KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

Portland, *Oregon*

The State of Oregon, Acting By and Through Its Public Employees' Benefit Board "PEBB"

Dental Plan Evidence of Coverage

Group Number: 7029 / 14029

This *EOC* is effective January 1, 2008 to December 31, 2008

Membership Services

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

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

Dental Appointment Center

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

TTY

All areas 1-800-735-2900

Language Interpretation Services

All areas……1-800-324-8010

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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 chart does not fully describe benefits, the benefit limitations, or exclusions in full. To see what is covered for each benefit (including exclusions and limitations), for complete explanations, and for additional benefits that are not included in this summary, please refer to the "Deductible, Copayments, Coinsurance and Benefits" and "Exclusions and Limitations" sections of this *Evidence of Coverage*, which is listed in the same order as in the "Benefit Summary." Exclusions and limitations that apply to all benefits are described in the "Exclusions and Limitations" section of this *Evidence of Coverage*. Deductible does not apply to preventive, diagnostic or orthodontic Services.

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

Benefit	**You Pay**
Dental Office Visit Charge	$0
Annual Benefit Maximum	$1,750
Calendar Year Deductible	
Family	$150
Individual	$50
Preventive and Diagnostic Services **(Not applicable to the Deductible)**	**You Pay**
Oral Exam	No additional charge
X-rays	No additional charge
Teeth cleaning	No additional charge
Fluoride treatments	No additional charge
Space maintainers	No additional charge
Basic Restorative Services	**You Pay**
Routine fillings	20%
Crowns (plastic/acrylic and steel)	20%
Simple extractions	20%
Oral Surgery	**You Pay**
Surgical tooth extractions including diagnosis and evaluation	20%
Major Oral Surgery	20%
Periodontics	**You Pay**
Diagnosis and evaluation	20%
Treatment of gum disease	20%
Scaling and root planing	20%
Endodontics	**You Pay**
Root canal, related therapy, including diagnosis and evaluation	20%
Major Restoration Services	**You Pay**
Gold or porcelain crowns	25%
Inlays	50%
Bridge abutments	50%
Pontics	50%
Dental Implants	50% up to Annual Benefit Maximum

Removable Prosthetic Services	**You Pay**
Full and partial dentures	50%
Relines	50%
Rebases	50%
Emergency Services	**You Pay**
From plan Providers	$25 for Emergency and Urgent Service visits on the same or next business day plus any other Charges that normally apply.
From non-plan providers	All Charges over $100
Other Benefits	**You Pay**
Nightguards	10%
Nitrous oxide	
Adults and children age 13 years and older	$15.00
Children age 12 years and younger	No Charge

INTRODUCTION

This *Evidence of Coverage* (*EOC*), including the "Benefit Summary" and any benefit riders attached to this *EOC*, describes the coverage of the Full-Time, Part-Time and Retiree Dental Plan provided under the Agreement between Kaiser Foundation Health Plan of the Northwest, and PEBB. This plan is not a federally qualified Health Benefit Plan. 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 "Health Plan," "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.

Term of this *EOC*

This *EOC* is effective for the period stated on the cover page, unless amended, or on the date this *EOC* has been fully executed by every party and approved by the Department of Justice. PEBB's benefits administrator can tell you whether this *EOC* is still in effect. PEBB will not pay Health Plan for Dental Services performed before the date this *EOC* becomes effective or after the termination of this *EOC*.

About Kaiser Permanente

Dental Group provides Services directly to you and your Dependents through an integrated dental care system. Our Health Plan, hospitals, and Dental Group work together to provide you with quality dental care Services. Our dental care program gives you access to all of the covered Services you may need, such as routine care with your own personal Dentist and other benefits described in the "Deductible, Copayments, Coinsurance and Benefits" section.

For more information contact Membership Services at 503-813-2000, for outside the Portland area 1-800-813-2000, and TTY at 1-800-735-2900.

DEFINITIONS

Annual Benefit Maximum. The maximum amount of benefits that will be paid in a Calendar Year, your benefit is limited–during each Calendar Year–to the amount shown on your "Benefit Summary."

If you are covered for orthodontic Services, please note that orthodontic care does not count toward your benefit maximum. Your orthodontic coverage may include a separate maximum.

Benefit Summary. A brief description of your dental plan benefits and what you pay for covered Services, found in the front of this booklet.

Calendar Year. The twelve consecutive months time period of January 1 through December 31 of the same year.

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

- The dollar amount Dental Group charges as described in Health Plan's schedule for dental care Services by Dental Group provided to you and your Dependents.
- The dollar amount charged for Services a Provider (other than Dental Group) is compensated on a capitation basis that Kaiser Permanente negotiates with the capitated Provider.
- The dollar amount a Kaiser Permanente owned and operated pharmacy would charge a Member if the Member's benefit plan did not cover the pharmacy item.
- All other dollar amounts charged for Services, provided by Kaiser Permanente minus Copayment, Coinsurance or Deductible.

Coinsurance. A percentage of Charges that you must pay when you receive a covered Service as described in the "Deductible, Copayments, Coinsurance and Benefits" section.

Copayment. The defined dollar amount that you must pay when you receive a covered Service as described in the "Deductible, Copayments, Coinsurance and Benefits" section.

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

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

Dentally Necessary and Appropriate. A Service that, in the judgment of a licensed Dentist, is required to prevent, diagnose, or treat a dental condition. A Service is Dentally Necessary only if a 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.

Dental Office. Any facility listed in the Kaiser Permanente Dental Directory and Member Handbook for our Service Area. Dental Offices are subject to change. If you have questions about the current locations of Dental Office facilities, please call Membership Services.

Dentist. Any licensed Doctor of Dental Science (DDS) or Doctor of Medical Dentistry (DMD) who is an employee of the Dental Group, or any licensed Dentist who, under a contract directly or indirectly with the Dental Group, has agreed to provide covered Services to Members with an expectation of receiving payment, other than Copayments, Coinsurance, or Deductibles, from Dental Group rather than from the Member.

Dependent. A Member who meets the eligibility requirements as a Dependent.

Emergency Services. Dentally Necessary Services that require immediate treatment for acute infection, hemorrhage, relief of extreme pain or on account of injury.

***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/her Spouse and/or Dependents.

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

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

Kaiser Permanente. Kaiser Foundation Hospitals (a California nonprofit corporation), Health Plan, and the Dental Group delivery system.

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

Premium. Monthly membership charges paid by Group.

Provider. (a) A person regulated under state law, to practice dental or dental-related Services or otherwise practicing 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 Dental Group, has agreed to provide covered Services to Members with an expectation of receiving payment, other than Copayments, Coinsurance, or Deductibles, from Kaiser Permanente rather than from the Member.

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

Services. Dental care Services, supplies or items.

Spouse. Your legal husband or wife. If your Group permits coverage of domestic partners, then for the purposes of this *EOC*, the term "Spouse" includes your domestic partner in accord with your Group's requirements that we have approved in writing.

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.

Urgent Services. Treatment for a condition that requires prompt dental attention to keep it from becoming more serious, but 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 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.

Utilization Review. The formal application of criteria and/or other organizational approved criteria designed to ensure that each Member is receiving care at the appropriate level, used as a technique to monitor the use of or evaluate the dental necessity, appropriateness, effectiveness, or efficiency of a specific Service, procedure or setting.

PREMIUM, ELIGIBILITY, AND ENROLLMENT

Premium

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

Who Is Eligible

The Public Employees' Benefit Board (PEBB) eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. **You should refer to the PEBB Eligibility Handbook for detailed information and program requirements.**

HOW TO OBTAIN SERVICES

Using Your Identification card

We provide each Member with a Health Plan ID card that contains your health record number. Please have your health record number available when you call for advice, make an appointment, or go to a Provider for care. We use your health record number to identify your dental records and membership information. You should always have the same health record number. If we ever inadvertently issue you more than one health record number, please let us know by calling Membership Services. If you need to replace your ID card, please call Membership Services.

Your ID card is for identification only. 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 identity.

Getting Assistance

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

Most 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 Web site at **kaiserpermanente.org.**

Membership Services representatives can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. 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 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" section.

Emergency Services

There will be an additional $25 Charge added to any other Copayments or Coinsurance when you receive emergency dental Services for an Urgent Care appointment on the same or next business day.

Emergency Services outside the Service Area will be reimbursed up to $100 for all charges on an approved out of area claim incurred by the Member for emergency dental Services per incident. You are responsible for any balance after payment of the Usual and Customary Charge and any additional Deductible, Copayment or Coinsurance.

Elective care and care for conditions that could have been reasonably foreseen are not covered under your Emergency Services benefit. Follow-up and continuing care is covered only at our Dental Offices. You pay the amount shown on your "Benefit Summary" located in the front of this *EOC*.

In a Dental Emergency

Dental Emergency Service is available 24 hours a day, every day of the week. Call the Dental Appointment Center to receive advice or arrange to be seen for a dental emergency. You pay the amount shown on your "Benefit Summary" located in the front of this *EOC*.

Dental Appointment Center

From Portland	503-286-6868
From Vancouver	360-254-9158
From Salem	503-370-4311
From Longview	360-575-4800
TTY All areas	1-800-735-2900

Choosing a Personal Dentist

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

DEDUCTIBLE, COPAYMENTS, COINSURANCE AND BENEFITS

The Services described in this "Deductible, Copayments, Coinsurance and 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 Dentist determines that the Services are Dentally Necessary and Appropriate;
- The Services are provided, prescribed, authorized, and/or directed by a Dentist or Provider inside our Service Area, except where specifically noted to the contrary in the "Emergency Services" section.

Deductible

In any Calendar Year, we will not cover Services that are subject to the Deductible until you meet the Member Deductible or the Family Unit Deductible listed in the "Benefit Summary" during that Calendar Year. The only payments that count toward the Deductible are those you make for covered Services that are subject to the Deductible under this "*EOC*."

For Services that are subject to the Deductible, you must pay Charges for the Services when you receive them, until you meet your Deductible. After you meet the Deductible, you pay the applicable Copayment or Coinsurance for those Services for the remainder of the Calendar Year, subject to the limits described under "Annual Out-Of-Pocket Maximum" in the "Benefit Summary". Services that are subject to the Deductible are so noted in the "Benefit Summary."

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service is described in the "Benefit Summary." Copayments or Coinsurance are due when you receive the Service. If we must bill you, an accounting fee of $10 or more will be added to offset handling costs. If you miss an appointment without canceling you will owe a missed appointment fee of $25.

Your Benefits Described

You are covered for the Services described in this booklet when you receive Services from a Health Plan Provider. Your dental "Benefit Summary" describes your benefits and lists your Deductible, Copayment, Coinsurance, and Annual Benefit Maximum. Below are additional details about some of the covered Services.

Preventive and Diagnostic Services

Diagnostic Examination. Examination of your mouth, X-rays to check for cavities, and determining the condition of your teeth and gums.

Preventive Services. Preventive care includes such Services as routine teeth cleaning (prophylaxis) and fluoride treatments.

Prophylaxis. Preventive cleaning of the teeth. You are covered for, at minimum, one visit for oral prophylaxis treatment in any 12 consecutive month period, except when you are receiving periodontal treatment or if additional cleans are determined necessary by your Dentist.

Space Maintainer. Appliance used to maintain spacing after removal of a tooth or teeth.

X-rays. Non-diagnostic bitewing X-rays in patients who are clinically determined by a Dentist to have low risk for dental disease are limited to:

- Once every 24 months for patients 15 years of age or older
- Once every 12 months for patients 14 years of age or younger

- Except when determined to be clinically indicated by a Dentist, full mouth or panoramic X-rays are limited to once ever 5 years

Basic Restorative Services

Basic Restorative Services. Your plan covers routine fillings and stainless steel and plastic/acrylic crowns.

Simple Extractions. Removal of a tooth (or teeth), not requiring surgery, when prescribed by your Dentist. Your plan covers simple tooth extractions.

Oral Surgery Services

Oral Surgery. Surgical tooth extractions, including diagnosis and evaluation, are covered.

Periodontics

Periodontics (gum treatment). Treatment of disease of the gums. Diagnosis, evaluation, and treatment of disease of the gums, including scaling and root planing, are provided. Periodontal scaling and root planing are covered once ever 24 months per quadrant.

Endodontics

Endodontics (root canal therapy). Treatment of the root canal or tooth pulp. Your benefit includes root canal and related therapy, including diagnosis and evaluation.

Major Restoration Services

Major Restorative Services. Your plan covers gold and porcelain crowns, inlays, bridge abutments and pontics, and other cast metal restorations. If you request a procedure or material not covered, or in excess of what is recommended by your Provider, you will be responsible for the additional fees. Repair or replacement of prosthetic appliances that are less than seven years old is not covered.

Pontic. An artificial tooth on a dental bridge.

Removable Prosthetic Services. Covered Services include full and partial dentures, relines and rebases. Your plan covers 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 seven years.

Prosthetic Device. Artificial teeth such as 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.

Dental Implants. 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; and Services associated with postoperative conditions and complications arising from implants are covered as shown on your "Benefit Summary"

Emergency Services

Urgent Condition. A dental problem such as 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.

Emergency Services. Care for a condition requiring immediate treatment for acute infection, hemorrhage, injury to the gums and/or teeth or relief of extreme pain that would lead a prudent layperson possessing an average knowledge of health and medicine to reasonably expect that immediate dental attention is needed. Coverage includes local anesthesia and premedication.

Other Benefits

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

Nitrous Oxide. Covered for adults and children age 13 years and older with a $15 charge. Children age 12 years and under receive nitrous oxide without charge when administered by a pediatric Dentist, oral surgeon, or periodontist.

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; or b) a crown, bridge, or gold restoration for which a tooth was prepared before your coverage became effective, are considered Works-In-Progress.

Exclusions and Limitations

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.
- 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.
- Medical and hospital services.
- Prescription drugs obtainable with or without a prescription. These may be covered under your medical benefits.
- 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.
- Restorative or reconstructive treatment for specific congenital or developmental malformations.
- 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 an Emergency Service.
- 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.

Limitations

- Repair or replacement needed due to normal wear and tear of fixed and removable prosthetics appliances that are less than seven (7) years old.

- Sedation and general anesthesia including, but not limited to, intramuscular IV sedation, non-IV sedation and inhalation sedation (including Nitrous Oxide, except when administered by an oral surgeon, periodontist or pediatric Dentist for covered Services).
- 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% of the Usual and Customary Charges, subject to Deductibles and Out of Pocket Maximums.

Coordination of Benefits

The Services covered under this *EOC* are subject to Coordination of Benefits (COB) rules which in some cases may reduce the amount of coverage we provide. COB applies when you have other health care coverage, so that we will coordinate benefits with the other coverage under the COB rules of the applicable state law so that your total benefit under all plans does not exceed the actual expense. Those rules are incorporated into this *EOC*.

Applicability. This COB provision applies when you have health care coverage under more than one plan. If you are covered by more than one health plan, the Order of Benefit Determination Rules described in this "Coordination of Benefits" section determines which plan is primary. The benefits of Health Plan:

- Shall not be reduced when, under the Order of Benefit Determination Rules, Health Plan is Primary, but
- May be reduced, or the reasonable cash value of any Service or supply provided covered by Health Plan may be recovered from the Primary Plan when, under the Order of Benefit Determination Rules, another Plan is Primary.

Definitions for this "Coordination of Benefits" section:

- **Plan.** (for this section only) "Plan" is a form of coverage with which coordination is allowed by law. Separate parts of a Plan for members of a group that are provided through contracts that are intended to be part of a coordinated package of benefits are considered one Plan and there is no COB among the separate parts of the Plan.
- **Primary Plan/Secondary Plan.** The Order of Benefit Determination Rules determines whether Health Plan is the Primary Plan or Secondary Plan with respect to another Plan covering the person. When we are the Primary Plan, benefits are provided or paid without considering the other Plan's benefits. When we are the Secondary Plan, benefits may be reduced and we may recover from the Primary Plan the reasonable cash value of the Services provided by us.
- **Allowable Expense.** A necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made. "Allowable Expense" does not include coverage for dental care, vision care, prescription drug or hearing aid programs. When Health Plan provides Services, the reasonable cash value of each Service is the Allowable Expense and is a benefit paid.
- **Claim Determination Period.** A Calendar Year, however, it does not include any part of a Calendar Year during which a person has no Health Plan coverage, or any part of a Calendar Year before the date this COB provision or a similar provision takes effect.

Order of Benefit Determination Rules

General. When a Member receives Services by or through Health Plan or is otherwise entitled to claim benefits from Health Plan, and the Services are a basis for a claim under another Plan, Health Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless one of the following is true:

- The other Plan has rules coordinating its benefits with us
- Both the other Plan's rules and our rules require that we be considered the Primary Plan

Rules. We determine whether we are Primary Plan or a Secondary Plan under the first of the following rules that apply:

- **Subscriber/Dependent.** A Plan that covers a person as a Subscriber is Primary to a Plan that covers the person as a Dependent
- **Dependent Child/Parents Not Separated or Divorced.** Except as stated below, when Health Plan and another Plan cover the same child as a Dependent of different persons, called "parents":
  - The Plan of the parent whose birthday falls earlier in the Calendar Year is Primary to the Plan of the parent whose birthday falls later in the Calendar Year; but
  - If both parents have the same birthday, the Plan that covered a parent longer is Primary
- **Dependent Child/Separated or Divorced Parents.** If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - First, the Plan of the parent with custody of the child
  - Then, the Plan of the spouse of the parent with custody of the child
  - Finally, the Plan of the parent not having custody of the child

If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the Plan obligated to pay or provide the benefits of that parent has actual knowledge of those terms, that Plan is Primary. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the payer has that actual knowledge.

- **Active/Inactive Employee.** A Plan that covers a person as an employee who is neither laid off nor retired (or as such an employee's Dependent) is Primary to a Plan which covers that person as a laid off or retired employee (or as such an employee's Dependent)
- **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the Plan that has covered a Subscriber longer is Primary to the Plan which has covered the Subscriber for the shorter time

Effect on the Benefits of This Plan. This section applies when we are a Secondary Plan to one or more other Plans. In that event our benefits may be reduced under this section.

Reduction in this Plan's Benefits. We may reduce benefits payable or may recover the reasonable cash value of Services provided when the sum of:

- The benefits that would be payable for, or the reasonable cash value of, the Services provided as Allowable Expenses by Health Plan in the absence of this COB provision
- The benefits that would be payable for Allowable Expenses under one or more of the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim thereon is made, exceeds Allowable Expenses in a Claim Determination Period. In that case, our benefits will be reduced, or the reasonable cash value of any Services provided by us may be recovered, from the Primary Plan, so that they and the benefits payable under the other Plans do not total more than the Allowable Expenses.

Right to Receive and Release Needed Information. Certain information is needed to apply these COB rules. We will decide the information we need, and may get that information from, or give it to, any other organization or person involved in resolution of the claims, in agreement with personal health information

privacy and security laws. Each person claiming benefits under Health Plan must give us any information we need to resolve the claim.

Facility of Payment. If a payment made or a Service provided under another Plan includes an amount that should have been paid or provided by or through us, we may pay that amount to the organization which made that payment. The amount paid will be treated as though it were a benefit paid by us.

Right of Recovery. If the amount of payments by us are more than we should have paid under this COB provision, or if we have provided Services that should have been paid by the Primary Plan, we may recover the excess or the reasonable cash value of the Services, as applicable, from one or more of:

- The persons we have paid or for whom we have paid
- Insurance companies
- Other organizations

REQUESTING DENTAL SERVICES AND BENEFITS

Post Service Claims—Services Already Received

If you have a dental bill from a non-Kaiser Permanente (non-Plan) Provider or facility, Claims Administration will handle the claim. Membership Services can assist you with questions a about specific claim or about the claim procedures in general.

If you receive non-Plan Services following an authorized referral from Kaiser Permanente, the non-Plan provider will send the bill to us directly. You are not required to file the claim. If you receive Services from a non-Plan provider or facility without an authorized referral and you believe Kaiser Permanente should cover the Services, you need to send a completed Non-Plan Care Information form (claim form) and the itemized bill to:

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

You can request a claim form from Membership Services or download it from our web site. To download a claim form, go to **kaiserpermanente.org** and select the appropriate link. When you submit the claim, include a copy of your dental records from the non-Kaiser Permanente facility if you have them. If you don't submit the dental records and we determine they are necessary to decide your claim, we will notify you.

The non-Kaiser Permanente 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 tills us directly.

You must submit a claim within 90 days after receiving care, or as soon as reasonably possible. We will not review a claim if we do not receive a complete claim form within 12 months from the time the completed claim form is due, unless you lack legal capacity to file the claim within 12 months.

We will reach a decision on your claim and pay the covered charges within 30 calendar days unless additional information 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 regarding 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 Kaiser Permanente, 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 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 "Complaints, Grievances, and Appeals" for more information on filing a grievance.

Pre-Service Claims—Requesting Future Care or Service

When you need care, talk with your dental care provider about your dental needs or request for dental Services. We provide treatment and Services based on dental necessity and appropriateness. Your dental care 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 provider. Your dental care 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 provider believes is not dentally appropriate or necessary and you disagree, you may ask for a second opinion from another dental care provider at Kaiser Permanente. Contact the manager in the dental office where your dental care 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 provider and facilitate a second opinion if necessary. If your dental care provider continues to believe the treatment, Service, or dental appliance you requested is not dentally necessary, you may file a written 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.

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.

Complaints, Grievances, and Appeals—Member Satisfaction

Everyone associated with Kaiser Permanente wants you to receive the best care and Service possible. If you have questions about your coverage or how to use our Services, or if you need help finding the right dental care resource, call Membership Services. If you have a compliment or suggestion, please call or send a letter to the administrator of the facility where you received care. We'll share your comments with the employees who assisted you and their supervisors.

Discuss any issues about your care with your dental care provider or another member of your dental care team. If you are not satisfied with your dental care provider, you may request another. Contact Membership Services for assistance. You always have the right to a second opinion within Kaiser Permanente.

Most issues can be resolved with your dental care team. 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.

Oral Complaints

If you want to talk with someone because you are dissatisfied with the availability, delivery, or quality of our Services, benefits, or other administrative matters, you can file an oral complaint. Examples include, but are not limited to, things like appointment delays, the manner of communication by our staff, or concerns about our policies and procedures. If you have a concern involving a denial of future care or payment for Services you already received, refer to "Written Grievances."

To file a complaint, 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. If you decide to file a written grievance, follow the procedures described in "Written Grievances."

Written Grievances

A grievance is a written complaint requesting a specific action, submitted by or on behalf of a Member.

You can file a written grievance:

- If you are not satisfied with our response to your complaint regarding the availability, delivery, or quality of our Services, benefits, or other administrative matters. Examples include complaints that you want reported and resolved regarding delays in receiving care, or dissatisfaction with care that you already received
- If you disagree with charges on a bill from Kaiser Permanente.
- If we denied your claim for Services that you received from a non-Kaiser Permanente provider or facility and you disagree with the claim determination, you must file the grievance within 185 days of the denial notice.
- If you disagree with your dental care provider's determination that the care, Service or equipment you requested is not dentally necessary or appropriate, or if you disagree with an explanation about benefits, copayments, or exclusions for care that you have not yet received, you may file a written grievance.

Grievance Procedures

To file a written grievance, outline your concerns in writing and be specific about your request. You may submit any written comments, documents, records, and other information related to your grievance. Send your grievance 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 Member Relations. We will acknowledge receipt of your grievance within seven days. An independent review will be conducted and we will provide you with a written response. Most grievance decisions will be provided within 30 days.

We will expedite a response on all grievances according to the clinical urgency of the situation, not to exceed 72 hours, if your grievance involves a denial of urgently needed care.

If your grievance included a specific request and that request is denied, the decision letter you receive will include detailed information about the basis for the decision and how to appeal the decision.

Appeals

The process for requesting reconsideration of a denied grievance is outlined in the following appeal procedures. These procedures reflect the requirements of state and federal laws. Receipt of appeals will be acknowledged within seven days.

- If you disagree with the decision rendered following a written grievance, you have 185 days to submit an appeal.
- If your appeal involves urgently needed care, a request for an expedited appeal may be submitted orally or in writing.

To submit an appeal, follow the instructions in the denial letter you receive, or send your appeal to Member Relations. You have the right to include with your appeal any written comments, documents, records, and other information relating to the claim.

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 care. Member Relations will conduct an independent review of your appeal and provide a written response. 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.

Injuries or Illnesses Alleged to be Caused by Third Parties

You must pay us Charges for covered Services you receive for an injury or illness that is alleged to be caused by a third party's act or omission, except that you do not have to pay us more than you receive from or on behalf of the third party. If there is no recovery, you are only responsible for the applicable cost-sharing under this *EOC*.

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 the 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 of Charges for the relevant 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. 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:

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

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 place and hold in trust a portion of the proceeds of your recovery that is sufficient to satisfy our claim(s) under this provision pending final resolution of the claim(s). You must provide us with written notice before you settle a claim or obtain a judgment against any third party for relevant Services already furnished or provided by us.

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.

If you are entitled to Medicare, Medicare law may apply with respect to Services covered by Medicare.

PEBB REQUIREMENTS AND AGREEMENTS

Inclusion of pebb.benefits. Health Plan agrees to administer the PEBB benefit program utilizing the web-based PEBB Benefit Management System, pebb.benefits.

- PEBB will provide enrollment data through pebb.benefits to Health Plan in HIPAA 834 format. Health Plan agrees to download and process the HIPAA 834 file on a weekly basis or more frequently if requested by PEBB.
- Health Plan agrees to use the PEBB benefit number (P number) for eligibility purposes. The PEBB benefit number is the identification number used in the premium files from payroll centers and third party administrators.
- Health Plan agrees to provide data and other information PEBB deems necessary to maintain and implement changes to the pebb.benefits system.
- Health Plan will establish and ensure compliance with security regulations adequate to safeguard the pebb.benefits system and data. Any breach of security to the system, PEBB data, or PEBB information will be reported to PEBB administration within 24 hours of an identification that a breach has occurred.

Health plan shall comply with all federal, state, and local laws, regulations, executive orders and ordinances applicable to this *EOC*.

Without limiting the generality of the foregoing, Health Plan expressly agrees to comply with the following laws, regulations, and executive orders to the extent they are applicable to this *EOC*: (i) Titles VI and VII of Civil Rights Act of 1964, as amended; (ii) Sections 503 and 504 of the Rehabilitation Act of 1973, as amended; (iii) the Americans with Disabilities Act of 1990, as amended; (iv) Executive Order 11246, as amended; (v) The Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended; (vi) The Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended; (vii) ORS Chapter 659, as amended; (viii) all regulations and administrative rules established pursuant to the foregoing laws; (ix) all other applicable requirements of federal and state laws governing the handling, processing, packaging, storage, labeling, and transportation of product. All laws, regulations and executive orders applicable to this *Agreement* are incorporated by reference where so required by law. PEBB's performance is conditioned upon Health Plan's compliance with ORS 279B.220, 279.230, 279B.235, and 279B.270, as applicable, the terms of which are incorporated by reference into this *EOC*.

Records Maintenance; Access. Health Plan shall maintain all fiscal records relating to this *EOC* in accordance with generally accepted accounting principles. In addition, Health Plan shall maintain any other records pertinent to this *EOC* in such a manner as to clearly document Health Plan's performance. Health Plan acknowledges and agrees that PEBB and the Oregon Secretary of State's Office and the federal government and their duly elected authorized representatives shall have access to such fiscal records and other books, documents, papers, plans, and writings of Health Plan that are pertinent to this *EOC* to perform examinations and audits and make excerpts and transcripts. Health Plan shall retain and keep accessible all such fiscal records, books, documents paper, plans, and writings for a minimum of three (3) years, or such longer period as may be required by applicable law, following final payment and termination of this *EOC*, or

until the conclusion of any audit, controversy or litigation arising out of or related to this *EOC*, whichever date is later.

Order of Precedence: All terms and conditions of this *EOC* are governed by PEBB Administrative Rules (OAR chapter 101) including, but not limited to, Eligibility for Coverage, Continuation of Coverage and Dispute/Grievance Resolution. In the event that this *EOC*'s terms and conditions conflict with the PEBB rules, the PEBB rule shall take precedence over the terms and conditions of this *EOC*.

TERMINATION OF MEMBERSHIP

PEBB is required to inform the Subscriber in your Family of the date your membership terminates. If your membership terminates for reasons other than Medicare eligibility, all rights to benefits end at 11:59 p.m. on the termination date. In addition, Dependents' memberships end at the same time the Subscribers' membership ends.

You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan, Dentists and Providers have no further liability or responsibility under this *EOC* after your membership terminates.

PEBB may terminate this *EOC* or an agency's participation in the *EOC* pursuant to ORS 243.145(2). Termination of this *EOC* may occur for any reason permitted by law and this *EOC* including but not limited to:

- PEBB fails to receive funding, or appropriations, limitations or other expenditure authority at levels sufficient to pay for its obligations under this *EOC*;
- Federal or state laws, regulations or guidelines are modified or interpreted in such a way that either the services to be performed under this *EOC* are prohibited or PEBB is prohibited from paying for such services from the planned funding source;
- Health Plan is in default under this *EOC*.

In the event of termination of this *EOC* pursuant to paragraphs (a) or (b) above, Health Plan's sole remedy will be a claim for the sum due Health Plan through the date of termination, less previous amounts paid and any claim(s) which State has against Health Plan. If previous amounts paid to Health Plan exceed the amount due to Health Plan under this section, Health Plan will pay any excess to PEBB upon demand. In the event of termination pursuant to Paragraphs (c) above, PEBB will have any remedy available to it in law or equity.

Termination Due to Loss of Eligibility

You and your Dependents must remain eligible to maintain your PEBB coverage. You must report to PEBB any changes in eligibility status, such as a Spouse's divorce or a Dependent's marriage, leaving school, or reaching the Dependent age limit. If you no longer meet the eligibility requirements described in "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section, please confirm with your Group's benefits administrator when your membership will end. PEBB must report membership changes (including sending appropriate membership forms) within the time limit for retroactive changes. Per Oregon Administrative Rules 101-040-008- (5)(b), effective 12/4/03, PEBB will approve correction of the enrollment error retroactive to the initial effective date but no earlier than the first of the previous plan year.

Termination for Cause

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

- You abuse or threaten the safety of Health Plan personnel or of any person or property at a Dental Office;
- You fail to comply with the provisions of the Health Plan;
- You knowingly commit fraud in connection with membership, Health Plan, or a Provider. Some examples of fraud include:
- misrepresenting eligibility information about you or a Dependent
- presenting an invalid prescription or dental order
- misusing a Health Plan ID card (or letting someone else use it)
- giving us incorrect or incomplete material information
- failing to notify us of changes in family status or Medicare coverage that may affect your eligibility or benefits
- If we terminate your Membership because you abuse or threaten the safety of Plan personnel or of any person or property at a Plan Facility, you and your Dependents will not be allowed to enroll in Health Plan in the future.
- 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 PEBB 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 Health Plan or Dental Group from any payment we make to you.

Termination of Group Agreement

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

Termination of a Product or all Products

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

Multiple Employer Trusts

If this *EOC* is issued to a multiple employer trust, termination of this *EOC* includes termination of an employer's participation under this *EOC*, whether or not the PEBB policy itself terminates. If this *EOC* is issued to a multiple employer trust, termination by an employer of the employer's participation under this *EOC* is effective on the date of the employer's termination of participation.

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

Through this agreement, PEBB makes our Dental coverage available to Members who are eligible. By electing coverage or accepting benefits under this *EOC*, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this *EOC*.

Amendment of Agreement

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

Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this *EOC*. All statements from Members or PEBB are deemed representations and not warrantees.

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 Health Plan or Providers, 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 Health Plan whether or not set forth in this *EOC*.

Group and Members not Health Plan's Agents

Neither PEBB nor any Member is the agent or representative of Health Plan. PEBB is the agent of each Member for the purposes of this *EOC*.

Hold Harmless

Health Plan agrees to hold Members harmless from any claim or action by a Plan Provider for any amounts owed by Health Plan for the provision of covered Services or benefits under this Agreement. This provision shall not apply to (a) Copayments; (b) Charges for Services rendered after exhaustion of benefits under this Agreement; or (c) Services and benefits not provided under this Agreement.

Litigation Venue

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

Named Fiduciary

Under our Agreement with your Group, we have assumed the role of a "named fiduciary," to review and evaluate claims that arise under this *EOC*. This means that we are the party responsible for determining whether you are entitled to benefits under this *EOC*. We conduct this evaluation independently by interpreting the provisions of this *EOC*.

No Waiver

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

Nondiscrimination

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

Notices

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

Overpayment Recovery

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

Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require contracting Providers to protect your PHI. PHI is health information that includes your name, social security number, or other information that reveals who you are. 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, and health care operations purposes, including health research and measuring the quality of care and Services. In addition, we are sometimes required by law to give PHI to government agencies or in judicial actions. In addition, we may share your PHI with employers 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* explains our privacy practices in detail. To request a copy, please call Membership Services. Our *Notice of Privacy Practices* is also available on the internet at kaiserpermanente.org.

Unusual Circumstances

KFHPNW is not responsible for delay or failure to render Service because of unusual circumstances, such as wars, riots, labor disputes not involving KFHPNW, or major disasters or epidemics affecting KFHPNW, Kaiser Permanente facilities or personnel, or Providers contracted with KFHPNW. Nonemergency care may be postponed in the event of labor disputes involving KFHPNW, Kaiser Permanente organizations or KFHPNW contracted Providers.

Coordination of Benefits

Consumer Explanatory Booklet

IMPORTANT NOTICE

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in your evidence of coverage, which determines your benefits.

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, state law permits issuers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your evidence of coverage or contact your state insurance department.

Primary or Secondary?

You will be asked to identify all the plans that cover members of your family. We need this information to determine whether we are the "primary" or "secondary" benefit payer. The primary plan always pays first when you have a claim.

Any plan that does not contain your state's COB rules will always be primary.

When This Plan is Primary

If you or a family member is covered under another plan in addition to this one, we will be primary when:

Your Own Expenses

- The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.

Your Spouse's Expenses

- The claim is for your spouse, who is covered by Medicare, and you are not both retired.

Your Child's Expenses

- The claim is for health care expenses of your child who is covered by this plan; and
  - You are the parent of the child and your birthday is earlier in the year than that of the other parent; or
  - You are separated or divorced and you have informed us of a court decree that makes you responsible for the child's health care expenses; or
  - There is no court decree, but you have custody of the child.

Other Situations

- We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits according to the terms of your evidence of coverage, just as if you had no other health care coverage under any other plan.

How We Pay Claims When We Are Secondary

When we are knowingly the secondary plan, we will make a reasonable estimate of the primary plan payment and base our payment on that amount. After payment information is received from the primary plan, we may recover from the primary plan any excess amount paid under the "right of recover" provision in the plan. We may not delay our payments because of lack of information from the primary plan. We are required to pay claims within ninety days of receipt.

If there is a difference between the amounts the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of the primary plan, whichever is higher. Health maintenance organizations (HMOs) and health care service contractors usually have contracts with their provider as do some other plans.

We will determine our payment by subtracting the amount we estimate that the primary plan will pay from the amount we would have paid if we had been primary. We must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal to one hundred percent of the total allowable expense (the highest of the amounts allowed under each plan involved) for your claim. We are not required to pay an amount in excess of our maximum benefit plus any accrued savings. If your provider negotiates reimbursement amounts with the plan(s) for the service provided, your provider may not bill you for any excess amounts once he/she has received payment for the highest of the negotiated amounts. When our deductible is fully credited, we will place any remaining amounts in a medical savings account to cover future medical claims which might not otherwise have been paid. For example, if the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we may pay for those expenses.

Questions About Coordination of Benefits?

Contact Your State Insurance Department