KAISER PERMANENTE®

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest. 500 NE Multnomah St., Suite 100, Portland, OR 97232.

# New and Renewing Group Application for groups with 51 or more employees

| Company's legal name | DBA(s) |
|---|---|
| CWCOG - City of Woodland | |
| Group number: 04551 | |

## Coverage requested

☐ New coverage ____ Submit this application, copy of selected proposal(s), and enrollment forms. To ensure timely processing of your enrollment, please return this form by the first of the month prior to your effective date.

■ Coverage renewal ____ Complete sections I, V, VI, and VII. If you are making benefit changes or changes affecting your rate, attach a copy of the selected proposal(s). If we have not heard from you or your producer, we will begin to implement your renewal, with no changes other than those required, 30 days before the effective date.

☐ Information change ____ If renewing coverage with changes, complete all other applicable sections. If renewing coverage with no changes, check the "no change" box in other sections.

*Term of contract* January 1, 2014 (Date) *through* December 31, 2014 (Date)

## Is your group new to Kaiser Foundation Health Plan of the Northwest (KFHPNW)?

So that your application can be processed quickly, please use this new coverage checklist to make sure the application materials are complete.

☐ Completed and signed application (includes tax identification number and workers' compensation information).
☐ Completed and signed employee enrollment forms and waiver information.
☐ Check made out to KFHPNW for the first month's premium (no postdated checks).

## Section I: Plan and optional rider selection

Plans and riders offered and underwritten by **KFHPNW**

### Base plan

Please check the plan you would like.

■ Traditional Copayment Plan 14D w/ 15/30 Rx
☐ Deductible Plan
■ High Deductible Health Plan (HSA qualified) 1500/3000 w/ 15/30 Rx
☐ Added Choice® Plan (point of service)

Do you have employees who work outside our service area who are eligible for this plan?* ☐ Yes ☐ No

■ Dental Plan HMO EA & PPO FC

### Riders

Please check each rider you wish to purchase.

■ Prescription drug rider 15/30
■ Alternative care rider
☐ Chiropractic care rider (Oregon only)
☐ Hearing aid rider
☐ Vision hardware rider
■ Dental orthodontics rider $1500 Plan E
☐ Expanded Choice rider

**☒ *IMPORTANT: You must attach a copy of all selected proposals and return it with this form.***

***Oregon employers only:** If you have employees who both live and work outside our service area, they will be enrolled in an Added Choice Plan designed for out-of-area employees.*

## Section II: Employer information ☒ No change

| Type of business | NAIC code (required) | Tax identification number |
|---|---|---|
| | | |

Please check all that apply:
☐ Publicly traded corporation ☐ Privately held corporation ☐ State government ☐ Local government ☐ Church group
☐ Corporation ☐ Partnership ☐ Limited partnership ☐ Proprietor ☐ Not-for-profit ☐ Other

In business since

Do you have workers who are independent contractors or who do seasonal work? ☐ Yes ■ No

Group plan sponsor
☐ Association ☐ Employer ☐ Labor organization ☐ Trustees or fund established by one or more employers or labor organizations

| Is the business a branch office? ☐ Yes ■ No | Is the business a subsidiary? ☐ Yes ☐ No |
|---|---|

| **Group administrator/primary contact**<br>Name<br>Address | City | State | ZIP |
|---|---|---|---|
| Email | Telephone | Fax | |
| Billing name<br>Billing address | City | State | ZIP |
| Email | Telephone | Fax | |
| Corporate headquarters address (if different from above) | City | State | ZIP |

Has your firm ever contracted with KFHPNW? ■ Yes ☐ No

If so, what was the legal name of the contracting firm? _____

Dates of previous contract with KFHPNW _____

Are your benefit plans subject to the ERISA claim regulations issued by the U.S. Department of Labor? ■ Yes ☐ No

## Section III: Eligibility* ☒ No change

| How many hours per week must employees work to be eligible for health care coverage? _____<br>New-hire eligibility date<br>☐ Date of hire ☐ First of month following date of hire<br>☐ First of month following _____ days from date of hire<br>☐ Group determines _____ | Overage dependent limiting age (cannot be under 26)<br>To 26 _____ years | Overage student limiting age (cannot be under 26)<br>To 26 _____ years |
|---|---|---|

| This plan will cover<br>■ Employees and dependents<br>☐ Employees only | Domestic partner coverage (non-state registered)? ■ Yes ☐ No<br>As required by state law, coverage for state registered domestic partners is included in all group plans when dependents are covered. | |
|---|---|---|
| Number of eligible employees | Number of ineligible employees | Total number of employees |

Does the firm self-produce HIPAA certificates of coverage? ☐ Yes ■ No If no, please answer the next question.
Does the firm request KFHPNW to produce the HIPAA certificate of coverage? ■ Yes ☐ No

*Custom Employee Enrollment Forms must be reviewed by Kaiser Permanente and potentially filed with the state prior to use.

## Section IV: Existing insurance information ☒ No change

| | | | |
|---|---|---|---|
| Workers' compensation/state industrial carrier | Policy number(s) | | |
| Current health insurance carrier | Policy number(s) | | |
| Address | City | State | ZIP |
| Current dental insurance carrier | Policy number(s) | | |

Open enrollment period _____ through _____ | Effective date

Renewal notification
☐ 90 days ■ 120 days ☐ Other (how many days?) _____ (requires approval)

Employer contributions
Employee $ _____ or _____% Dependent(s) $ _____ or _____%

Do any of your employees have Medicare? ☐ Yes ☐ No

Retiree eligibility age ☐ No retirement plan offered ☐ Younger than 65 ☐ 65 or older

If retirees are 65 or older, how is your retirement drug plan set up? ☐ Medicare Part D ☐ Retiree Drug Subsidy (RDS) ☐ Other

## Section V: Dual choice requirements and contractual provisions ☒ No change

**Multiple carrier offering**

Is KFHPNW the only medical and/or dental carrier offered by the group? ■ Yes ☐ No

If no, complete the following information:

Name of other carrier _____ Number of employees enrolled with other carrier _____

Name of other carrier _____ Number of employees enrolled with other carrier _____

## Section VI: Employer contribution

The group will contribute the following amounts of the monthly premium. If different employee classes are chosen, please indicate the contribution for each class. The minimum employer contribution amount is 50 percent of the employee premium for the lowest cost medical plan or dental plan.

| | Description | % or $ of employee premium | % or $ of dependent premium | For renewing groups, is this a change in the employer contribution percentages? ☐ Yes ■ No<br>If yes, was prior underwriting approval obtained? ☐ Yes ☐ No |
|---|---|---|---|---|
| Medical plan 1: | Traditional 14D | As negociated | As negociated | |
| Medical plan 2: | HDHP 1500/3000 | As negociated | As negociated | |
| Dental plan: | EA & FC | As negociated | As negociated | |
| Class of employee: | | | | |
| Class of employee: | | | | |
| Class of employee: | | | | |

## Section VII: Producer of record

☒ No change

**Please complete this section if you are represented by one of our appointed health insurance producers.**

Effective date 1/1/2014, employer hereby appoints Corey E. Balkan

producer of Interwest Benefit Consultants, Inc. (agency)

as producer of record to represent the employer in matters of group health benefits provided by KFHPNW and/or its subsidiaries. This appointment rescinds all previous appointments and will remain in effect until terminated in writing by either party.

Producer may make requests concerning premiums, benefits, eligibility requirements, and other matters relating to health coverage. The employer understands that commissions due to the producer for services provided pursuant to the appointment are governed by an agreement between the producer and KFHPNW.

**Producer/commission**

Premiums include the following producer/commission level: ☐ standard commission, or per CWCOG % of premium.

## Section VIII: Authorizing signature(s)

*This form is not valid if selected proposals are not attached and if it is not signed.*

| Authorized employer signature | Title | Date |
|---|---|---|
| Print name of principal/corporate officer | Title | Date |
| If you are a producer who completed this application on behalf of a client, please indicate so by signing. | Title/firm name<br>Principal, Interwest Benefits | Date<br>11/14/13 |

*You acknowledge by your signature that the information you have supplied on this form is true and correct. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.*



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532KPMC-12/4-12

## Rates at a Glance

**Contract Period:** 01/01/2014 – 12/31/2014

**Rates ***

**Group Name:** GC CWCOG 2013 8 groups HMO-DHMO **Region:** Northwest

**Group Number(s):** 1127,1985,3028,3359,4551,8859,16675,17490

**Subgroup(s):** 003,007,001,002,003,005,006, 007,001,002,005,001,002,003

| | Current Rates | Change % | Proposed Rates |
|---|---|---|---|
| **4551-001 KWM 2014 Cust 14B -no mbrs:** | | | |
| Subscriber only | $665.56 | 5.94% | $705.09 |
| Subscriber and 1 dependent | 1,331.11 | 5.94% | 1,410.18 |
| Subscriber and 2 or more dependents | 1,996.67 | 5.94% | 2,115.27 |
| **4551-002 KWM 2014 LEOFF I Custom 14B-no mbrs:** | | | |
| Subscriber only | $669.95 | 5.94% | $709.75 |
| Subscriber and 1 dependent | 1,339.90 | 5.94% | 1,419.49 |
| Subscriber and 2 or more dependents | 2,009.84 | 5.94% | 2,129.22 |
| **4551-005 KWM 2014 SB5777 Cust 14G-no mbrs:** | | | |
| Subscriber only | $638.25 | 5.94% | $676.16 |
| Subscriber and 1 dependent | 1,276.52 | 5.94% | 1,352.35 |
| Subscriber and 2 or more dependents | 1,914.77 | 5.94% | 2,028.51 |
| **4551-012 KWM 2014 Cust 14D Actives:** | | | |
| Subscriber only | $595.31 | 5.94% | $630.67 |
| Subscriber and 1 dependent | 1,190.62 | 5.94% | 1,261.34 |
| Subscriber and 2 or more dependents | 1,785.93 | 5.94% | 1,892.02 |

*Benefit plan descriptions are summarized, please see Rate and Benefit Summary for full descriptions.

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KAISER FOUNDATION HEALTH PL

## Rate and Benefit Summary - Commercial

**Region:** Northwest

**Group Name:** WOODLAND, CITY OF

**Contract Period:** 01/01/2014 - 12/31/2014

**Group Numbers:** 4551

**Subgroups:** 012,013

| | Apr12 - Mar13 |
|---|---|
| **Average Members*:** | 1,404 |

**Product Type:** Traditional

**Quote Name:** 4551-012 KWM 2014 Cust 14D Actives

### Current Rates

| Rate Tiers | Medical | Dental | Total | Ratio |
|---|---|---|---|---|
| Subscriber only | $595.31 | $0.00 | $595.31 | 1.00 |
| Subscriber and 1 dependent | 1,190.62 | 0.00 | 1,190.62 | 2.00 |
| Subscriber and 2 or more dependents | 1,785.93 | 0.00 | 1,785.93 | 3.00 |

### Proposed Rates

| Rate Tiers | Subscribers | Medical | %Change | Dental | %Change | Total | %Change | Ratio |
|---|---|---|---|---|---|---|---|---|
| Subscriber only | 8 | $630.67 | 5.94% | $0.00 | 0.00% | $630.67 | 5.94% | 1.00 |
| Subscriber and 1 dependent | 4 | 1,261.34 | 5.94% | 0.00 | 0.00% | 1,261.34 | 5.94% | 2.00 |
| Subscriber and 2 or more dependents | 10 | 1,892.02 | 5.94% | 0.00 | 0.00% | 1,892.02 | 5.94% | 3.00 |

**Monthly Rates Per Member When Medicare Is the Primary Payor and Member Age 65+ Is not Enrolled in Senior Advantage**

| | Rate |
|---|---|
| Neither A nor B | $1,102.35 |
| A and B | 617.03 |
| A Only | 937.34 |
| B Only | 1,102.35 |

**Estimated Monthly Cost:** $29,011

**Billing Frequency:** Monthly

### Proposed Traditional Benefits

**Annual Deductible: Individual / Family per calendar year(s) :** None

**Out-of-Pocket Maximum: Individual / Family :** $600 (STANDARD TRAD) / $1200 (STANDARD TRAD)

**Lifetime Maximum: Individual / Family :** NO MAXIMUM

**Prescription Drugs :** $15/GEN $30/BR

**Outpatient**

Primary Care, Excluding Urgent Care : $15 (EXCL URGENT CARE)

Urgent Care Office Visit : $35 COPAY FOR URGENT CARE

Preventive Care Services : $0

Prenatal Care : $0

Specialty Care Office Visit : $15 SPEC OV/$0 HCR FLEX

Outpatient Administered Drugs : NO CHARGE

* Includes Actives and/or pre 65 Retirees only.

## Rate and Benefit Summary – Commercial

**Region:** Northwest

**Group Name:** WOODLAND, CITY OF

**Contract Period:** 01/01/2014 – 12/31/2014

**Group Numbers:** 4551

**Subgroups:** 012,013

| | Apr12 – Mar13 |
|---|---|
| **Average Members*:** | 1,404 |

**Product Type:** Traditional

**Quote Name:** 4551-012 KWM 2014 Cust 14D Actives

**Other Professional**

Outpatient Surgery : $20; $0 FOR HCR PREVEN
Alternative Care / Chiropractic : CHIRO: $15
Referred Alternative Care : MATCHES OVSP-SEE LONG
Routine Eye Exam : $15
Infertility – Diagnosis – Laboratory : 50% COINS FOR DIAGNOSIS
Infertility – Diagnosis Office Visit : 50% COINS FOR DIAGNOSIS
Infertility – Treatment : 50% COINS FOR TREATMENT
Outpatient Therapy – Cardiac & Respiratory : $15 COPAY
Outpatient Therapy – Chemotherapy & Radiation : $15 COPAY
Outpatient Therapy – Dialysis : $15 COPAY
Outpatient Therapy PT OT ST & Multidisciplinary : $15 COPAY
Home Health Care : NO CHARGE, 130 VISITS YR

**Ambulance and Emergency Services**

Ambulance : $75
Emergency Room : $75 COPAY; WAIVE IF ADMIT

**Laboratory and Imaging**

X-Rays, Imaging, Laboratory, and Special Diagnostic Procedures : $15 COPAY NON-PREVENTIVE
Lab, X-Ray Preventive Procedures : $0 HCR PREVENTION
Lab, X-Ray Specialty Scans : $15 COPAY-SPEC SCANS

**Hospital Inpatient**

Inpatient Per Admit : NOT APPLICABLE
Inpatient Per Day : $50
Inpatient Copay Maximum : $250 MAXIMUM PER ADMIT
Skilled Nursing Facility Care Benefit Max : 100 DAYS/CAL YEAR
Skilled Nursing Facility Copay : NO CHARGE
Skilled Nursing Facility Copay Max : NO COPAY MAXIMUM

**Mental Health and Chemical Dependency**

Mental Health : FEDERAL PARITY
Chemical Dependency : FEDERAL PARITY

**Other**

Durable Medical Equipment : 20% MBR COIN-SEE LONG DES
Vision Hardware : NOT COVERED
Hearing Aids : NOT COVERED, NOT COVERED, NOT COVERED
Allergy Shots and Other Injections : $10
Travel Services : TRAV SVCS/IMMS EXCL

ADMDA/ALTBWA/ALTCRC/AMBR/CDAP/DMEMB/EMKPP/HABPX/HACVX/HAMXX/HHA1/INFLG/INFOG/INFTG/IPCAY/IPCDB/IPCXB/LXEC/LXPR0/LXSSEC/MHAP/OPMFL/OPM
ILL/OSRGEC/OVN1/OVIJG/OVPN0/OVPV0/OVSPCC/OVVXN/PLMXA/PLMXA/RXDM/SNBXD/SNCOA/SNCXA/THCA15/THCR15/THDI15/THPT15/TRSVA/UCOVM/VXX

* Includes Actives and/or pre 65 Retirees only.

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## Rate and Benefit Summary – Commercial

**Region:** Northwest

**Group Name:** WOODLAND, CITY OF

**Contract Period:** 01/01/2014 – 12/31/2014

**Group Numbers:** 4551

**Subgroups:** 001 ,002 ,003 ,004 ,005 ,012,013, 014,016

**Average Members*:** Apr12 – Mar13: 1,404

**Product Type:** Traditional-High Deductible

**Quote Name:** 4551-014 KWHD 2014 Single 1500 Deduct

### Current Rates

| Rate Tiers | Medical | Dental | Total | Ratio |
|---|---|---|---|---|
| Subscriber only | $595.31 | $0.00 | $595.31 | 1.00 |
| Subscriber and 1 dependent | 1,190.62 | 0.00 | 1,190.62 | 2.00 |
| Subscriber and 2 or more dependents | 1,785.93 | 0.00 | 1,785.93 | 3.00 |

### Proposed Rates

| Rate Tiers | Subscribers | Medical | %Change | Dental | %Change | Total | %Change | Ratio |
|---|---|---|---|---|---|---|---|---|
| Subscriber only | 8 | $417.95 | (29.79)% | $0.00 | 0.00% | $417.95 | (29.79)% | 1.00 |
| Subscriber and 1 dependent | 4 | 835.90 | (29.79)% | 0.00 | 0.00% | 835.90 | (29.79)% | 2.00 |
| Subscriber and 2 or more dependents | 10 | 1,253.85 | (29.79)% | 0.00 | 0.00% | 1,253.85 | (29.79)% | 3.00 |

**Monthly Rates Per Member When Medicare Is the Primary Payor and Member Age 65+ Is not Enrolled in Senior Advantage**

| | Rate |
|---|---|
| Neither A nor B | $851.93 |
| A and B | 366.61 |
| A Only | 686.92 |
| B Only | 851.93 |

**Estimated Monthly Cost:** $19,226

**Billing Frequency:** Monthly

### Proposed Traditional Benefits

**Annual Deductible: Individual / Family per calendar year(s):** $1,500/YEAR (HSA) / NOT APPLICABLE

**Out-of-Pocket Maximum: Individual / Family:** $5,000 (GROUP HSA) / NOT APPLICABLE

**Lifetime Maximum: Individual / Family:** NO MAXIMUM

**Prescription Drugs:** AFT DED: $15/GEN $30/BR

**Outpatient**

- Primary Care, Excluding Urgent Care: 20% COINS AFTER DEDUCT
- Urgent Care Office Visit: 20% COINS AFT DED
- Preventive Care Services: $0
- Prenatal Care: $0
- Specialty Care Office Visit: AFT DED 20%; $0 HCR PREV
- Outpatient Administered Drugs: 20% COINS AFT DED

* Includes Actives and/or pre 65 Retirees only.

KAISER PERMANENTE

KAISER FOUNDATION HEALTH PLAN, INC.

## Rate and Benefit Summary – Commercial

**Region:** Northwest

**Group Name:** WOODLAND, CITY OF

**Contract Period:** 01/01/2014 – 12/31/2014

**Group Numbers:** 4551

**Subgroups:** 015,017

| | Apr12 – Mar13 |
|---|---|
| **Average Members*:** | 0 |

**Product Type:** Traditional–High Deductible

**Quote Name:** 4551–015 KWHD 2014 Family 3000 Deduct

### Current Rates

| Rate Tiers | Medical | Dental | Total | Ratio |
|---|---|---|---|---|
| Subscriber only | $595.31 | $0.00 | $595.31 | 1.00 |
| Subscriber and 1 dependent | 1,190.62 | 0.00 | 1,190.62 | 2.00 |
| Subscriber and 2 or more dependents | 1,785.93 | 0.00 | 1,785.93 | 3.00 |

### Proposed Rates

| Rate Tiers | Subscribers | Medical | %Change | Dental | %Change | Total | %Change | Ratio |
|---|---|---|---|---|---|---|---|---|
| Subscriber only | 0 | $417.95 | (29.79)% | $0.00 | 0.00% | $417.95 | (29.79)% | 1.00 |
| Subscriber and 1 dependent | 0 | 835.90 | (29.79)% | 0.00 | 0.00% | 835.90 | (29.79)% | 2.00 |
| Subscriber and 2 or more dependents | 0 | 1,253.85 | (29.79)% | 0.00 | 0.00% | 1,253.85 | (29.79)% | 3.00 |

**Monthly Rates Per Member When Medicare Is the Primary Payor and Member Age 65+ Is not Enrolled in Senior Advantage**

| | Rate |
|---|---|
| Neither A nor B | $851.93 |
| A and B | 366.61 |
| A Only | 686.92 |
| B Only | 851.93 |

**Estimated Monthly Cost:** $0

**Billing Frequency:** Monthly

### Proposed Traditional Benefits

**Annual Deductible: Individual / Family per calendar year(s) :** NOT APPLICABLE / $3,000/YEAR (HSA)

**Out-of-Pocket Maximum: Individual / Family :** NOT APPLICABLE / $10,000 (HSA EXCL)

**Lifetime Maximum: Individual / Family :** NO MAXIMUM

**Prescription Drugs :** AFT DED:$15/GEN $30/BR

**Outpatient**

Primary Care, Excluding Urgent Care : 20% COINS AFTER DEDUCT

Urgent Care Office Visit : 20% COINS AFT DED

Preventive Care Services : $0

Prenatal Care : $0

Specialty Care Office Visit : AFT DED 20%; $0 HCR PREV

Outpatient Administered Drugs : 20% COINS AFT DED

* Includes Actives and/or pre 65 Retirees only.

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## Rate and Benefit Summary – Dental

**Region:** Northwest

**Group Name:** Woodland, City of
**Group Numbers:** 04551-008, 009
**Product Type:** Traditional
**Quote Name:** KHD EA Preventamax

**Contract Period:** 01/01/2014 – 12/31/2014
**Average Members:** 3

### Current Rates

| Rate Tiers | Dental | Ratio |
|---|---|---|
| Subscriber only | $43.58 | 1.00 |
| Subscriber and 1 dependent | 87.16 | 2.00 |
| Subscriber and 2 or more dependents | 130.74 | 3.00 |

### Proposed Rates

| Rate Tiers | Subscribers | Dental | %Change | Ratio |
|---|---|---|---|---|
| Subscriber only | 2 | $43.58 | 0.0% | 1.00 |
| Subscriber and 1 dependent | 0 | 87.16 | 0.0% | 2.00 |
| Subscriber and 2 or more dependents | 0 | 130.74 | 0.0% | 3.00 |

**Estimated Monthly Cost:** $87

### Proposed Traditional Benefits

**Dental Plan:** EA

Preventive and diagnostic: 100%
Restorative: 80%
Extractions: 80%
Oral surgery: 80%
Periodontics: 80%
Endodontics: 80%
Prosthetics: 50% coverage for prosthetics (crown / bridge)
Removable prosthetics: 50% coverage for removable prosthetics
Implants: Not Covered
Benefit Max: $1,500 benefit maximum (Preventive services do not apply)

**Orthodontics Plan:** E

Eligibility: Orthodontic benefits are for adults and children
Coverage: Member pays 50% of charges up to $1,500 maximum Plan payment

**Deductible Benefit:** X

Annual deductible: No Deductible

**Office Visit Benefit:** 10

Office visit copay: $10.00

## Rate and Benefit Summary – Dental

Region: Northwest

Group Name: Woodland, City of
Group Numbers: 04551-010, 011
Product Type: PPO
Quote Name: PPO Plan FC

Contract Period: 01/01/2014 – 12/31/2014
Average Members: 4

### Current Rates

| Rate Tiers | Dental | Ratio |
|---|---|---|
| Subscriber only | $47.45 | 1.00 |
| Subscriber and 1 dependent | 94.90 | 2.00 |
| Subscriber and 2 or more dependents | 142.35 | 3.00 |

### Proposed Rates

| Rate Tiers | Subscribers | Dental | %Change | Ratio |
|---|---|---|---|---|
| Subscriber only | 0 | $47.45 | 0.0% | 1.00 |
| Subscriber and 1 dependent | 0 | 94.90 | 0.0% | 2.00 |
| Subscriber and 2 or more dependents | 1 | 142.35 | 0.0% | 3.00 |

**Estimated Monthly Cost: $142**

### Proposed PPO Benefits

**Dental Plan: FC**

Preventive and diagnostic: 100%
Restorative: 80%
Extractions: 80%
Oral surgery: 80%
Periodontics: 80%
Endodontics: 80%
Prosthetics: 50% coverage for prosthetics (crown / bridge)
Removable prosthetics: 50% coverage for removable prosthetics
Implants: Not Covered
Benefit Max: $1,500 benefit maximum (Preventive services do not apply)

**Out of Network Benefits: MAC**

Preventive and diagnostic: 100%
Restorative: 80%
Extractions: 80%
Oral surgery: 80%
Periodontics: 80%
Endodontics: 80%
Prosthetics: 50% coverage for prosthetics (crown / bridge)
Removable prosthetics: 50% coverage for removable prosthetics
Benefit Max: $1,500 benefit maximum. (Preventive services do not apply)

**Orthodontics Plan: E**

Eligibility: Orthodontic benefits are for adults and children
Coverage: Member pays 50% of charges up to $1,500 maximum Plan payment

**Deductible Benefit: X**

Annual deductible: No Deductible

**Office Visit Benefit: 00**

Office visit copay: $0.00