Regence Copay Plan B with Alternative Care
$20 Copay
$500 Deductible, 20/40/40% Coinsurance

Effective Date: January 1, 2018
Visit www.regence.com for a detailed description of your plan benefits listed below on or after 1/1/2018

cis benefits
cisbenefits.org

Benefit Summary	
Deductible per calendar year (Applies to 3 Claimants)	$500 Individual/$1,500 Family
Out-of-Pocket maximum **(Includes Deductible)	$2,500 Individual/$5,500 Family (Preferred & Participating Providers) $4,500 Individual/$9,500 Family (Non-Participating Providers)
After the Out-of-Pocket maximum is met, the plan pays	100% for the remainder of the calendar year
****Important Note**: The Family Out-of-Pocket Maximum for a Calendar Year is satisfied when two or more Family Members' Deductibles, Copayments and Coinsurance for Covered Services for that Calendar Year total and meet the Family's Out-of-Pocket Maximum amount. One Member may not contribute more than the individual Out-of-Pocket Maximum amount.	

Covered Medical Service (Per Member)	***Member Responsibility* Preferred Provider**	***Member Responsibility* Participating Provider**	***Member Responsibility* Non-Participating Provider**
Preventive Care For a list of services covered under this benefit, please visit our website (sign in and click on the "Preventive care" link)	0% (deductible waived)		40%
Office Visits	$20 copay (deductible waived)	40%	
Outpatient Laboratory and Radiology Services (Upfront Benefit) ▪ The first $400 per calendar year	0% (deductible waived)	N/A	
After the Upfront Benefits are Exhausted ▪ Laboratory and radiology services	20%	40%	
Professional Services ▪ Surgery, inpatient visits, diagnostic procedures and therapeutic injections	20%	40%	
Alternative Care ▪ Covers acupuncture and chiropractic spinal manipulations ▪ $1,000 per Claimant per Calendar Year ▪ Does not accrue towards out-of-pocket maximum	$20 (deductible waived)		
Ambulance Services	20%		
Durable Medical Equipment	20%	40%	
Emergency Room (Including Professional Charges) ▪ Copay applies to the facility charge, even if the deductible has been met ▪ Copay waived if admitted directly to a hospital or facility on an inpatient basis	20% after $100 copay (for each visit)		
Hospital Care ▪ Inpatient ▪ Outpatient	20%	40%	
Ambulatory Surgical Center	10% coinsurance for ambulatory surgery centers 20% coinsurance for all other facilities	40%	
Maternity Care	20%	40%	
Mental Health/Chemical Dependency Services - Inpatient, Residential	20%		40%
Outpatient ▪ Copayment applies to therapy visit only	$20 Copay (deductible waived for outpatient services)		40%
Rehabilitation Services ▪ Inpatient: Unlimited per calendar year ▪ Outpatient: 77 visit limit per calendar year	20%	40%	40%

Prescription Medication Benefits		
If you need drugs to treat your illness or condition, your prescription drug coverage is administered through Express Scripts (ES). Please visit Express Scripts' web site at www.express-scripts.com or contact their customer service at 1 (800) 496-4182. Regence BlueCross BlueShield of Oregon assumes no liability for the accuracy of your prescription drug benefits information.	**Generic drugs**	$5 copay / retail prescription $10 copay / mail order prescription
	Preferred brand drugs	$25 copay / retail prescription $50 copay / mail order prescription
	Non-Preferred brand drugs	$50 copay / retail prescription $100 copay / mail order prescription
	Specialty drugs	Refer to generic, preferred brand and non–preferred brand drugs costs above, for specialty medication or self-administrable cancer chemotherapy drug coverage.
	Limitations & Exceptions	**Out-of-pocket limit** $2,500 / claimant / year. Coverage is limited to 30-day supply retail or 90-day supply mail order. Specialty drug coverage is limited to a 30-day supply. Specialty medication filled at a retail pharmacy is subject to 100% copay/coinsurance, and this amount does not accumulate towards the out-of-pocket maximum. Certain preventive items and services as defined by the Affordable Care Act are covered at zero-dollar cost share. No charge for generic and preferred brand drugs designated as preventive for treatment of chronic diseases that are on the Preventive Medications List. You are responsible for the difference in cost between a dispensed brand–name drug and the equivalent generic drug, in addition to the **copayment** and/or **coinsurance**, unless your **provider** specifies "dispense as written."

MDLIVE (Telehealth)

With MDLIVE's telehealth service, you can see a doctor or therapist from home, work or on the go, 24/7/365. Board-certified doctors visit with you by phone or secure video to treat non-emergency medical conditions. They can diagnose symptoms, prescribe medication, and send prescriptions to your pharmacy. To learn more, please call 1 (888) 725-3097 or go to the CIS Health Manager at www.regence.com and hover on "Programs", then click on Telehealth.

hubbub

Hubbub health turns healthy behavior change into a game, with challenges that inspire you to move, nourish, balance, mingle, rewind and prosper. To learn more, go to the CIS Health Manager at www.regence.com and click on the hubbub health button.

Case Management

Receive one-on-one help and support in the event you have a serious or sudden illness or injury. An experienced, compassionate case manager will serve as your personal advocate during a time when you need it most. Your case manager is a licensed health care professional who will help you understand your treatment options, show you how to get the most out of your available plan benefits and work with your physician to support your treatment plan. To learn more, please call 1 (866) 543-5765 or go to the CIS Health Manager at www.regence.com and hover on "Programs", then click on Case Management.

Disease Management

Disease Management is a support and education program for people with chronic conditions such as diabetes, heart disease, asthma and/or depression. The Disease Management nurses and behavioral health care coordinators provide tailored educational materials, tools and other services to help you get on track with your care and stay there. They can help you understand the care plan you've developed with your physician, and make smarter choices for better health. To learn more, please call 1 (866) 543-5765 or go to the CIS Health Manager at www.regence.com and hover on "Programs", then click on Disease Management.

BabyWise Program

Pregnancy is a time of planning and excitement, but it can also be a time of confusion and questions. BabyWise can provide answers and assistance so that you can relax and enjoy those nine life-changing months.

This program offers expectant mothers access to a nurse 24/7/365, an informative maternity book or DVD and educational materials tailored to their needs. To learn more, please call 1 (888) 569-2229 or go to the CIS Health Manager at www.regence.com and hover on "Programs", then click on Maternity.

Weight Management and Obesity Treatment

CIS also offers a weight management program for all eligible members. For details go to www.cisbenefits.org; from there select "Healthy Benefits & Wellness," then "Enroll in a Weight Management Program."

BlueCard® Program (Out-of-Area Services)

The BlueCard Program is a unique program that enables you to access hospitals and physicians when outside the four-state area Regence serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world. Find a provider near you at **www.regence.com** or call **1 (800) 810-BLUE (2583)**.

Please note: This benefit summary provides a brief description of your health care plan benefits and is not a guarantee of payment. Once enrolled, please review your plan booklet (online at www.regence.com) for a complete list of benefits, limitations and/or exclusions, and a definition of medical necessity.

Your health coverage is insured by CIS, but administered by Regence BlueCross BlueShield of Oregon. This means CIS, not Regence BlueCross BlueShield of Oregon, pays for your covered medical services and supplies.

Regence

Your Regence Vision Plan 3 (24/24/24) Benefit Summary

VSP Coverage Effective Date: 01/01/18 – 12/31/18

VSP Doctor Network: VSP Choice

Keep your eyes healthy with Regence Vision Plan 3, administered by the Vision Service Plan Insurance Company (VSP).

Using your benefit is easy.

- **Register at regence.com.** Once your plan is effective, review your benefit information.

- **Find any eye care provider who's right for you.** With open access to see any eye care provider, you can see the one who's right for you. The VSP Choice network offers more than 81,000 provider points of access across the country, including both community-based providers as well as the most popular retail chains*, such as Costco®, Walmart®, Sam's Club®, ShopKo®, Visionworks® and any out-of-network provider (lower reimbursement rates).

  *Please note: participation in the VSP network is voluntary; therefore, not all doctors at a retail location may be on the VSP network. To find out if your doctor is a VSP network provider, visit regence.com or call 800.877.7195.

- At your appointment, tell the provider you have VSP and show them your member ID card.

That's it! There are no claim forms to complete when you see a VSP doctor.

Personalized Care

A VSP doctor provides personalized care that focuses on keeping you and your eyes healthy year after year. Plus, when you see a VSP doctor, you'll get the most out of your benefits, have lower out-of-pocket costs, and your satisfaction is guaranteed.

Benefit	Description	Copay
Your coverage with a VSP Provider		
WellVision Examination®	• Focuses on your eye health and overall wellness • Every calendar year – Children under 19 • Every other calendar year – All members 19 and over	$0
Prescription Glasses		
Frame	• $120 allowance for a wide selection of frames ($65 allowance at Costco, Walmart, Sam's Club,) • 20% savings on the amount over your allowance • Every other calendar year	$0
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Progressive lenses • Polycarbonate lenses covered for dependent children • Every calendar year – Children under 19 • Every other calendar yeas – All members 19 and over	$0 $50 $0
Lens Enhancements	• Average savings of 20-25% on lens enhancements	
Contacts (instead of glasses)	• $166 allowance for contact lenses (including the fitting examination and evaluation) • 15% savings on a contact lens exam • Every other calendar year – Adults • Every calendar year - Children	$0
Safety Glasses (Employee-only Coverage)		
Frame	• $65 frame allowance for safety frames • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection • Every other calendar year	$0 for frame and lenses
Lenses	• Prescription single vision, lined bifocal, and lined trifocal lenses • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection • Every calendar year	$0 combined with frames
Extra Savings and Discounts	**Glasses and Sunglasses** • 20% off additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your routine examination. Or get 20% off from any VSP provider within 12 months of your last routine examination. **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities **Please see reverse side**	

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options for you and your family.

Your vision plan is issued by Regence BlueCross BlueShield of Oregon and insured by CIS, but administered by VSP. This means that CIS, not Regence BlueCross BlueShield of Oregon, pays for your covered vision services and supplies.

Your Coverage with Out-of-Network Providers	
If you plan to see a provider other than a VSP doctor, visit **regence.com** for details. VSP guarantees coverage from VSP doctors only.	
Exam……..up to $45 Single Vision Lenses……..up to $30 Lined Bifocal Lenses……..up to $50 Lined Trifocal Lenses……..up to $65	Lenticular Lenses……up to $100 Frame ……up to $70 Elective Contacts……..up to $105 Necessary Contacts ……..up to $210
Submit claims for out-of-network providers to: VSP OA Claims; PO Box 385018, Birmingham, AL 35238-5018	

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  *Please note: participation in the VSP network is voluntary; therefore, not all doctors at a retail location may be on the VSP network. To find out if your doctor is a VSP network provider, visit regence.com or call 800.877.7195.

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Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Progressive lenses • Polycarbonate lenses covered for dependent children • Every calendar year – Children under 19 • Every other calendar yeas – All members 19 and over	$0 $50 $0
Lens Enhancements	• Average savings of 20-25% on lens enhancements	
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Copay B: Alternative Care & Vision **January 1, 2018 - December 31, 2018**	
Out-of-Pocket Maximum (Note: All Copayment, and Coinsurance amounts count toward the Out-of-Pocket Maximum, unless otherwise noted.)	
For one Member	$1,500
For an entire Family	$3,000
Office visits	**You pay**
Routine preventative physical exam	$0
Primary Care	$20
Specialty Care	$30
Urgent Care	$40
Tests (outpatient)	**You pay**
Preventive Tests	$0
Laboratory	$20 per department visit
X-ray, imaging, and special diagnostic procedures	$20 per department visit
CT, MRI, PET scans	$50 per department visit
Medications (outpatient)	**You pay**
Prescription drugs (up to a 30 day supply)	Generic $10, Preferred $20, Non-preferred $40, Specialty $40 (Per prescription)
Mail Order Prescription drugs (up to a 90 day supply)	2 x Copay
Administered medications, including injections (all outpatient settings)	20% Coinsurance
Nurse treatment room visits to receive injections	$10
Maternity Care	**You pay**
Scheduled prenatal care and first postpartum visit	$0
Laboratory	$20 per department visit
X-ray, imaging, and special diagnostic procedures	$20 per department visit
Inpatient Hospital Services	$200 per day up to $1,000 per admission
Hospital Services	**You pay**
Ambulance Services (per transport)	$75
Emergency department visit	$200 (Waived if admitted)
Inpatient Hospital Services	$200 per day up to $1,000 per admission
Outpatient Services (other)	**You pay**
Outpatient surgery visit	$50
Chemotherapy/radiation therapy visit	$30
Durable medical equipment, external prosthetic devices, and orthotic devices	20% Coinsurance
Physical, speech, and occupational therapies (up to 20 visits per therapy per Calendar Year)	$30
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services (up to 100 days per Calendar Year)	$0
Chemical Dependency Services	**You pay**
Outpatient Services	$20
Inpatient hospital & residential Services	$200 per day up to $1,000 per admission
Mental Health Services	**You pay**
Outpatient Services	$20

Inpatient hospital & residential Services	$200 per day up to $1,000 per admission
Alternative Care*	**You pay**
Alternative care (self-referred)	$20 per visit for acupuncture, chiropractic, and naturopathic visits. $25 per massage therapy visit (up to 12 visits per Calendar Year). $1,000 benefit maximum for all Services combined. Must use Complimentary Healthcare Plan Providers.
Vision Services	**You pay**
Routine eye exam (through first month of age 19)	$0
Vision hardware and optical Services (through first month of age 19)*	No charge for eyeglass lenses or frames or contact lenses every 12 months.
Routine eye exam (age 19 and older)	$20
Vision hardware and optical Services (ages 19 years and older)*	Balance after $150 allowance, once every two calendar years

* **Any amount you pay for covered Services does not count toward the Out-of-Pocket Maximum.***

kp.org Resources:

Here are some ways to make managing your care easier:
Sign on to our convenient online services and stay on top of your treatment from the comfort of your home.

- Find or switch doctors
- View lab test results
- Health risk assessments
- Order prescription refills
- Schedule and cancel appointments
- Exchange secure emails with your doctor and health care team
- Find locations or our medical centers and offices

Appointment Alternatives:

-Advice Nurse Line - If you have a health concern but aren't sure where to go for care, call the Kaiser Permanente advice nurse line at (800) 813-2000. Available 24 hours a day, our advice nurses can give you guidance on getting the care you need, view your medical record, and help schedule an appointment if needed.
-Virtual Care - Virtual care options are available for many health concerns. You can skip a copay and schedule a visit to see a doctor using your computer or mobile device. Call (800) 813-2000 (toll free), (503) 813-2000, or 711 (TTY for the hearing/speech impaired). You can use online scheduling to make an appointment with our Urgent Care providers. We offer both same-day Urgent Care Telephone Appointments and Urgent Care Video Visits.
-Email Your Doctor - You can send a secure email to your doctor and care team for answers to non-urgent health and wellness questions at any time by logging on to kp.org on your computer or mobile device.

Disease Management:

Our integrated health care delivery system provides comprehensive and coordinated care for our members with chronic conditions. All members who are identified by specified criteria are automatically enrolled in one of our disease management programs. Your personal physician, specialists, pharmacists, nurses, nutritionists, class instructors, and others will care for the whole you, body and mind.

Healthy Lifestyle Programs: kp.org/healthylifestyles or **kphealthylifestyles.org**.:

Digital and telephonic health coaching programs are available at no cost to members. These personalized interactive programs can help a member's goals to lose weight, eat better, manage stress, quit smoking, and more.
The online healthy lifestyle programs include:

- **Balance®** - A weight management program
- **Breathe®** - A program to help you quit smoking (**kp.org/quit smoking)**
- **Care® for Your Back –** Delivers personalized strategies for preventing and managing back pain
- **Care® for Diabetes –** Tools for managing Diabetes
- **Care for Pain® -** For members living with chronic pain
- **Care® for Depression –** Help with managing depression
- **Care® for sleep –** Tools for sleeping better
- **Relax® -** Stress management

Member Discounts: kp.org/choosehealthy

Available to you at no cost through your health plan, ChooseHealthy™offers a directory of complementary care providers, an online store, fitness club discounts, savings on health products and services, and more. You'll find reduced rates on:

- Fitness facility memberships
- Massage therapy services
- Chiropractic care
- Acupuncture
- Health & fitness books & videos
- Herbs, vitamins, and supplements

Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). EOCs are available upon request or you may go to http://www.kp.org/plandocuments

Questions? Call Member Services (M-F, 8 am-6 pm) or **visit kp.org** Portland area: 503-813-2000
All other areas: 1-800-813-2000 TTY.711. Language Interpretation Services, all areas 1-800-324-8010

This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on benefit coverage, claims review, and adjudication procedures, please see your EOC or call Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.

cis benefits
www.cisbenefits.org

Dental Plan II
CIS
Effective January 1, 2018

How To Use this Dental Plan

When you visit your dental provider, tell him or her that you are a member of a Delta Dental program.

Calendar year maximum, per member*	**$1,500**
Calendar year deductible, per member	**$0**

Service	Benefit Amount
CLASS I - PREVENTIVE [1] - Examination/X-rays - Prophylaxis - Fissure Sealants	**** 1st year - 70%** **2nd year - 80%** **3rd year - 90%** **4th year - 100%**
CLASS II - BASIC - Restorative Dentistry (treatment of tooth decay with amalgam or composite) - Oral Surgery (surgical extractions & certain minor surgical procedures) - Endodontic (pulp therapy & root canal filling) - Periodontics (treatment of tissues supporting the teeth) - Space Maintainers - Repair or reline of dentures and bridges	**** 1st year - 70%** **2nd year - 80%** **3rd year - 90%** **4th year - 100%**
CLASS III - MAJOR[2] - Crowns - Implants - Denture and Bridge Work (construction of fixed bridges, partials and complete dentures)	**50%**

* Annual dental maximum does not apply to members under age 16.

** Under this plan, benefits start at 70% your first calendar year of coverage. Thereafter, payments increase by 10% each calendar year (up to a maximum benefit of 100%) provided the individual has visited the dentist at least once during the previous calendar year. If in any calendar year the individual fails to receive covered dental services, the percentage for Class I and II services will decrease by 10% the next calendar year, but it will never be reduced below 70%.

[1] Any amount paid by the plan for Preventive services does not apply towards the calendar year maximum.

[2] There is a 12 month waiting period for Late Enrollees. A Late Enrollee is anyone not enrolled when initially eligible.

MEMBER SERVICES

Through our online service, **myModa**, you can download your member handbook, view claims status and payment information, search for participating providers, order ID cards, view personal information, and email dental customer service. You can access myModa at **www.modahealth.com,** or the CIS website at **www.cisbenefits.org**.

Dental Optimizer™ is a free resource on myModa that enables you to assess your risk level for oral health concerns and use that assessment to learn about reducing your risks and treatment costs. Dental Optimizer is comprised of a cavities risk assessment, dental health suggestions, and a Savings Optimizer based on a personal survey.

DELTA DENTAL®

Delta Dental provides dental claims payment services only and does not assume financial risk or obligation with respect to payment of claims

This is a benefit summary only. Any errors or omissions are unintentional.

For a more detailed description of benefits, refer to your member handbook, which can be accessed through myModa, or by calling Customer Service for a copy.

Delta Dental Customer Service 888-217-2365 - Delta Dental's website www.modahealth.com

See back for additional information

ADVANTAGES

DELTA DENTAL

* **Freedom to choose your dentist:** Delta Dental is unique in that we have contracts with more than 2,300 licensed dentists in Oregon.
* **Professional Arrangements:** Delta Dental has specific fee arrangements with our participating dentists in Oregon to ensure that actual charges made by the dentist do not exceed his or her accepted fees on file with Delta Dental. We believe that the unique feature in all Delta Dental programs is that every participating dentist becomes a party to cost control as well as the quality of care. Participating dentists will update your records with your new information and will submit claims to Delta Dental for vou.
* **Pre-determination:** As a service to our customers, your dental office can submit a pre-treatment plan to Delta Dental on your behalf, and we will return it to your dentist, indicating the dollar allowance that will be covered by your plan **before** you go forward with treatment.

LIMITATIONS

If an eligible person selects a more expensive plan of treatment than is functionally adequate, Delta Dental will pay the applicable percentage of the maximum plan allowance for the least costly treatment. The patient will then be responsible for the remainder of the dental providers' fees.

Class I - Preventive

* **Diagnostic:** Supplementary bitewing x-rays are covered once in any 12-month period. Complete series x-rays or a panoramic film are covered once in any 5-year period.

Class II - Basic

* **Restorative:** A separate charge for general anesthesia and/or IV sedation is not covered when used for non-surgical procedures. A separate charge for anesthesia may be covered when, in our judgment, it is necessary for complex oral surgery or due to the existence of a concurrent medical condition.

Class III - Major

* **Restorative:** If a tooth can be restored with a material such as amalgam, but another type of restoration is selected by the patient and dentist, the covered expense will be limited to the cost of amalgam. Crowns and other cast restorations (including onlays and replacement inlays) are covered once in a seven (7) year period on any tooth.

* **Prosthodontic:** A prosthetic device will be covered once in a seven (7) year period provided the tooth has not been crowned within the past seven (7) years. Specialized or personalized prosthetics are limited to the cost of standard devices.

EXCLUSIONS

* Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
* Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing teeth.
* Services started prior to the date the individual became eligible for services under the program.
* Hypnosis, prescribed drugs, premedications or analgesia (e.g. nitrous oxide) or any other euphoric drugs.
* Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
* General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office.
* Plaque control and oral hygiene or dietary instructions.
* Experimental procedures.
* Missed or broken appointments.
* Orthodontic services.
* Services for cosmetic reasons.
* Claims submitted more than 12 months after the date of rendition of the services.
* All other services or supplies, not specifically covered.

Delta Dental Customer Service 888-217-2365 - Delta Dental's website www.modahealth.com

Delta Dental provides dental claims payment services only and does not assume financial risk or obligation with respect to payment of claims.

cis benefits
www.cisbenefits.org

KAISER PERMANENTE®

Effective January 1, 2018- December 31, 2018

Dental	
Annual Deductible	None
Annual Benefit Maximum	Unlimited
Dental Office Visit Charge – applies to all visits	$10
Preventive and Diagnostic Care – includes oral examinations and x-rays, teeth cleaning (prophylaxis), fluoride treatments, instruction in the care of your teeth and gums, and prescribed space maintainers	No additional charge
Restorative Services – includes routine fillings, plastic and stainless steel crowns	No additional charge
Simple Extractions	No additional charge
Oral Surgery	No additional charge
Periodontic Procedures – includes diagnosis, evaluation, and treatment of disease of the gums, including scaling and root planning	No additional charge
Endodontic Procedures – includes root canal and related therapy, including diagnosis and evaluation	No additional charge
Major Restorative Services – includes gold or porcelain crowns, inlays, bridge abutments and pontics	$45 for each
Removable Prosthetics – Full and partial dentures Relines Rebasis	 $95 for each partial denture, $65 for each full denture $25 $25
Orthodontics	Not covered

PLEASE NOTE:

- You will be charged a $25 fee when you miss a dental appointment without calling in advance to cancel.
- You pay $15 for nitrous oxide for adults and children 13 and older.
- You pay 10% of charges for night-guards.

EXCLUSIONS

The following are not covered:

- Service not approved by a Kaiser Permanente dentist. Kaiser Permanente does not pay for unauthorized services from dentists or facilities not affiliated with Kaiser Permanente, except as indicated under "Emergency Treatment."
- Conditions covered by workers' compensation or that are the employer's responsibility.
- Procedures not generally and customarily available in the service area.
- Surgery to correct malocclusion or temporomandibular joint disorders; treatment for problems of the jaw joint, including temporomandibular joint syndrome and craniomadibular 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.
- Restorative or reconstructive treatment for specific congenital or developmental malformations.
- Full-mouth reconstruction and occlusal rehabilitation including appliances, restorations, and procedures needed to alter vertical dimension or occlusion or to splint or correct attrition or abrasion.
- Cosmetic services.
- Prescription Drugs.
- Experimental or investigational services.
- Orthodontic services.
- More than two visits for routine teeth cleaning (oral prophylaxis) in any twelve consecutive month period.
- Conditions covered by government agencies or programs other than Medicaid.
- Genetic testing.
- 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.
- Removal and replacement, with alternative materials, of clinically acceptable material or restorations for any reason except the pathological condition of the tooth or teeth.
- General anesthesia and intravenous sedation.
- Medical, hospital, and certain dental services.
- Work in progress before your coverage is effective.
- Replacement of prefabricated, non-cast crowns, including stainless steel crowns, that were not placed by a Kaiser Permanente dentist.
- Repair or replacement of fixed prosthetics or removable prosthetic appliances that are less than five years old.

This summary provides a brief description of your dental plan benefits. Any errors or omissions are unintentional. Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). EOCs are available upon request or you may go to http://www.kp.org/plandocuments.

Questions? Call Member Services (M-F, 8 am-6 pm) or **visit kp.org** Portland area: 503-813-2000
All other areas: 1-800-813-2000 TTY.711. Language Interpretation Services, all areas 1-800-324-8010

This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on benefit coverage, claims review, and adjudication procedures, please see your EOC or call Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.

Summary of Benefits

Group Number: OR27
Effective Date: January 1, 2018

Willamette Dental Group

CIS

BENEFITS	COPAYS
Annual Maximum	No Annual Maximum
Deductible	No Deductible
General & Orthodontic Office Visit	You pay a $10 Copay per Visit
DIAGNOSTIC AND PREVENTIVE SERVICES	
Routine and Emergency Exams	Covered with the Office Visit Copay
X-rays	Covered with the Office Visit Copay
Teeth Cleaning	Covered with the Office Visit Copay
Fluoride Treatment	Covered with the Office Visit Copay
Sealants (per Tooth)	Covered with the Office Visit Copay
Head and Neck Cancer Screening	Covered with the Office Visit Copay
Oral Hygiene Instruction	Covered with the Office Visit Copay
Periodontal Charting	Covered with the Office Visit Copay
Periodontal Evaluation	Covered with the Office Visit Copay
RESTORATIVE DENTISTRY	
Fillings	Covered with the Office Visit Copay
Porcelain-Metal Crown	Covered with the Office Visit Copay
PROSTHODONTICS	
Complete Upper or Lower Denture	Covered with the Office Visit Copay
Bridge (per Tooth)	Covered with the Office Visit Copay
ENDODONTICS AND PERIODONTICS	
Root Canal Therapy – Anterior	Covered with the Office Visit Copay
Root Canal Therapy – Bicuspid	Covered with the Office Visit Copay
Root Canal Therapy – Molar	Covered with the Office Visit Copay
Osseous Surgery (per Quadrant)	Covered with the Office Visit Copay
Root Planing (per Quadrant)	Covered with the Office Visit Copay
ORAL SURGERY	
Routine Extraction (Single Tooth)	Covered with the Office Visit Copay
Surgical Extraction	You pay a $50 Copay
ORTHODONTIA TREATMENT	
Pre-Orthodontia Treatment	You pay a $150 Copay*
Comprehensive Orthodontia Treatment	You pay a $1,500 Copay
MISCELLANEOUS	
Local Anesthesia	Covered with the Office Visit Copay
Dental Lab Fees	Covered with the Office Visit Copay
Nitrous Oxide	You pay a $10 Copay
Specialty Office Visit	You pay a $30 Copay per Visit
Out of Area Emergency Care Reimbursement	You pay charges in excess of $100

*Copay credited towards the Comprehensive Orthodontia Treatment copay if patient accepts treatment plan.

Underwritten by Willamette Dental Insurance, Inc.
This plan provides extensive coverage of services and supplies to prevent, diagnose, and treat diseases or conditions of the teeth and supporting tissues. Presented are just some of the most common procedures covered in your plan. Please see the Certificate of Coverage for a complete plan description, limitations, and exclusions.

cis benefits
www.cisbenefits.org

Exclusions and Limitations

Willamette Dental Group

Exclusions

- Bridges, crowns, dentures or any prosthetic devices requiring multiple treatment dates or fittings if the prosthetic item is installed or delivered more than 60 days after termination of coverage.
- The completion or delivery of treatments, services, or supplies initiated prior to the effective date of coverage.
- Dental implants, including attachment devices, maintenance, and dental implant-related services.
- Endodontic services, prosthetic services, and implants that were provided prior to the effective date of coverage.
- Endodontic therapy completed more than 60 days after termination of coverage.
- Exams or consultations needed solely in connection with a service not listed as covered.
- Experimental or investigational services or supplies and related exams or consultations.
- Full mouth reconstruction, including the extensive restoration of the mouth with crowns, bridges, or implants; and occlusal rehabilitation, including crowns, bridges, or implants used for the purpose of splinting, altering vertical dimension, restoring occlusions or correcting attrition, abrasion, or erosion.
- General anesthesia, moderate sedation and deep sedation.
- Hospitalization care outside of a dental office for dental procedures, physician services, or facility fees.
- Nightguards.
- Orthognathic surgery.
- Personalized restorations.
- Plastic, reconstructive, or cosmetic surgery and other services or supplies, which are primarily intended to improve, alter, or enhance appearance.
- Prescription and over-the-counter drugs and pre-medications.
- Provider charges for a missed appointment or appointment cancelled without 24 hours prior notice.
- Replacement of lost, missing, or stolen dental appliances; Replacement of dental appliances that are damaged due to abuse, misuse, or neglect.
- Replacement of sound restorations.
- Services and related exams or consultations that are not within the prescribed treatment plan and/or are not recommended and approved by a Willamette Dental Group dentist.
- Services and related exams or consultations to the extent they are not necessary for the diagnosis, care, or treatment of the condition involved.
- Services by any person other than a licensed dentist, denturist, hygienist, or dental assistant.
- Services for the diagnosis or treatment of temporomandibular joint disorders.
- Services for the treatment of an injury or disease that is covered under workers' compensation or that are an employer's responsibility.
- Services for treatment of injuries sustained while practicing for or competing in a professional athletic contest.
- Services for treatment of intentionally self-inflicted injuries.
- Services for which coverage is available under any federal, state, or other governmental program, unless required by law.
- Services not listed as covered in the contract.
- Services where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

Limitations

- If alternative services can be used to treat a condition, the service recommended by the Willamette Dental Group dentist is covered.
- Services listed in the contract, which are provided to correct congenital or developmental malformations which impair functions of the teeth and supporting structures will be covered for dependent children if primarily for the purpose of controlling or eliminating infection, controlling or eliminating pain, or restoring function.
- Crowns, casts, or other indirect fabricated restorations are covered only if dentally necessary and if recommended by the Willamette Dental Group dentist.
- When initial root canal therapy was performed by a Willamette Dental Group dentist, the retreatment of such root canal therapy will be covered as part of the initial treatment for the first 24 months. When the initial root canal therapy was performed by a non-participating provider, the retreatment of such root canal therapy by a Willamette Dental Group dentist will be subject to the applicable copayments.
- The services provided by a dentist in a hospital setting are covered if medically necessary; pre-authorized by a Willamette Dental Group dentist; the services provided are the same services that would be provided in a dental office; and applicable copayments are paid.
- The replacement of an existing denture, crown, inlay, onlay, or other prosthetic appliance is covered if the appliance is more than 5 years old and replacement is dentally necessary.