your identity.

Getting Assistance

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

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

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

Choosing a Personal Care Dentist

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

Emergency and Urgent Dental Care

In a Dental Emergency

If you have a medical emergency, call 911. This Plan does not cover medical care. If you have an Emergency Dental Condition that is not a medical emergency, Emergency Dental Care is available 24 hours a day, every day of the week. Call the Dental Appointment Center and a representative will assist you or arrange for you to be seen for a dental emergency. We cover limited Emergency Dental Care received outside of our Service Area from Non-Participating Providers and Non-Participating Dental Offices. You will need to contact these providers and offices directly to obtain Emergency Dental Care from them. See “Emergency Dental Care” in the “Dental Benefits” section for details about your Emergency Dental Care coverage.

Obtaining Urgent Care

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

Dental Appointment Center

From Portland..... 503-286-6868

From Vancouver..... 360-254-9158

From Salem 503-370-4311

From Longview..... 360-575-4800

TTY 1-800-735-2900

WHAT YOU PAY

Copayments

The Copayment you must pay for each covered Service is shown in the “Benefit Summary.” Copayments are due when you receive the Service.

Coinsurance

The Coinsurance you must pay for each covered Service is shown in the “Benefit Summary.” The Coinsurance amount is due when you receive the Service.

Benefit Maximum

This Plan has a Calendar Year dental Benefit Maximum as shown in the Benefit Summary. Orthodontic and implant Services may not count toward the Benefit Maximum.

Questions Regarding Benefits and Coverage

This Plan contains information about the benefits specific to the Healthy KidsConnect Plans. Please be sure to read carefully for the terms, conditions, provisions, limitations, and Exclusions of this Plan.

OUT-OF-POCKET MAXIMUM

Your Out-of-Pocket Maximum

There is a maximum to the total dollar amount of Copayments and Coinsurance that you must pay for certain covered Services that you receive within the same Calendar Year under this *EOC*. This Out-of-Pocket Maximum shown in the “Benefit Summary” is per Calendar Year per individual. After you reach the Out-of-Pocket Maximum, you are not required to pay Copayments and Coinsurance for these Services for the remainder of the year. Membership Services can provide you with the amount you have paid toward your Out-of-Pocket Maximum.

You are responsible for the Copayment and Coinsurance amounts for each covered dental Service listed in the Benefit Summary until you reach your Out-of-Pocket Maximum amount. The dental Out-of-Pocket Maximum amount accumulates based your own paid Charges.

Emergency Dental Care Charges do count towards the dental Out-of-Pocket Maximum

DENTAL BENEFITS

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

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

- The Services are provided in a Participating Dental Office, except where specifically noted to the contrary in this *EOC*.
- Coverage is based on the least costly treatment alternative. If you request a Service that is a more costly treatment alternative from that recommended by your Participating Dentist, but that accomplishes the same goal, we will provide that Service if all of the following requirements are met:
 - The Service would have been covered if it was recommended by your Participating Dentist.
 - A Participating Dentist determines that the Service is dentally appropriate.
 - You receive the Service from a Participating Provider in a Participating Dental Office inside our Service Area.

We will cover the Services up to the benefit level of the less costly treatment alternative. You will be responsible for any additional Charges.

Your “Benefit Summary” lists the Copayment or Coinsurance for each covered Service. The Services covered by this Plan are described below.

Preventive and Diagnostic Services

We cover the following preventive and diagnostic Services:

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

Basic Restorative Services

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

Simple extractions. We cover simple tooth extractions.

Oral Surgery Services

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

Orthodontic Services

Orthodontic Services: Coverage for orthodontic treatment only for persons with a diagnosis of cleft palate with cleft lip.

Orthodontic treatment will be covered so long as you meet the following conditions:

- Allow no significant lapse in the continuous orthodontic treatment process.
- Maintain continuous Eligibility under this or any other Company plan containing an orthodontic benefit.
- Make timely payment of amounts due.
- Treatment must be started prior to a Member becoming 18 years of age.

In all other cases, orthodontic treatment may be completed at the full Charge of the Service.

Orthodontic Services Exclusions

- Changes in treatment necessitated by an accident.
- Replacement of broken appliances.
- Re-treatment of orthodontic cases.
- Treatment of micrognathia.
- Treatment of macroglossia.
- Treatment of primary/transitional dentition.

Periodontics

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

Endodontics

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

Major Restoration Services

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

Pontic. An artificial tooth on a fixed partial denture (a bridge).

Removable Prosthetic Services

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

Prosthetic device. Artificial teeth including dentures or bridges.

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

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

Emergency Dental Care and Urgent Dental Care

Emergency Dental Care. We cover Emergency Dental Care, including local anesthesia and premedication, only if the Services would have been covered under other headings of this “Dental Benefits” section (subject to the “Benefit Limitations” and “Benefit Exclusions” sections) if they were not emergency dental Services.

Inside our Service Area

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

Outside our Service Area

If you are temporarily outside our Services 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.”

Copayments, Coinsurance, and reimbursement. You pay the amount shown in the “Benefit Summary.” There may be an additional fee as shown in the “Benefit Summary” added to any other applicable Copayments or Coinsurance when you receive Emergency Dental Care or an Urgent Dental Care appointment from a Participating Provider by the next business day after you contact us.

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

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

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

Other Benefits

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

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

Nitrous oxide. Covered for children when administered by a pediatric dentist, oral surgeon, or periodontist.

BENEFIT LIMITATIONS

- Repair or replacement needed due to normal wear and tear of fixed and removable prosthetics appliances that are less than five years old.
- Works-in-Progress started prior to your effective date are not covered and are the liability of the Member, or a prior dental insurance carrier. The only exception is a root canal in which the pulpal debridement has been completed. Dental Services to complete the root canal following pulpal debridement will be covered at 50 percent of the Usual and Customary Charges, subject to Benefit Maximum as shown in the “Benefit Summary.”

BENEFIT EXCLUSIONS

- Conditions for which Service or reimbursement is required by law to be provided at or by a government agency.
- Cosmetic Services, supplies, or prescription drugs that are intended primarily to improve appearance, repair, and/or replace cosmetic dental restorations.
- Dental implants, including bone augmentation and fixed or removable prosthetic devices attached to or covering the implants; all related Services, including diagnostic consultations, impressions, oral surgery, placement, removal, and cleaning when provided in conjunction with dental implants; and Services associated with postoperative conditions and complications arising from implants.
- Drugs obtainable with or without a prescription. These may be covered under your medical benefits.
- Experimental or investigational treatments, procedures, and other Services that are not commonly considered standard dental practice or that require governmental approval.
- Full mouth reconstruction and occlusal rehabilitation, including appliances, restorations, and procedures needed to alter vertical dimension, occlusion, or correct attrition or abrasion.
- Genetic testing.
- “Hospital call fees,” “call fees,” or similar Charges associated with Dentally Necessary Services that are performed at ambulatory service centers or hospitals.
- Medical or Hospital Services, unless otherwise specified in the *EOC*.
- Missed appointment fees a provider may charge for a missed appointment.
- Prosthetic devices following your decision to have a tooth (or teeth) extracted for nonclinical reasons or when a tooth is restorable.
- Replacement of prefabricated, noncast crowns, including noncast stainless steel crowns that were not placed by a Participating Provider.
- Sedation and general anesthesia (including, but not limited to, intramuscular IV sedation, non-IV sedation and inhalation sedation) are not covered, except when administered by an oral surgeon, periodontist or pediatric dentist pursuant to the Nitrous Oxide benefit as described in the “Other Benefits” section.
- Services for conditions that are covered by workers’ compensation or that are the employer’s responsibility.
- Services provided or arranged by criminal justice institutions for Members confined therein, unless care would be covered as Emergency Dental Care.
- Speech aid prosthetic devices and follow up modifications.
- Surgery to correct malocclusion or temporomandibular joint disorders; treatment for problems of the jaw joint, including temporomandibular joint syndrome and craniomandibular disorders; and treatment of conditions of the joint linking the jaw bone and skull and of the complex of muscles, nerves, and other tissues related to that joint.
- Treatment to restore tooth structure lost due to attrition, erosion, or abrasion.

REDUCTIONS

Injuries or Illnesses Alleged to be Caused by Third Parties

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

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

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

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

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

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

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

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

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

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

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

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

No Dual Enrollment or Double Coverage

Members may not be enrolled in and receive benefits from other private, public, or government sponsored health insurance plan while receiving benefits from Healthy KidsConnect Plans. There may be three exceptions to this:

- 1) There may be brief times of transition (typically less than 30 days) when a Member of Healthy KidsConnect is changing to or from another plan such as the Oregon Medical Insurance Pool or Oregon Health Plan.
- 2) If a child with end stage renal disease who is in need of dialysis or a kidney transplant is covered by other health coverage including Medicare, Company is secondary in all cases.
- 3) Tribal members may be enrolled in a qualified tribal health plan in which case the tribal health plan is secondary to Healthy KidsConnect coverage.

WORKERS' COMPENSATION OR EMPLOYER'S LIABILITY

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

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

REQUESTING DENTAL SERVICES AND BENEFITS

Post-Service Claims—Services Already Received

If you have a dental bill from a provider other than a Participating Provider, Claims Administration will handle the claim. Membership Services can assist you with questions about a specific claim or about the claim procedures in general.

If you receive Services from a provider who is not a Participating Provider following an authorized referral from a Participating Provider, the provider who provided the Services will send the bill to us directly. You are not required to file the claim. If you receive Services from a provider or facility without an authorized referral and you believe Company should cover the Services, you need to complete a Non-Plan Care Information form and obtain from the provider one of the following completed forms (as appropriate): an American Dental Association (ADA) Dental Claim Form or a CMS 1500 claim form for professional Services, or a UB-92 form for hospital claims. Send these items to:

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

You can request a dental claim form from Membership Services or download it from our website. To download a claim form, go to kp.org/dental/nw and select the appropriate link. When you submit the claim, include a copy of your dental records from the Non-Participating Dentist if you have them. If you do not submit the dental records and we determine they are necessary to decide your claim, you will be notified and required to submit them.

The provider may bill us directly. We accept the American Dental Association (ADA) and CMS 1500 claim forms for professional Services and UB-92 form for hospital claims. You still need to send the Non-Plan Care Information form even if the provider bills us directly.

You must submit a claim for a Service within 90 days after receiving that Service. If it is not reasonably possible to submit a claim within 90 days, then you must submit a claim as soon as reasonably possible, but in no case more than 15 months after receiving the Service, except in the absence of legal capacity.

We will reach a decision on your claim and pay the covered Charges within 30 calendar days 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. The written notice will tell you 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, contact Membership Services for an explanation. If you believe the Charges are not appropriate, Membership Services will advise you how to proceed. If you believe the Charges are not appropriate due to concerns involving our Services or your benefits, you may file a written grievance. If you think the Charges are in error (such as a bill for Services you did not receive or that you paid at the time of Service), the Participating Dental Office or Membership Services can assist you. If records indicate the Charges are accurate you will be given an explanation along with information about how to file a grievance if you are dissatisfied. Refer to “Grievances” in the “Dispute Resolution, Complaints, Grievances, and Appeals” section for more information on filing a grievance.

Pre-Service Claims—Requesting Future Services

When you need care, talk with your dental care Participating Provider about your dental needs, or request for dental Services. We provide treatment and Services based on dental necessity and appropriateness. Your dental care Participating Provider will use his or her judgment to determine if a treatment or Service is dentally appropriate. If you think you need a specific treatment or Service, talk with your Kaiser Permanente dental care Participating Provider. Your dental care Participating Provider will discuss your needs with you and recommend the most appropriate course of treatment.

If you request treatment, Service, or a dental appliance that your dental care Participating Provider believes is not Dentally Necessary and you disagree, you may ask for a second opinion from another Participating Provider. Contact the manager in the Participating Dental Office where your dental care Participating Provider is located. Membership Services can connect you with the correct manager, who will listen to your issues and discuss your request with your dental care Participating Provider and facilitate a second opinion if necessary. If the Participating Provider who provides the second opinion believes the Services are not Dentally Necessary, you can file a grievance with Member Relations.

If you request treatment, Service, or a dental appliance but you learn there may be coverage limitations or exclusions, and you have questions, contact Membership Services. If you are not satisfied after talking with Membership Services, you may file a written grievance with Member Relations. We will generate a benefit determination within 15 days. If you are not satisfied after receiving the benefit determination, you may then file an appeal.

Expedited procedures are available if your request for treatment, Service, or a dental appliance is considered urgent. A request is urgent if the normal decision time frames would cause a delay that would seriously jeopardize your life, health, or ability to regain maximum function. It also applies if a dental care provider who is familiar with your dental condition believes the delay would subject you to severe pain that cannot be adequately managed without the care or treatment at issue. In urgent situations, we will respond to you as quickly as your condition requires, not to exceed 24 to 72 hours depending on applicable state and federal laws.

DISPUTE RESOLUTION, COMPLAINTS, GRIEVANCES, AND APPEALS

We want you to be satisfied with the Services you receive from Kaiser Permanente. If you have questions about Services or your coverage, please contact Membership Services.

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

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

Complaints

If you want to talk with someone because you are dissatisfied with the availability, delivery, or quality of our Participating Provider Services, benefits, or administrative matters, you can make an oral complaint. Examples include appointment delays or the manner of communication by staff members. If you have a concern involving a denial of future care, refer to “Your Appeal Rights” in this section. If your concern involves a claims “Grievances” denial for Services you already received, refer to “Grievances” in this section.

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

If you remain dissatisfied, you can file a written grievance by following the procedures described in “Grievances.”

Grievances

If you want to talk with someone because you are dissatisfied with the availability, delivery, or quality of our Participating Provider Services, benefits, or administrative matters, you can make an oral complaint. Examples include appointment delays or the manner of communication by staff members. If you have a concern involving a denial of future care, refer to “Your Appeal Rights” in this section. If your concern involves a claims “Grievances” denial for Services you already received, refer to “Grievances” in this section.

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

If you remain dissatisfied, you can file a written grievance by following the procedures described in “Grievances.”

File a written grievance by writing to:

Member Relations
Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099

If you need assistance filing a written grievance, or if your grievance is urgent, contact Membership Services at 1-800-813-2000.

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

If your grievance involves a denial of urgently needed future care, we will expedite our response according to the clinical urgency of the situation, and we will send our response not later than 72 hours after we receive your written grievance.

If your grievance included a specific request and we deny that request, our decision letter will include detailed information about the basis of the decision, how to appeal the decision, and the clinical urgency of the situation, not to exceed 72 hours.

Your Appeal Rights

Please read this explanation carefully. It explains your right to request a review of our adverse benefit determination.

You, or anyone you formally designate to represent you, have the right to request an appeal (reconsideration) related to a denied grievance or a denial of service following a utilization review determination made by Kaiser (also referred to as “Company”). You must submit your appeal in writing within 185 days from the date on the initial denial notice. The process is described in the following appeal procedures. These procedures reflect the requirements of state and federal laws.

- A claim for Services you already received was denied and you disagree with the claim determination, you must file an appeal within 185 days of the date on the denial notice.
- You were issued a benefit denial in writing after you requested a pre-Service benefit determination, you must file the appeal within 185 days of the date on the denial notice. This includes circumstances such as a pre-Service denial based on a decision that you are not eligible for benefits.
- You disagree with a denial for future Services following a prior-authorization decision requested by your Participating Provider, you have 185 days from the date of the denial notice to submit an appeal. If your appeal involves urgently needed future care, a request for an expedited appeal may be submitted orally or in writing.

To file a written appeal, outline your concerns in writing and be specific about your request. You have the right to include with your appeal any written comments, documents, records, and other information relating to the appeal.

To submit an appeal, follow the instructions in the denial letter you receive, or send your appeal to:

Member Relations
Kaiser Permanente
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099

Receipt of appeals will be acknowledged within seven days. Appeals will be decided within 30 days after we receive your appeal. A decision will be expedited to meet the clinical urgency of the situation, not to exceed 72 hours if it involves a denial of urgently needed future care. Member Relations will conduct an independent review of your appeal and provide a written response. The review panel will consist of individuals not previously involved. If your appeal is denied, the written notice you receive will explain the basis for the decision, along with other important disclosures as required under state and federal laws.

TERMINATION OF MEMBERSHIP

Healthy KidsConnect Program is required to inform you of the date your membership terminates. If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date.

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

Termination for Cause

If you commit one of the following acts, we may terminate your membership by sending written notice, including the specific reason with supporting evidence to you at least 31 days before the membership termination date:

- You abuse or threaten the safety of Company personnel or of any person or property at a Participating Dental Office;
- You knowingly commit fraud in connection with membership, Company, or a Participating Provider. Some examples of fraud include intentionally:
 - Misrepresenting eligibility information about you.
 - Presenting an invalid prescription or dental order.
 - Misusing an ID card (or letting someone else use it).
 - Giving us incorrect or incomplete material information.
 - Failing to notify us of changes in family status or Medicare coverage that may affect your eligibility.
- We may report fraud and other illegal acts to the authorities for prosecution.

If we terminate your membership for cause we will:

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

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

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

Termination of Healthy KidsConnect Agreement

If Healthy KidsConnect's *Agreement* with us terminates for any reason, your membership ends on the same date. We require Healthy KidsConnect to notify you in writing if the Healthy KidsConnect's *Agreement* with us terminates.

Termination of a Product or All Products

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

MISCELLANEOUS PROVISIONS

Administration of Agreement

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

Agreement Binding on Members

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

Amendment of Agreement

The *Agreement* between Healthy KidsConnect and Kaiser Foundation Health Plan of the Northwest will change periodically. If these changes affect this *EOC*, revised materials will be available to you.

Applications and Statements

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

Assignment

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

Attorney Fees and Expenses

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

Governing Law

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

Group and Members not Company's Agents

Neither Healthy KidsConnect nor any Member is the agent or representative of Company.

Litigation Venue

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

No Waiver

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

Nondiscrimination

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

Notices

We will send our notices to the Member at the most recent address we have on record. The Member's parent or legal guardian is responsible for notifying us as soon as possible of any change in address.

Overpayment Recovery

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

Privacy Practices

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

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

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices*, which provides additional information about our privacy practices and your rights regarding your PHI, is available and will be furnished to you upon request. 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 health care needs in the event of unusual circumstances that delay or render impractical the provision of Services under this *EOC*, such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Participating Dental Office facility, complete or partial destruction of facilities, and labor disputes. However, in these circumstances, neither we, nor Dental Group, or any Participating Provider shall have any liability or obligation because of a delay or failure to provide these Services. In the case of a labor dispute involving Company, we may postpone non-Emergency Dental Care until after resolution of the labor dispute.