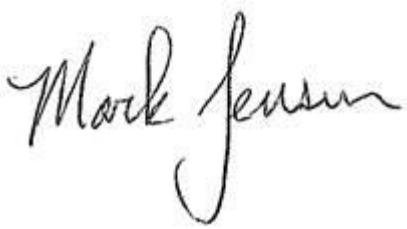
PROVIDENCE
Health Plan

2022
Oregon Individual Contract

Progressive Dental



Mark Jensen, Chief Service Operations Office
Providence Health Plan
P.O. Box 4327
Portland, OR 97208-4327

PROVIDENCE HEALTH PLAN QUICK REFERENCE GUIDE

Please see our Quick Reference Guide for customer service information.

Customer Service Quick Reference Guide:

General assistance with your Plan	503-574-7500 (local / Portland area) 800-878-4445 (toll-free) 711 (TTY) ProvidenceHealthPlan.com
Predetermination requests	800-638-0449 (toll-free) 503-574-6464 (fax)
Provider Directory	ProvidenceHealthPlan.com/findaprovider

Monthly Premium Payment Options

Pay online	Providence.org/PremiumPay
Pay by phone	888-821-2097 (toll-free)
Pay by mail	Providence Health Plan P.O. Box 5728 Portland, OR 97228-5728

TABLE OF CONTENTS

1. INTRODUCTION

Thank you for choosing Providence Health Plan. We look forward to meeting your dental needs. The following is a brief outline of several key aspects of your Providence Progressive Dental Plan.

- Some capitalized terms have special meanings. Please see section 11, Definitions.
- In this Contract, Providence Health Plan is referred to as "we," "us" or "our." Members enrolled under this Providence Progressive Dental Plan are referred to as "you" or "your."
- If after examining this Contract you are not satisfied with it for any reason, you may cancel this policy within 10 days of receipt. Your decision to cancel this policy must be provided to us in writing within the 10-day period, and we will provide a full refund of your premium and consider the policy void and never effective.
- Coverage under this Providence Progressive Dental Plan is provided through:
    - Our In-Network Dentists located in our Service Area.
- Covered Services must be obtained from In-Network Dentists, with the following exceptions:
    - Covered Services delivered by an Out-of-Network Dentist when those Services have been approved in advance through the Prior Authorization procedures specified in section 3.2.
- More extensive care (fillings, dentures, crowns, root canals, periodontal care, oral surgery, etc.) is covered at increasing levels the more years you are covered under this Plan, progressing through years one, two and three. After year three, the coverage level will remain the same.
- A printable directory of In-Network Dentists in our Service Area is available at ProvidenceHealthPlan.com/findaprovider. Members without Internet access or who would like a hard copy of our Provider Directory, may contact Customer Service for assistance.
- **Covered Class II and Class III Services (except restorative fillings) require an approved Predetermination, as specified in section 3.3.**
- Coverage limitations and exclusions apply to certain Services, as stated in sections 3, 4 and the Benefit Summary.
- All Covered Services are subject to the provisions, limitations and exclusions that are specified in this Providence Progressive Dental Plan. You should read the provisions, limitations and exclusions before seeking Covered Services because not all dental services are covered by this Plan.
- The Dental Contract for this Providence Progressive Dental Plan consists of this Dental Contract plus the Dental Benefit Summary, any Endorsements and amendments that accompany these documents, and those policies maintained by Providence Health Plan which clarify any of these documents. In the event of any conflict between these documents, they are to be interpreted in the following order of priority: (1) Endorsements and amendments, (2) Dental Contract, (3) Dental Benefit Summary and (4) applicable Providence Health Plan policies.

2. WELCOME TO THE PROVIDENCE PROGRESSIVE DENTAL PLAN

The Providence Progressive Dental Plan is offered by Providence Health Plan to Members who are covered under one of our Individual & Family Plan Contracts.

2.1 YOUR PROVIDENCE PROGRESSIVE DENTAL PLAN

Your Providence Progressive Dental Plan allows you to receive Covered Services from In-Network Dentists in our Service Area.

It is your responsibility to verify whether or not a dentist is an In-Network Dentist and whether or not the dental care is a Covered Service even if you have been directed or referred for care by an In-Network Dentist.

If you are unsure about a dentist's participation with Providence Health Plan, visit the Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider, before you make an appointment. You can also call Customer Service to get information about a dentist's participation with Providence Health Plan and your benefits.

Whenever you visit a Dentist:

- Bring your Providence Health Plan Member ID Card with you.
- Be prepared to make a Copayment at the time of visit if the office visit is subject to a Copayment.
- If your dental Covered Services are subject to a Coinsurance (a percentage of the amount billed for Services), your dentists may ask you to pay an estimate of what you may owe at the time you receive services, and bill or credit you for the balance later. Some dentists may send you a bill for what you owe. Be sure to check with your dentist's office regarding payment policies prior to receiving services.

2.2 DENTAL CONTRACT

The Dental Contract contains important information about the dental plan coverage we offer. It is important to read this Dental Contract carefully as it explains your Providence Health Plan benefits and Member responsibilities. If you do not understand a term that is used, you may find it in Definitions, section 11. If you need additional help understanding anything in this Dental Contract, please call Customer Service at 503-574-7500 or 800-878-4445. *See section 2.3 for additional information on how to reach Customer Service.*

This Dental Contract is not complete without your:

- **Progressive Dental Benefit Summary** and any other Benefit Summary documents. These documents are available at ProvidenceHealthPlan.com when you register for a myProvidence account as explained in section 2.4. Benefit Summaries detail your Copayments and Coinsurance for Covered Services and also provide important information about your Benefits.
- **Provider Directory** which lists In-Network Dentists, available online at ProvidenceHealthPlan.com/findaprovider. If you do not have Internet access, please call Customer Service to obtain a hard copy of the directory.

If you need more detailed information for a specific problem or situation, contact Customer Service.

2.3 CUSTOMER SERVICE

We want you to understand how to use your Providence Health Plan benefits and to be satisfied with your dental plan coverage. Customer Service is available to assist you in understanding your benefits and resolving any problems you may have, including:

- Specific benefit or claim questions.
- Address and name changes.
- Questions or concerns about adding or dropping a Dependent.
- Enrollment issues.
- Questions or concerns about your dental care or Service.

Contacting Providence Customer Service

Customer Service representatives are available by phone from 8 a.m. to 5 p.m., Monday through Friday, (excluding holidays). **Please have your Member ID Card available when you call**:

- **Members in the Portland-metro area, please call 503-574-7500.**
- **Members in all other areas, please call toll-free 800-878-4445.**
- **Members with hearing impairment, please call the TTY line 711.**

You may **access claims and benefit information 24 hours a day, seven days a week** online through your myProvidence account.

2.4 REGISTERING FOR A MYPROVIDENCE ACCOUNT

Members can create a myProvidence account online. A myProvidence account enables you to view your personal health plan information (including your Dental Contract and Benefit Summary), view claims history and benefit payment information, order a replacement Member ID Card, and access other health and wellness tools and services.

2.5 YOUR MEMBER ID CARD

Each Member of Providence Health Plan receives a Member ID Card. Your Member ID Card lists information about your health plan coverage, including:

- Your Member number
- Important phone numbers

The Member ID Card is issued by Providence Health Plan for Member identification purposes only. It does not confer any right to Services or other benefits under this Dental Contract.

When scheduling an appointment or receiving health services, identify yourself as a Providence Health Plan Member, present your Member ID Card and pay your Copayment or Coinsurance.

If you are unable to provide your card at your appointment your dentist can contact us for your member information.

Please keep your Member ID Card with you and use it when you:

- Visit your In-Network Dentist or facility.
- Register online for your myProvidence account.
- Call or correspond with Customer Service.

2.6 PRIVACY OF MEMBER INFORMATION

At Providence Health Plan, we respect the privacy and confidentiality of your protected health information (PHI). We are required by law to maintain the privacy of your protected health information, (commonly called PHI or your personal information) including in electronic format. When we use the term "personal information" we mean information that identifies you as an individual such as your name and Social Security Number, as well as financial, health and other information about you that is nonpublic, and that we obtain so we can provide you with insurance coverage. Providence Health Plan maintains policies that protect the confidentiality of personal information, including Social Security numbers, obtained from its Members in the course of its regular business functions.

Members may request to see or obtain their dental records. Call your dentist's office to ask how to receive a copy.

For more information about uses and disclosures of Member information, including uses and disclosures required by law, please refer to our Notice of Privacy Practices. A copy is available at https://healthplans.providence.org/members/rights-notices or by calling Customer Service.

Appointment of Authorized Representative

You are entitled to appoint an individual to act as your Authorized Representative to pursue any claim you have for benefits. To ensure privacy and to address other issues, Providence's policy on Appointment of Authorized Member Representatives, and the form for doing so, may be accessed through our website at https://healthplans.providence.org/members/understanding-plans-benefits/benefit-basics/forms/. The policy does not apply to an attorney at law retained by you directly to represent your interests with respect to your benefits, but does apply to attorneys who represent a dentist whose services are a part of the claim in issue.

3. HOW TO USE YOUR PLAN

This section describes how to use this Plan and how benefits are applied. It is important to remember that your benefits are determined according to the plan option that you have elected and the kinds of Services and dentists that you have selected for your care. The level of benefits for Covered Services is shown in the Benefit Summary and described in section 4 of this Dental Contract.

3.1 IN-NETWORK DENTISTS

Providence Health Plan has contractual arrangements with certain dentists and facilities located in our Service Area. Our agreements with these "In-Network Dentists" enable you to receive quality dental care for a reasonable cost.

For Services to be covered, you must receive Services from In-Network Dentists. It is your responsibility to verify whether or not a dentist is an In-Network Dentist even if you have been directed or referred for care by an In-Network Dentist.

3.1.1 Choosing an In-Network Dentist

To choose an In-Network Dentist, or to verify if a dentist is an In-Network Dentist, please refer to the Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider. If you do not have access to our website, please call Customer Service to request In-Network Dentist Information.

Advantages of Using an In-Network Dentist

- Your In-Network Dentist will work with Providence Health Plan to arrange for any Predetermination requirements that may be necessary for certain Covered Services. For more information on Predetermination, see section 3.3.
- In most cases when you use an In-Network Dentist, higher benefit levels will apply and your out-of-pocket expenses will be reduced.
- You will have a wide variety of high quality In-Network Dentists to help you with your dental needs.

So remember, it is to your advantage to meet your dental needs by using an In-Network Dentist.

3.1.2 Established Patients with Dentists

If you and your family already see a dentist, you may want to check the provider directory to see if your dentist is an In-Network Dentist with Providence Health Plan. If your dentist is participating with us, let his or her office know you are now a Providence Health Plan Member.

3.1.3 Selecting a New In-Network Dentist

We recommend that you choose an In-Network Dentist from our Provider Directory, available online, for each covered Family Member. Call the dentist's office to make sure he or she is accepting new patients. It is a good idea to have your previous dentist transfer your dental records to your new In-Network Dentist as soon as possible. The first time you make an appointment with your In-Network Dentist, let him or her know you are now a Providence Health Plan Member. On your first visit, make a list of questions or information you would like to discuss with your new In-Network Dentist, including the following:

- What are the office hours?

- How can I get dental advice after hours?
- What do I do in a dental emergency?

3.1.4 Changing Your In-Network Dentist

You are encouraged to establish an ongoing relationship with your In-Network Dentist. If you decide to change your In-Network Dentist, please remember to have your dental records transferred to your new In-Network Dentist.

3.2 SERVICES PROVIDED BY OUT-OF-NETWORK DENTISTS

Providence Health Plan may approve and provide reimbursement for Out-of-Network Qualified Practitioners and Facilities. Benefits for Covered Services by an Out-of-Network Dentist will be provided, as shown in the Benefit Summary when we determine **in advance**, in writing, that the Out-of-Network Dentist possesses unique skills which are required to adequately care for you and are not available from In-Network Dentists.

Under no circumstances will we cover Services received from an Out-of-Network Dentist *unless* we have approved the Out-of-Network Dentist and the Services received.

IMPORTANT NOTE: Your Plan only pays for Covered Services received from approved, Prior Authorized Out-of-Network Dentists at the Usual, Customary, and Reasonable (UCR) charges (see Section 11, Definitions). If an Out-of-Network Dentist charges more than the UCR charges allowed under your Plan, that dentist may bill you directly for the additional amount that is not covered by your Plan. That amount is in addition to any Deductible, Copayment or Coinsurance for which you may be responsible.

If you choose to receive Covered Services from an approved, Prior Authorized Out-of-Network Dentist, those Services are still subject to the terms of this Dental Contract. Providence Health Plan will only pay for Dentally Necessary Covered Services. The treatments, supplies, and medications excluded by this Contract are not covered.

Payment for Out-of-Network Dentists (UCR)

If we have approved an Out-of-Network Dentist, and if the Services provided are Dentally Necessary Covered Services, we will provide payment to Out-of-Network Dentists according to the Usual, Customary and Reasonable (UCR) charges. UCR charges do not include sales taxes, handling fees and similar surcharges; such taxes, fees and surcharges are not covered expenses. Charges which exceed UCR are the Member's responsibility. See section 11 for the definition of UCR.

You will be responsible for costs that are not covered or allowed by your Out-of-Network benefits, as shown in the following example (amounts shown are only estimates of what may apply).

	Dentist's Status	
Item	In-Network	Out-of-Network
Dentist's standard charges	$100	$100
Allowable charges under this Plan	$80 (contracted)	$80 (if that is UCR)
Plan benefits (for this example only)	$64 (if 80% benefit)	$56 (if 70% benefit)
Balance you owe	$16	$24
Additional amount dentist may bill to you	$-0-	$20 ($100 minus $80)
Total amount you would pay	$16	$44 ($24 plus $20)

Thus, you may incur significantly larger out-of-pocket costs, perhaps a multiple of what would have applied, if you use Out-of-Network Dentists.

3.3 PREDETERMINATION OF BENEFITS

If the charge is for Class II or Class III services, except restorative fillings, the Plan requires the Dentist to submit a treatment plan prior to initiating services. The Plan may request x-rays, periodontal charting or other dental records to evaluate the Predetermination request. The proposed services will be reviewed, and a Predetermination will be issued to the Member or Dentist. The Predetermination is not a guarantee of coverage and does not supersede other specific provisions of this Plan regarding coverage, limitations, exclusions and Dental Necessity. Predetermination is considered valid for 180 days.

If a Dental Emergency exists which prevents you from obtaining Predetermination, we must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, to continue coverage of these Services.

Services received from In-Network Dentists:
When Services are received from an In-Network Dentist, the In-Network Dentist is responsible for obtaining Predetermination.

Services received from Out-of-Network Dentists:
When Services are received from an Out-of-Network Dentist, the Member is responsible for obtaining Predetermination. You or your Out-of-Network Dentist must contact us to obtain Predetermination. See section 3.2 for additional information about Out-of-Network Dentists.

Dental Emergency
Dental Emergency means the sudden and unexpected onset of a condition, or exacerbation of an existing condition, requiring Dentally Necessary care to control pain, swelling or bleeding in or around the teeth and gums. Such emergency care must be provided within 48 hours following the onset of the Dental Emergency and includes treatment for acute infection, pain, swelling, bleeding, or injury to natural teeth and oral structures. The emergency dental care does not include follow-up care such as, but not limited to, crowns, root canal therapy or prosthetics.

Providence Health Plan will provide a Predetermination form upon oral or written request. If you need information on how to obtain Predetermination, please call Customer Service at the number listed on your Member ID Card.

Predetermination Requests:
The Member or the Dentist must call us at 1-800-638-0449 to obtain Predetermination. Please have the following information ready when calling to request a Predetermination:

- The Member's name and date of birth.
- The Member's Providence Health Plan Member number (as listed on your Member ID card).
- The Dentist's name, address and telephone number.
- The scheduled date of admission or date Services are to begin.
- The Service(s) to be performed.

3.4 DENTAL COST MANAGEMENT

Coverage under this Plan is subject to the dental cost management protocols established by us to ensure the quality and cost effectiveness of Covered Services. Such protocols may include Predetermination and concurrent review.

We reserve the right to deny payment for Services that are not Dentally Necessary in accordance with the criteria maintained by us.

Alternative Service:
If the Plan determines that a less expensive alternate procedure, service or course of treatment can be performed in place of the proposed treatment to correct a dental condition; and the alternate treatment will produce a professionally satisfactory result; then the maximum the Plan will allow will be the charge for the less expensive treatment.

3.4.1 Coverage of New Technology and New Application of Existing Technology

New technologies and new applications of existing technologies are evaluated and approved for coverage when they provide a demonstrable benefit for a particular illness or disease, are scientifically proven to be safe and most effective, and there is no equally effective or less costly alternative.

Emerging and innovative technologies are monitored by Providence Health Plan through review of trend reports from technology assessment bodies, government publications, dental journals, and information provided by dentists and professional societies.

A systematic process for evaluating a new technology or new application of an existing technology is proactively initiated when sufficient scientific information is available.

3.5 DENTALLY NECESSARY SERVICES

We believe you are entitled to comprehensive dental care within the standards of good dental practice. Our dental directors determine which Services are Dentally Necessary, as defined in section 11. Services that do not meet Dentally Necessary criteria will not be covered.

Although a dental treatment was prescribed or performed by a Dentist, it does not necessarily mean that it is Dentally Necessary under our guidelines. Obtaining confirmation of coverage from Providence Health Plan beforehand is always recommended.

3.5.1 Teledental Services

Teledental services are covered at the applicable benefit level for the Covered Service, as shown in the Benefit Summary, had the service been received in person provided that the service:

- Is Medically Necessary;
- Is provided by a Qualified Dentist;
- Is determined to be safely and effectively provided using two-way interactive video conferencing or audio telephone technology, between a dentist and a patient for the purpose of diagnosis or consultation, according to generally accepted health care practices and standards; and
- The application and technology used to provide the teledental service meet all standards required by state and federal laws governing the privacy and security of protected health information.

3.6 HOW BENEFITS ARE APPLIED

Benefits are subject to the following provisions, if applicable, as specified in the Benefit Summary:

- The Deductible;
- The Copayment or Coinsurance amount; and
- The benefit limits and/or maximums.

3.7 DEDUCTIBLE AND MAXIMUM BENEFIT

Your Dental Plan has a Deductible and a Maximum Benefit, as stated in your Benefit Summary.

3.7.1 Understanding the Deductible

Your Deductible is the dollar amount shown in the Benefit Summary that you are responsible to pay every Calendar Year when receiving most Covered Services before benefits are provided by the Plan for that Member. Deductible amounts are payable to your Dentist after we have processed your claim.

Certain Covered Services, such as most preventive care, are covered without a Deductible. Please see your Benefit Summary for information about these Services.

Your Costs that Do Not Apply to Deductibles: The following out-of-pocket costs do not apply towards Your Individual and Family Deductibles:

- Services not covered by this Plan;
- Services in excess of any benefit limit and/or maximum;
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges;
- Any penalties you must pay if you do not follow Providence Health Plan's Predetermination requirements; and
- Copayments or Coinsurance specified as not applicable toward the Deductible in any Benefit Summary issued with this Plan.

3.7.2 Understanding the Maximum Benefit

The Maximum Benefit is the total amount this Plan will pay per Member in any Calendar Year for Covered Services received by that Member. See your Benefit Summary.

Your Costs that Do Not Apply to the Common Maximum Benefit: The following out-of-pocket costs do not apply toward your Common Maximum Benefit:

- Class I Diagnostic and Preventive Services;
- Services not covered by this Plan;
- Services not covered because Predetermination was not obtained, as required in section 3.3;
- Services in excess of any benefit limit;
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges; and
- Deductibles, Copayments or Coinsurance amounts paid by Members for Covered Services.

4. COVERED SERVICES

This section describes Services that, when Dentally Necessary and not otherwise excluded or limited, are covered under this Plan.

Benefits and Plan provisions such as Deductibles, Copayments, Coinsurances and Maximum Benefit are listed in your Benefit Summary. You can view your Member materials by registering for a myProvidence account on our website at ProvidenceHealthPlan.com (see section 2.4). If Providence Health Plan is required by law to modify your benefits, you will be notified in writing of the changes.

Dental Benefits are provided for preventive care and for the treatment of dental conditions when such treatment is Dentally Necessary and provided by a Dentist, as described in this section and shown in the Benefit Summary.

4.1 CLASS I PREVENTIVE SERVICES

This Plan provides coverage for the preventive services listed below.

When those services are received from In-Network Dentists, coverage is provided in full. If you have coverage in full for these services under another Providence Health Plan medical or dental plan, this Plan will not duplicate that coverage.

If you receive these services from Out-of-Network Dentists, coverage is provided, as shown in your benefit Summary:

- Two evaluations in total per Calendar Year including a maximum of one comprehensive evaluation per 36 months and one limited oral evaluation per 12 months.
- Two prophylaxes (cleaning, scaling and polishing teeth) per Calendar Year.
- Bitewing x-rays, two per Calendar Year.
- One topical fluoride per Calendar year, age 16 and under.
- One sealant per tooth per lifetime, age 16 and under (limited to permanent first and second molars).
- One interim caries arresting medicament application per primary tooth is covered per lifetime.
- Space maintainers to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment).
- Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service).
- Teledentistry, synchronous (D9995) or asynchronous (D9996), must be accompanied by a covered procedure.

4.2 CLASS II BASIC SERVICES

Basic Services for all Members are listed below and covered, as shown in the Benefit Summary:

- Simple extraction of teeth.
- Amalgam and composite fillings excluding posterior composites (anterior restorations of mesiolingual, distolingual, mesiobuccal and distobuccal surfaces are considered single surface restorations), per tooth, per surface every 24 months.
- Pin retention of fillings (multiple pins on the same tooth are allowable as one pin).

- Antibiotic injections administered by a Dentist.
- Periapical x-rays.
- One full mouth or panoramic x-ray per 60 months.

4.3 CLASS III MAJOR RESTORATIVE SERVICES

Major Restorative Services for all Members are listed below and covered, as shown in the Benefit Summary:

- One study model per 36 months.
- Crown build-up for non-vital teeth.
- Recementing bridges, inlays, onlays and crowns after 12 months of insertion and per 12 months per tooth thereafter.
- One repair of dentures or fixed bridgework per 24 months.
- General anesthesia and analgesia, including intravenous sedation, in conjunction with covered oral surgery or periodontal surgery.
- Restoration services, limited to:
    - Cast metal, stainless steel, porcelain/ceramic, all ceramic and resin-based composite inlay, onlay or crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling.
        - This Plan provides coverage for the least costly Dentally Necessary crown. If a Member chooses a more costly crown, the Member will be responsible for the difference in cost.
    - Replacement of existing inlay, onlay, or crown, after seven years of the restoration initially placed or last replaced.
    - Post and core in addition to the crown when separate from the crown for endodontically treated teeth with a good prognosis endodontically and periodontally.
- Prosthetic services, limited to:
    - Initial placement of removable dentures or fixed bridges.
    - Replacement of removable dentures or fixed bridges that cannot be repaired after seven years from the date of last placement.
    - Addition of teeth to existing partial denture.
    - One relining or rebasing of existing removable dentures per 24 months (only after 24 months from date of last placement, unless an immediate prosthesis replacing at least three teeth).
- Oral surgery, including postoperative care for:
    - Removal of teeth, including impacted teeth.
    - Extraction of tooth root.
    - Coronectomy, intentional partial tooth removal, one per lifetime.
    - Alveolectomy, alveoplasty, and frenectomy.
    - Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy.
    - Tooth reimplantation and/or stabilization: tooth transplantation.
    - Excision of a tumor or cyst and incision and drainage of an abscess or cyst.
- Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
    - Root canal therapy (not covered if pulp chamber was opened before effective date of coverage).
    - Pulpotomy.
    - Apicoectomy.
    - Retrograde fillings, per root per lifetime.

- Periodontic services, limited to:
    - Two periodontal maintenance visits, following surgery per Calendar Year.
    - One scaling and root planing per quadrant (D4341 or D4342) per 24 months from age 21.
    - Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1110/D1120, limited to once per two years.
    - Occlusal adjustment performed with covered surgery.
    - Gingivectomy.
    - Osseous surgery including flap entry and closure.
    - One pedicle or free soft tissue graft per site per lifetime.
    - One appliance (night guards) per five years within six months of osseous surgery.
    - One full mouth debridement per lifetime.

4.4 EXCLUDED SERVICES

- Services which are covered under worker's compensation or employer's liability laws.
- Services which are not necessary for the Member's dental health.
- All Class IV Orthodontia services.
- Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
- Oral surgery requiring the setting of fractures and dislocations.
- Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
- Dispensing of drugs.
- Hospitalization for any dental procedure.
- Implant removal or the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
- Diagnosis or treatment of Temporomandibular Disorder (TMD) and/or occlusal disharmony.
- Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth.
- Implants and related services.
- Replacement of lost, stolen or damaged prosthetic or orthodontic appliances.
- Athletic mouthguards; precision or semi-precision attachments; denture duplication;
- Periodontal splinting of teeth.
- Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
- Procedures that in the opinion of the Plan are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
- Treatment of cleft palate, malignancies or neoplasms.
- Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 36 months of Member's continuous coverage under the plan.

4.5 GENERAL EXCLUSIONS

General Exclusions:

We do not cover Services and supplies which:

- Are not provided;
- Are provided without charge or for which you would not be required to pay if you did not have this coverage;
- Are received before the Effective Date of Coverage;
- Are not listed as a Covered Service or relate to complications resulting from a Non-Covered Service;
- Are not furnished by a Qualified Dentist;
- Are provided by or payable under any plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law;
- Are provided while you are confined in a Hospital or institution owned or operated by the United States Government or any of its agencies, except to the extent provided by 38 U. S. C. § 1729 as it relates to non-military Services provided at a Veterans Administration Hospital or facility;
- Are provided while you are in the custody of any law enforcement authorities or while incarcerated;
- Are provided for convenience, educational or vocational purposes including, but not limited to, videos and books, educational programs to which drivers are referred by the judicial system, and volunteer mutual support groups;
- Are performed in association with a Service that is not covered under this Plan;
- Are provided for any injury or illness that is sustained by any Member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the Member. This exclusion also applies to injuries and illnesses that are the subject of a disputed claim settlement or claim disposition agreement under a Workers' Compensation Act or similar law. This exclusion does not apply to Members who are exempt under any Workers' Compensation Act or similar law;
- Are payable under any automobile medical, personal injury protection, automobile no-fault, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance makes benefits or Services available to you, whether or not you make application for such benefits or Services and whether or not you are refused payment for failure to satisfy any term of such coverage. If such coverage is required by law and you unlawfully fail to obtain it, benefits will be deemed to have been payable to the extent of that requirement. This exclusion also applies to charges applied to the deductible of such contract or insurance. Any benefits or Services provided under this Plan that are subject to this exclusion are provided solely to assist you and such assistance does not waive our right to reimbursement or subrogation as specified in section 5.3. This exclusion also applies to Services and supplies after you have received proceeds from a settlement as specified in section 5.3;
- Are provided for treatment or testing required by a third party or court of law which is not Dentally Necessary;
- Are Experimental/Investigational;
- Are determined by us not to be Dentally Necessary for diagnosis and treatment of a dental condition;
- Have not been Predetermined as required by this Plan;

- Relate to any condition sustained by a Member as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Member, if such Member is convicted of a crime on account of such illegal engagement or act. For purposes of this exclusion, "illegal" means any engagement or act that would constitute a felony or misdemeanor punishable by up to a year's imprisonment under applicable law if such Member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or a medical condition (i.e., a physical or mental health condition).

We do not cover:

- Charges that are in excess of the Usual, Customary and Reasonable (UCR) charges;
- "Get acquainted" visits without physical assessment or diagnostic or therapeutic intervention provided and online treatment sessions;
- Missed appointments;
- Transportation or travel time, food, lodging accommodations and communication expenses;
- Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
- Any vitamins, dietary supplements, and other non-prescription supplements, except as required by federal or Oregon state law;
- Sales taxes, handling fees and similar surcharges, as explained in the definition of UCR.

5. CLAIMS ADMINISTRATION

This section explains how we treat various matters having to do with administering your benefits and/or claims, including situations that may arise in which your health care expenses are the responsibility of a source other than us.

5.1 CLAIMS PAYMENT

Our payments for most Services are made directly to the dentists of Services. Except as otherwise specifically provided in this Plan, if you are billed directly and pay for benefits which are covered by this Plan, reimbursement from us will be made only upon your written notice to us of the payment. Payment will be made to the Subscriber, subject to written notice of claim, or, if deceased, to the Subscriber's estate, unless payment to other parties is authorized in writing by you.

Explanation of Benefits (EOB)

You will receive an EOB from Providence Health Plan after we have processed your claim. An EOB is not a bill. An EOB explains how Providence Health Plan processed your claim, and will assist you in paying the appropriate Member responsibility to your dentist. Copayment or Coinsurance amounts, Deductible amounts, services or amounts not covered and general information about our processing of your claim are explained on an EOB.

Time Frames for Processing Claims

If Providence Health Plan denies your claim, we will send an EOB to you with an explanation of the denial within 30 days after we receive your claim. If we need additional time to process your claim for reasons beyond our control, we will send a notice of delay to you explaining those reasons within 30 days after we receive your claim. We will then complete our processing and send an EOB to you within 45 days after we receive your claim. If we need additional information from you to complete our processing of your claim, we will send you a separate request for information and you will have 45 days to submit the additional information. Once we receive the additional information from you we will complete our processing of the claim within 30 days.

Claims Involving Predetermination (Pre-Service Claims)

- For Predetermination of services that do not involve urgent dental conditions: Providence Health Plan will notify your dentist or you of its decision within two business days after the Predetermination request is received. If additional information is needed to process the request, Providence Health Plan will provide written notice to the Member and the dentist within two business days of receiving the Prior Authorization request. The Member and the dentist will have 15 days to submit the additional information. Within two business days of receipt of the additional information, Providence Health Plan will complete its review and provide written notice of its decision to the Member and the dentist. If the additional information is not received within 15 days, the request will be denied.
- For Predetermination of services that involve urgent dental conditions: Providence Health Plan will notify your dentist or you of its decision within 72 hours after the Predetermination request is received. If Providence Health Plan needs additional information to complete its review, it will notify the requesting dentist or you within 24 hours after the request is received. The requesting dentist or you will then have 48 hours to submit the additional information. Providence Health Plan will complete its review and notify the requesting dentist or you of its decision by the earlier of (a)

48 hours after the additional information is received or, (b) if no additional information is provided, 48 hours after the additional information was due.

Claims Involving Concurrent Care Decisions

If an ongoing course of treatment for you has been approved by Providence Health Plan and it then determines through its dental cost management procedures to reduce or terminate that course of treatment, you will be provided with advance notice of that decision. You may request a reconsideration of that decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. Providence Health Plan will then notify you of its reconsideration decision within 24 hours after your request is received.

5.1.1 Timely Submission of Claims

We will make no payments for claims received more than 365 days after the date of Service. Exceptions will be made if we receive documentation that you lacked legal capacity during that period. Payment of claims submitted by the Oregon state Medicaid agency or a prepaid managed care health services organization described in ORS 414.651 (i.e., a Coordinated Care Organization) will be made in accordance with ORS 743B.470, which establishes payment requirements for claims submitted by the Oregon state Medicaid agency.

Payment of all claims will be made within the time limits required by OAR 836-080-0235, the Oregon Division of Financial Regulation's administrative rule setting standards for prompt payment.

Dental Benefit claims should be submitted to:

Dental Processing Center, Inc.
P.O. Box 211424
Eagan, MN 55121

5.1.2 Right of Recovery

We have the right, upon demand, to recover from a recipient the value of any benefit or claim payment that exceeded the benefits available under this Plan. Our right of recovery applies to any excess benefit, including, but not limited to, benefits obtained through fraud, error, or duplicate coverage relating to any Member. If timely repayment is not made, we have the right, in addition to any other lawful means of recovery, to deduct the value of the excess benefit from any future benefit that otherwise would have been available to the affected Member(s) from us under any contract.

5.2 COORDINATION OF BENEFITS

This Coordination of Benefits (COB) section applies when a Member has health care coverage under more than one Plan. The term "Plan" is defined below for the purposes of this COB section. The order of benefit determination rules governs the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

5.2.1 Definitions Relating to Coordination of Benefits

Plan

Plan means any of the following that provides benefits or Services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: group and individual health insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law; and group and individual insurance contracts and Subscriber contracts that pay or reimburse for the cost of dental care.
2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare Supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage listed under (1) or (2) above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan

This Plan means, as used in this COB section, the part of this contract providing health care benefits to which this COB section applies and which may be reduced because of the benefits of other plans. Any other part of this contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules listed in section 5.2.2 determine whether This Plan is a Primary plan or Secondary plan when a Member has health care coverage under more than one Plan.

When This Plan is primary, we determine payment for our benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, we determine our benefits after those of another Plan and may reduce the benefits we pay so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense

Allowable expense means a health care expense, including Deductibles, Coinsurance and Copayments that is covered at least in part by any Plan covering a Member. When a Plan provides benefits in the form of Services, the reasonable cash value of each Service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering a Member is not an Allowable expense. In addition, any expense that a dentist by law or in accordance with a contractual agreement is prohibited from charging a Member is not an Allowable expense.

The following are examples of expenses that are NOT Allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
2. If the Member is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If the Member is covered by two or more Plans that provide benefits or Services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If the Member is covered by one Plan that calculates its benefits or Services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or Services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the dentist has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the dentist's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
5. The amount of any benefit reduction by the Primary plan because the Member has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred dentist arrangements.

Closed panel plan

A Closed panel plan is a Plan that provides health care benefits to Members primarily in the form of Services through a panel of dentists that has contracted with or is employed by the Plan, and that excludes coverage for services provided by other dentists, except in cases of emergency or referral by a panel member.

Custodial parent

A Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the Dependent child resides more than one half of the Calendar Year excluding any temporary visitation.

5.2.2 Order of Benefit Determination Rules

When a Member is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Plan.
    1. Except as provided in Paragraph (2) below, a Plan that does not contain a COB provision that is consistent with the State of Oregon's COB regulations is always primary unless the provisions of both Plans state that the complying Plan is primary.
    2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and

surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network benefits.

B. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

C. Each Plan determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The Plan that covers a Member other than as a Dependent, for example, as an employee, Subscriber or retiree is the Primary plan and the Plan that covers the Member as a Dependent is the Secondary plan. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the Member as a Dependent; and primary to the Plan covering the Member as other than a Dependent (e.g., a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Member as an employee, Subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Member is a Dependent child covered by more than one Plan the order of benefits is determined as follows:
    a) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
        i. The Plan of the parent whose birthday falls earlier in the Calendar Year is the Primary plan; or
        ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
    b) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
        i. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
        ii. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
        iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
        iv. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the Dependent child are as follows:
            - The Plan covering the Custodial parent, first;
            - The Plan covering the Spouse of the Custodial parent, second;
            - The Plan covering the non-custodial parent, third; and then

- The Plan covering the Dependent Spouse of the non-custodial parent, last.

c) For a Dependent child covered under more than one Plan of individuals who are not the parents of the Dependent child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the Dependent child.

d) For a Dependent child:

i. Who has coverage under either or both parents' plans and also has coverage as a Dependent under a spouse's plan, the rule in paragraph (5) applies.

ii. In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Subparagraph (a) to the Dependent child's parent(s) and the Dependent's spouse.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a Member as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same Member as a retired or laid-off employee is the Secondary plan. The same would hold true if a Member is a Dependent of an active employee and that same Member is a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
4. COBRA or State Continuation Coverage. If a Member whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the Member as an employee, Subscriber or retiree or covering the Member as a Dependent of an employee, Subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Plan that covered the Member the longer period of time is the Primary plan and the Plan that covered the Member the shorter period of time is the Secondary plan.
6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than we would have paid had we been the Primary plan.

5.2.3 Effect on the Benefits of This Plan

When This Plan is secondary, we may reduce our benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the 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 do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

If a Member is enrolled in two or more Closed panel plans and if, for any reason, including the provision of services by a non-panel dentist, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

5.2.4 Right to Receive and Release Needed Information

Certain facts about health care coverage and Services are needed to apply this COB section and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying this section and determining benefits payable under This Plan and other Plans covering a Member claiming benefits. We need not tell, or get the consent of, any person to do this. Each Member claiming benefits under This Plan must give us any facts we need to apply this section and determine benefits payable.

5.2.5 Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of Services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of Services.

5.2.6 Right of Recovery

If the amount of the payments made by us is more than we should have paid under this COB section, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the Member. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

5.3 THIRD-PARTY LIABILITY/SUBROGATION

The following provisions will apply when you or any other Member has received Services for a condition for which one or more third parties may be responsible. "Third party" means any person other than the Member (the first party to the provisions of this Plan), and Providence Health Plan (the second party), and includes any insurance carrier providing liability or other coverage potentially available to the Member. For example, uninsured or underinsured motorist coverage, no-fault medical payments (auto, homeowners or otherwise), or other group insurance (including student plans) whether under the Member's policy or not, are subject to recovery by us as a third-party recovery. Failure by the Member to comply with the terms of this section will be a basis for us to deny any claims for benefits arising from the condition or to terminate the Member's coverage under this Plan as specified in section 8.3. In addition, you or the Member must execute and deliver to us and to other parties any document requested by us which may be appropriate to confirm or secure the rights and obligations of the Member and Providence Health Plan under these provisions.

5.3.1 Third-Party Liability/Subrogation and How It Affects You

Third-party liability refers to claims that are in whole or part the responsibility of someone besides Providence Health Plan or the Member. Examples of third-party liability are motor

vehicle accidents, workplace injury or illness, and any other situation involving injury or illness, including wrongful death, in which the Member or the Member's heirs, beneficiaries or relatives have a basis to bring a lawsuit or to make a claim for compensation against any person or for which the Member or the Member's heirs, beneficiaries or relatives may receive a settlement. Once it has been established that the third party is responsible to pay and is capable of paying for the expenses for the Services caused by that third party, we will not provide benefits for the Services arising from the condition caused by that third party. Such benefits are specifically excluded from coverage under this Plan.

If we make claim payments on any Member's behalf for any condition for which a third party is responsible, we are entitled to be repaid promptly for those payments, directly out of any recovery from the third party, including any settlement, award, verdict, payment or other monetary recovery.

"Subrogation" means that we may collect directly from the third party to the extent we have paid for third-party liabilities. Because we have paid for the Member's injuries, we, rather than the Member, are entitled to recover those expenses. Prior to accepting any settlement of the Member's claim against a third party, the Member must notify us in writing of any terms or conditions offered in settlement and must notify the third party of our interest in the settlement established by this provision.

To the maximum extent permitted by law, we are subrogated to the Member's rights against any third party who is responsible for the condition, have the right to sue any such third party in the Member's name, and have a security interest in and lien upon any recovery to the extent of the amount of benefits paid by us and for our expenses in obtaining a recovery. If the Member should either decline to pursue a claim against a third party that we believe is warranted or refuse to cooperate with us in any third party claim that the Member does pursue, we have the right to pursue such claim directly, including commencing a legal action against such third party or intervening in any action that the Member may have commenced.

To accomplish this process, we need detailed information from you or from the Member. A questionnaire will be sent to the Member for this information. It should be completed and returned to our office as soon as possible to minimize any claim review delay. If you or the Member has any questions or concerns regarding the questionnaire, please contact our office. A Providence Health Plan employee who specializes in third-party liability/subrogation can discuss our procedures and what you or the Member needs to do.

5.3.2 Proceeds of Settlement or Recovery

Subject to paragraph 5.3.4 below, if for any reason we are not paid directly by the third party, we are entitled to reimbursement from the Member or the Member's heirs, legal representatives, beneficiaries or relatives, and we may request refunds from the In-Network Dentists who treated the Member, in which case those dentists will bill the Member for their Services. To the fullest extent permitted by law, we are entitled to the proceeds of any settlement, award, verdict, or other payment that results in a monetary recovery from a third party, whether or not responsibility is accepted or denied by the third party for the condition, whether or not such monetary recovery is described by any person as something other than a recovery of dental expenses incurred by us, and whether or not the Member is alleged to have any fault, under principles of comparative negligence or otherwise. With respect to any workers' compensation recovery, we are entitled to the proceeds whether or not the loss is deemed to be compensable under the workers' compensation laws. We are entitled to recover up to the full value of the benefits provided by us for the condition, calculated using

the UCR charges for such Services, less our pro rata share of the Member's out-of-pocket expenses and attorney fees incurred in making the recovery. We are entitled to such recovery regardless of whether the Member has been fully compensated or "made whole" for the loss caused by the third party, and regardless of whether the Member has been partially compensated for such loss. We are entitled to first priority in repayment, over the Member and over any other person, for such charges.

By accepting benefits under this Plan, the Member acknowledges our first priority to this repayment and assigns to us any benefits the Member may have from other sources. The Member must cooperate fully with us in recovering amounts paid by us. If any Member seeks damages against the third party for the condition and retains an attorney or other agent for representation in the matter, that Member agrees to require the Member's attorney or agent to reimburse us directly from the settlement or recovery in the amount provided by this section.

The Member must complete our trust agreement, by which the Member and any Member's attorney (or other agent) must confirm the obligation to reimburse us directly from any settlement or recovery. We may withhold benefits for the Member's condition until a signed copy of this agreement is delivered to us. The agreement must remain in effect and we may withhold payment of benefits if, at any time, the Member's confirmation of the obligations under this section should be revoked. While this document is not necessary for us to exercise our rights under this section, it serves as a reminder to the Member and directly obligates any Member's attorney to act in accord with our rights.

5.3.3 Suspension of Benefits and Reimbursement

Subject to paragraph 5.3.4 below, after the Member has received proceeds of a settlement or recovery from the third party, the Member is responsible for payment of all dental expenses for the continuing treatment of the illness or injury that Providence Health Plan would otherwise be required to pay under this Plan until all proceeds from the settlement or recovery have been exhausted. If the Member has failed to reimburse us as required by this section, we are entitled to offset future benefits otherwise payable under this Plan, or under any future contract or plan with us, to the extent of the value of the benefits advanced under this section.

If the Member continues to receive dental treatment for the condition after obtaining a settlement or recovery from one or more third parties, we are not required to provide coverage for continuing treatment until the Member proves to our satisfaction that the total cost of the treatment is more than the amount received in settlement or recovered from the third party, after deducting the cost of obtaining the settlement or recovery. We will only cover the amount by which the total cost of benefits that would otherwise be covered under this Plan, calculated using the UCR charges for such Services, exceeds the amount received in settlement or recovery from the third party. We are entitled to suspend such benefits even if the total amount of such settlement or recovery does not fully compensate the Member for other damages, particularly including lost wages or pain and suffering.

Any settlement arising out of an injury or illness covered by this Plan will be deemed first to compensate you for your dental expenses, regardless of any allocation of proceeds in any settlement document that we have not approved in advance. In no event shall the amount reimbursed to us be less than the maximum permitted by law.

5.3.4 Special Rules for Motor Vehicle Accident Cases

If the third party recovery is payable to you or any enrolled family member as the result of a motor vehicle accident or by a motor vehicle liability or underinsured insurer, the rules in paragraphs 5.3.2 and 5.3.3 above are modified as provided below.

Before the Plan will be entitled to recover under from a settlement or recovery, you or your enrolled Family Member must first have received full compensation for your injuries. The Plan's entitlement to recover will be payable only from the total amount of the recovery in excess of the amount that fully compensates for the injured person's injuries.

The Plan will not deny or refuse to provide benefits otherwise available to you or your enrolled Family Member because of the potential that a third party recovery may potentially be available against the person who caused the accident or out of motor vehicle liability or underinsurance coverage.

6. PROBLEM RESOLUTION

6.1 INFORMAL PROBLEM RESOLUTION

All employees of Providence Health Plan share responsibility for assuring Member satisfaction. If you have a problem or concern about your coverage, including benefits or Services by In-Network Dentists or payment for Services by Out-of-Network Dentists, please ask for our help. Your Customer Service representative is available to provide information and assistance. You may call us or meet with us at the phone number and address listed on your Member ID card. If you have special needs, such as a hearing impairment, we will make efforts to accommodate your requirements. Please contact us so we may help you with whatever special needs you may have.

6.2 MEMBER GRIEVANCE AND APPEAL

Definitions:

Adverse Benefit Determination

An Adverse Benefit Determination means a:

- Denial of eligibility for or termination of enrollment in this Plan;
- Rescission or cancellation of coverage under this Plan;
- Source-of injury exclusion, network exclusion, Annual benefit limit or other limitation on otherwise Covered Services;
- Determination that a health care item or service is Experimental/Investigational or not Dentally Necessary; or
- Determination that a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care.

Appeal

A type of Grievance that is a written request from a Member or an Authorized Representative of the Member requesting further consideration of an Adverse Benefit Determination.

Authorized Representative

An individual who by law or by the authorization of a Member may act on behalf of the Member.

Concurrent Care

An approved ongoing course of treatment to be provided over a period of time or for a specified number of treatments.

Grievance

A communication from a Member or an Authorized Representative of a Member expressing dissatisfaction with an Adverse Benefit Determination, without specifically declining any right to Appeal or review, that is:

- In writing, for an internal Appeal or an external review; or in writing or orally, for an expedited response or an expedited external review; or
- A written complaint submitted by a Member or an Authorized Representative of a Member regarding the:
    - Availability, delivery or quality of a health care service;
    - Claims payment, handling or reimbursement for health care services and, unless the Member has not submitted a request for an internal Appeal, the complaint is not disputing an Adverse Benefit Determination; or

- Matters pertaining to the contractual relationship between a Member and Providence Health Plan.

6.2.1 Your Grievance and Appeal Rights

If you disagree with our decision about your dental bills or health care services, you have the right to an internal review. You may request a review if you have received an Adverse Benefit Determination. You may also file a quality of care or general complaint or Grievance with us. You may appoint an Authorized Representative to act on your behalf during your Grievance or Appeal. Please include as much information as possible including the date of the incident, the names of individuals involved, and the specific circumstances. In filing a Grievance or Appeal:

- You can submit written comments, documents, records and other information relating to your Grievance or Appeal and we will consider that information in our review process.
- You can, upon request and free of charge, have reasonable access to and copies of the documents, records and other information relevant to our decision, including the specific internal rule, guideline, protocol, or other similar criterion relied upon to make an Adverse Benefit Determination.
- You can be represented by anyone of your choice at all levels of Appeal.

Filing a Grievance or Appeal does not affect your right to receive benefits for Covered Services as otherwise provided under this Plan.

If you received the services that were denied in our Adverse Benefit Determination, and if the Adverse Benefit Determination is upheld by internal or external review, you will be financially responsible for any benefits paid by the Plan for such services pursuant to Oregon state law.

To the extent possible, Customer Service will resolve complaints filed by telephone at the point of service. We will acknowledge all non-urgent pre-service and post-service Grievances and Appeals within seven days of receipt and resolve within 30 days or sooner depending on the clinical urgency. Urgent dental conditions and concurrent care have different resolution timelines as noted below.

Urgent Dental Conditions*:* If you believe your health would be seriously harmed by waiting for our decision on your Grievance or Appeal of a denied Predetermination or Concurrent Care request, you may request an expedited review by calling a Customer Service representative at 503-574-7500 or 800-878-4445 outside the Portland area. If your Appeal is urgent and qualifies for external review, you may request to have both your internal and external Appeal expedited at the same time. We will let you know by phone and letter if your case qualifies for an expedited review. If it does, we will notify you of our decision within 72 hours of receiving your request.

Grievances and Appeals Involving Concurrent Care Decisions: If we have approved an ongoing course of treatment for you and determine through our dental management procedures to reduce or terminate that course of treatment, we will provide advance notice to you of that decision. You may request reconsideration of our decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. We will then notify you of our reconsideration decision within 24 hours of receiving your request.

6.2.2 Internal Grievance or Appeal

You must file your internal Grievance or Appeal within 180 days of the date on our notice of the initial Adverse Benefit Determination, or that initial Determination will become final. Please advise us of any additional information that you want considered in the review process. If you are seeing an Out-of-Network Dentist, you should contact the dentist's office and arrange for the necessary records to be forwarded to Providence Health Plan for the review process. Your Grievance or Appeal will be reviewed by Providence Health Plan staff not involved in the initial determination. You may present your case in writing. Once a final determination is made, you will be sent a written explanation of the decision.

6.2.3 How to Submit Grievances or Appeals and Request Appeal Documents

To submit your Grievance or Appeal, or to request our Annual reports, you may contact Customer Service at 503-574-7500 or 800-878-4445. If you are hearing impaired and use a Teletype (TTY) Device, please call our TTY line at 711. Written Grievances or Appeals should be sent to:

Providence Health Plan
Appeals and Grievance Department
P.O. Box 4158
Portland, OR 97208-4158

You may fax your Grievance or Appeal to 503-574-8757 or 800-396-4778, or you may hand deliver it (*if mailing, use only the post office box address listed above*) to the following address:

Providence Health Plan
3601 SW Murray Blvd., Ste. 10
Beaverton, OR 97005

6.2.4 Assistance with your Grievance or Appeal

You may, at any time during the Grievance and Appeal process, seek assistance from the Oregon Division of Financial Regulation with your concerns regarding our decisions and benefits. You may contact the Oregon Division of Financial Regulation at:

Oregon Division of Financial Regulation
Consumer Protection Unit
P.O. Box 14480
Salem, OR 97309-0405

503-947-7984 (phone)
888-877-4894 (toll-free)
503-378-4351 (fax)

DFR.InsuranceHelp@oregon.gov (e-mail)
https://dfr.oregon.gov (website)

7. ELIGIBILITY AND ENROLLMENT

This section outlines who is eligible for coverage, and how and when to enroll yourself and your Eligible Family Dependents. No benefits shall be available to anyone not enrolled under this Plan. You must provide Providence Health Plan with evidence of eligibility as requested.

7.1 POLICYHOLDER ELIGIBILITY AND ENROLLMENT

7.1.1 Eligibility Requirements

An individual is eligible for coverage as a Policyholder when:

1. The individual has applied for medical and dental coverage by completing our Individual Application;
2. The individual resides in our Service Area, as stated in section 12; and
3. The individual has been approved by Providence Health Plan for enrollment.

7.1.2 Open Enrollment and Effective Date of Coverage

This plan has an Annual Open Enrollment period.

To request coverage, an Eligible Individual must apply with Providence Health Plan during Open Enrollment. The Open Enrollment period is November 1st through December 31st, with coverage effective January 1st of the following calendar year. You may also apply from January 1st through January 15th for a February 1st effective date.

To be eligible for an offer of coverage, Providence Health Plan must receive your completed Individual Application by the last day of the Open Enrollment Period.

In order for coverage to become effective, Providence Health Plan must receive your initial month's Premium in full by the first day of the Plan Year, or the date specified in our written confirmation of your acceptance for coverage and notice of initial premium, whichever is later.

If your initial month's Premium is not received by the beginning of your Plan Year, or the date specified in our written confirmation of your acceptance for coverage and notice of initial premium, whichever is later, your application and our offer of coverage are void.

For enrollment outside of Open Enrollment, see section 7.4 Special Enrollment.

7.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

7.2.1 Eligibility Requirements

Each Dependent is eligible for coverage as an Eligible Family Dependent when:

1. The Dependent has applied for medical and dental coverage by completing and submitting to Providence Health Plan our Individual Application;
2. The Dependent resides in our Service Area, as stated in section 12 (this requirement applies only to Spouses and to individuals enrolling in Child-only coverage); and
3. The Dependent has been approved by Providence Health Plan for enrollment.

See section 7.3 for eligibility requirements for newborn, newly adopted children, and newly fostered children of existing Members.

7.2.2 Enrollment and Effective Date of Coverage when Applying During Open Enrollment

To obtain coverage, an Eligible Family Dependent must enroll with Providence Health Plan by completing our Individual Application during Open Enrollment. The Open Enrollment period is November 1st through December 31st, with coverage effective January 1st of the following calendar year. You may also apply from January 1st through January 15th for a February 1st effective date.

To be eligible for an offer of coverage, Providence Health Plan must receive the Dependent's completed application by the last day of the Open Enrollment period.

In order for coverage to become effective, Providence Health Plan must receive your initial month's Premium in full by the first day of the Plan Year, or the date specified in our written confirmation of your acceptance for coverage and notice of initial premium, whichever is later.

If your initial month's Premium is not received by the beginning of your Plan Year, or the date specified in our written confirmation of your acceptance for coverage and notice of initial premium, whichever is later, your application and our offer of coverage are void.

See section 7.3 for Enrollment and Effective Date of Coverage requirements for newborn, newly adopted children, and newly fostered children of existing Members.

7.3 NEWBORN, NEWLY ADOPTED CHILDREN, AND NEWLY FOSTERED CHILDREN ELIGIBILITY AND ENROLLMENT

A newborn, newly adopted child, or newly fostered child of an existing Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption or foster care if the newborn, newly adopted child, or newly fostered child is enrolled and the additional Premium is paid to us within 60 days of the date of birth, placement for adoption or foster care. If the enrollment and payment of the additional Premium due is not accomplished within this time period, no dental Services will be covered for the child. Enrollment after this period is subject to the requirements stated in sections 7.2.

7.4 SPECIAL ENROLLMENT

Providence Health Plan will accept applications for coverage outside of Open Enrollment if the applicant has experienced a Qualifying Event. After experiencing a Qualifying Event, the applicant must apply for a Providence Individual & Family Plan in order to be eligible to apply for a Providence Progressive Dental Plan.

<u>Qualifying Events:</u>

a) The person loses minimum essential coverage:
   - The person was covered under a COBRA Continuation or State Continuation provision and the coverage under such a provision was exhausted, except when the person failed to pay timely premium, or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact); or
   - The person was covered under a group health plan, individual health plan, or had other health coverage and the coverage was terminated as a result of:
     1. The individual's loss of eligibility for the coverage; including as a result of legal separation, divorce, death, termination of employment, or a

reduction in the number of hours of employment; except when the person failed to pay timely premium or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact); or

2. The individual's loss of eligibility for coverage under the Children's Health Insurance Program (CHIP), Medicaid, Medicare, TRICARE, Indian Health Service or domestic or foreign publicly sponsored or subsidized health plan; including, but not limited to, the Oregon Health Plan (OHP) or Qualified Health Plan coverage through the Oregon Health Insurance Marketplace or through the Federal Exchange; or
3. The termination of contributions toward such coverage by the current or former Employer; or
4. The individual incurring a claim that exceeds the lifetime limit on benefits.

b) The person previously resided outside of our Service Area and has moved into our Service Area and was covered under another group health plan, individual health plan or other health coverage for at least one day in the previous 60 days.
   - Exceptions to 60-day requirement:
     1. The person moves from out of country back to United States of America;
     2. The person gains status as a lawfully present individual or United States citizen;
     3. The person is released from incarceration.

c) The person gains a Dependent or becomes a Dependent through marriage, birth, adoption, placement for adoption or foster care.
d) The person becomes eligible for coverage under a state-sponsored or federal-sponsored premium assistance program.
e) The person is subject to a Qualified Medical Child Support Order or other court order requiring medical coverage.
f) The person is a survivor of domestic abuse/violence or spousal abandonment and wants to enroll in a health plan separate from the abuser or abandoner.
g) The person newly gains access to an individual coverage HRA (ICHRA) or is newly provided a qualified small employer health reimbursement arrangement (QSEHRA).

Providence Health Plan may modify Special Enrollment provisions consistent with federal or state guidance.

7.4.1 Enrollment and Effective Date of Coverage

To obtain coverage due to a Special Enrollment Qualifying Event through Providence Health Plan your application for coverage must be received within 60 days of the Qualifying Event. The Effective Date of Coverage is determined by the Qualifying Event, the date your completed application is received, as well as Providence Health Plan's timely receipt of your initial Premium:

- When the Qualifying Event is birth, adoption, placement for adoption or foster care of a child or court order, coverage will be effective from date of birth, placement or court order, provided your completed application and initial Premium payment are received within 60 days of birth, placement or court order.
- For all other Qualifying Events:
  - If the application is received the 1st of the month through the 15th of the month, coverage will be effective the first day of the following month, provided

Providence Health Plan receives your initial Premium payment by the first day of the effective month.

- If the application is received the 16th of the month through the end of the month, coverage will be effective the first day of the second following month, provided Providence Health Plan receives your initial Premium payment by the first day of the effective month.

See section 7.3 for Enrollment and Effective Date of Coverage requirements for newborn, newly adopted children, and newly fostered children of existing Members.

7.5 CHANGE IN RESIDENT ADDRESS

Your eligibility for coverage is determined by your residence address (where you live). Providence Health Plan will only issue coverage to Policyholders, Spouses, and Members enrolled on Child-only plans who reside within our Service Area. The Service Area for this Plan is listed in section 11.

If a Policyholder, Spouse, or Member enrolled on a Child-only plan moves outside of the Service Area, that individual will no longer be eligible for coverage under this Plan. Providence Health Plan offers coverage throughout the state of Oregon and in certain counties in Washington. Should a Policyholder, Spouse, or Member enrolled on a Child-only plan move outside of the Service Area for this Plan, that individual may be eligible for coverage under a different plan offered by Providence Health Plan. Customer Service can assist someone who has experienced a move in determining eligibility.

Policyholders enrolled through Providence Health Plan are responsible for communicating changes in residence address for themselves and all enrolled Family Members to Providence Health Plan in a timely manner. Failure to do so may result in termination of coverage, as discussed in section 8.3.

8. PREMIUMS, RENEWAL, REVISION, TERMINATION AND RESCISSION

8.1 PREMIUMS

8.1.1 Premium Billing Information

Providence Health Plan will provide a Premium billing statement on a monthly basis to the Policyholder listing the amount of Premium due. If you choose to set up recurring monthly premium payments using the Providence Electronic Payment System, you will receive a monthly notice of the amount charged to your account.

8.1.2 Changes in Premium Charges

The Premium may be changed only in accordance with the following provisions:

1. The Premium is subject to change upon renewal of this Contract for another Plan Year.
2. If at any time during a Plan Year any federal or state law or any order or regulation of a federal or state agency mandates a modification of benefits under this Contract, we may change the Premium and/or Covered Services accordingly and you will be notified of this change in writing. The change in Premium shall be effective on the effective date of the modification of benefits, as stated in the notice.
3. If at any time during a Contract Year any federal or state law enacts a tax or assessment associated with this Individual & Family Plan, Providence Health Plan may revise the Premium as necessary. The change in Premium shall be effective on the effective date of the tax or assessment, as stated in the notice.
4. The Premium may be adjusted to reflect changes in your family composition. The change in Premium shall be effective, as described in sections 7.3 and 7.4.

8.1.3 Premium Payment Due Date

The Premium is due on the first of the month. If the Policyholder does not pay the Premium on the first day of the month, we will mail a single Premium delinquency notice to the Policyholder. If the Policyholder does not pay the Premium by the last day of the grace period specified in the notice, coverage will be terminated, with no further notice to the Policyholder, on the last day of the monthly period through which Premium was paid. Failure to pay the Premium includes making a partial payment of the amount due as Premium. If we fail to send the Premium delinquency notice specified above, we will continue the Contract in effect, without payment of Premium, until we provide such notice.

8.2 RENEWAL AND REVISION

We may revise this Dental Contract upon renewal with prior approval from the Division of Financial Regulation and written notice to you at least 30 days prior to the start of a new Plan Year.

We may revise this Dental Contract outside of renewal if required by federal or state mandate. To the extent permissible by such mandate, we will provide you with at least 30 days' advance written notice of such revision.

Your payment of premium constitutes acceptance of any revisions to the provisions of this Dental Contract that may occur at renewal or outside of renewal as permissible by applicable federal or state law.

8.3 TERMINATION

This Dental Contract may be terminated for any of the following reasons:

1. When the Policyholder fails to pay the Premium by the due date as specified in section 8.1.3.
2. When the Policyholder makes a written request for termination of this Contract. The termination of coverage will be effective on the last day of the monthly period through which Premium was paid.
3. When a Policyholder, enrolled Spouse, or a Member enrolled in Child-only coverage ceases to reside in our Service Area, as described in section 12. The termination of coverage will be effective on the last day of the month in which the Member resides in our Service Area.
4. When a Family Member no longer qualifies as an Eligible Family Dependent. The termination of coverage will be effective on the last day of the month in which the individual ceased to qualify as an Eligible Family Dependent.
5. Upon our discovery of fraud or intentional misrepresentation on the part of the Policyholder or Member.
6. When we cease to offer or elect not to renew **all** Individual Dental Plans in this state. The termination will be effective on the date specified in the notice from us. This date shall not be earlier than 180 days from the date of the notice.
7. When we cease to offer or elect not to renew **an** Individual Dental Plan for all individuals in this state. We will send written notice to all Policyholders covered by the affected Plan at least 90 days prior to discontinuation. In addition, we will offer replacement coverage to all affected Policyholders in one of our ongoing Individual & Family Plans.
8. When we cease to offer or elect not to renew an Individual Dental Plan to individuals in a specified Service Area because of an inability to reach an agreement with the dentists or organization of dentists to provide Services under this Contract within that specified Service Area, we will send written notice to all Policyholders covered by this Contract at least 90 days prior to discontinuation. In addition, we will offer to all affected Policyholders all other Individual Dental Plans that we offer in our Service Area, for which the affected Policyholders are eligible.
9. When we are ordered by the Director to discontinue coverage in accordance with procedures specified or approved by the Director upon finding that the continuation of the coverage would not be in the best interests of the Members or impair our ability to meet contractual obligations.
10. In the case of a plan that delivers Covered Services through a network of In-Network Dentists, when we no longer have any Members living or residing in our Service Area.

8.3.1 Termination Date

Termination of Member coverage under this Dental Contract will occur on the earliest of the following dates:

1. The date this Dental Contract terminates as specified in this section 8;
2. The last day of the month through which the Premium was paid when the Policyholder requests termination of coverage;
3. For a Policyholder, the last day of the month in which the enrolled Policyholder ceases to reside in our Service Area, as stated in section 12;
4. For the enrolled Spouse of a Policyholder, the last day of the month in which the enrolled Spouse ceases to resides in our Service Area, as stated in section 12;
5. For a Dependent child enrolled on a Child-only Plan, the last day of the month in which the child ceases to resides in our Service Area, as specified in section 12;

6. For a Member, the date of disenrollment from this Contract, as described in section 8.3.2;
7. For a deceased Member after documentation has been submitted, the date of death; and
8. For a Family Member, the last day of the month in which the individual no longer qualifies as an Eligible Family Dependent.

Enrolled Family Members who no longer meet the definition of Eligible Family Dependent, as specified in section 11, may be eligible to maintain enrollment under a separate policy with no lapse in coverage provided that a completed application and the associated initial Premium payment is received by us no later than 30 days from the last date of coverage under this Dental Contract.

You are responsible for advising us of any changes in eligibility including the lack of eligibility of a Family Member. Coverage will not continue beyond the last date of eligibility, regardless of the lack of notice to us.

8.3.2 Disenrollment from this Dental Contract

"Disenrollment" means that your coverage under this Dental Contract is terminated by us because you have engaged in fraudulent or dishonest behavior, such as:

- You have filed false claims with us;
- You have allowed a non-Member to use your Member ID card to obtain Services; or
- You provided false information on your application for coverage, or on any subsequent form requesting a change to your coverage.

8.3.3 Termination and Rescission of Coverage Due to Fraud or Abuse

Coverage under this Dental Contract, either for you or for your covered Dependent(s) may be rescinded (meaning your coverage is retroactively canceled) or terminated in case of a fraud or intentional misrepresentation of material fact by you or by your covered Dependent in obtaining, or attempting to obtain, benefits under this Providence Progressive Dental Plan.

If coverage is rescinded, Providence Health Plan will retain any money you paid for coverage as liquidated damages and will have the right to recover from you or from your covered dependents the benefits paid as a result of such wrongful activity. We will provide all affected Plan participants with a 30-day notice before rescinding your coverage.

8.3.4 Non-Liability After Termination

Upon termination of this Dental Contract, we shall have no further liability beyond the effective date of the termination unless the Member continues, without lapse of membership, under another plan with Providence Health Plan.

8.3.5 Notice of Creditable Coverage

We will provide upon request written certification of the Member's period of Creditable Coverage when:

- A Member ceases to be covered under this Dental Contract; and
- A Member requests a Notice of Creditable Coverage within 24 months of the termination of coverage.

9. MEMBER RIGHTS AND RESPONSIBILITIES

9.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES

As a Member of Providence Health Plan, you should know what to expect from us, as well as what we ask from you. Nobody knows more about your health than you and your doctor. We take responsibility for providing the very best health care services and benefits possible; your responsibility is to know how to use them well. Please take time to read and understand your benefits. We want you to have a positive experience with Providence Health Plan, and we are ready to help in any way.

Members have the right to:

- Be cared for by people who respect your privacy and dignity.
- Be informed about Providence Health Plan, our providers, and the benefits and Services you have available to you as a Member.
- Receive information that helps you select a Qualified Practitioner whom you trust and with whom you feel comfortable.
- A candid discussion of appropriate or Dentally Necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Receive information and clinical guidelines from your health care provider or your health plan that will enable you to make thoughtful decisions about your health care.
- Actively participate in decisions that relate to your health and your dental care through discussions with your health care provider or through written advance directives.
- Have access to dental Services that are appropriate for your needs.
- Express a concern or an Appeal and receive a timely response from Providence Health Plan.
- Have your claims paid accurately and promptly.
- Request a review of any service not approved, and to receive prompt information regarding the outcome.
- Be informed about and make recommendations regarding Providence Health Plan's member rights and responsibilities policy.
- Refuse care from specific providers.

Members have the responsibility to:

- Read and understand the information in and the terms of your Plan. We will have no liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact us. We will assist you in understanding and complying with the terms of the Plan.
- Talk openly with your provider, understand your health problem and work toward a relationship built on mutual trust and cooperation.
- Develop mutually agreed upon treatment goals with your Qualified Practitioner, to the degree possible, and follow treatment plans and instructions.
- Supply, to the extent possible, information that Providence Health Plan and your physicians or providers need to provide care.
- Do your part to prevent disease and injury. Try to make positive, healthful choices. If you do become ill or injured, seek appropriate dental care promptly.
- Treat your dentists courteously.
- Make your required Copayment at the time of Service.

- Show your Member identification card whenever you receive dental Services.
- Let us know if you have concerns or if you feel that any of your rights are being compromised, so that we can act on your behalf.
- Call or write within 180 days of Service if you wish to request a review of Services provided or Appeal a Providence Health Plan decision.
- Notify Customer Service if your address changes.

Providence Health Plan has the responsibility to:

- Respect and honor your rights.
- Ensure timely access to appropriate health care Services.
- Enable you to see physicians or providers who meet your needs.
- Develop a variety of benefits to serve you well.
- Assure the ongoing quality of our dentists and Services.
- Contract with dentists who are capable, competent, and committed to excellence.
- Make it easy and convenient for you to Appeal any policy or decision that you believe prevents you from receiving appropriate care.
- Provide you with accurate up-to-date information about Providence Health Plan and In-Network Dentists.
- Provide you with information and services designed to help you maintain good health and receive the greatest benefit from the services we offer.
- Ensure privacy and confidentiality of your dental records with access according to law.
- Ensure that your interests are well represented in decisions about Providence Health Plan policy and governance.
- Encourage dentists to make dental decisions that are always in your best interest.

10. GENERAL PROVISIONS

10.1 AMENDMENT OF THE DENTAL CONTRACT

The provisions of the Dental Contract may be amended, subject to receiving any required regulatory approval(s), by agreement between the state of Oregon and us. Any such amendment shall become effective on the date specified in the amendment. The payment of Premium for any period of coverage after the effective date of an amendment shall constitute the acceptance of the amendment by the Policyholder if we have provided written notice of the amendment to the Policyholder prior to the payment of such Premium. Outside of renewal or as required by Oregon state or federal mandate, no material modification will be made to benefits, including preventive benefits, without providing notice to Members 60 days in advance of the effective date.

10.2 BINDING EFFECT

The Dental Contract shall be binding upon and inure to the benefit of the heirs, legal representatives, successors and assigns of the parties hereto.

10.3 CIRCUMSTANCES BEYOND THE CONTROL OF PROVIDENCE HEALTH PLAN

If a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within our control results in the facilities, personnel, or financial resources of Providence Health Plan being unavailable to provide, or make arrangements for basic or supplemental health Service, then we are required only to make a good-faith effort to provide, or make arrangements for the Service, taking into account the impact of the event. For this purpose, an event is not within the control of Providence Health Plan if we cannot exercise influence or dominion over its occurrence.

10.4 CHOICE OF STATE LAW

The laws of the state of Oregon govern the interpretation of this Dental Contract and the administration of benefits to Members.

10.5 DUPLICATING PROVISIONS

If any charge is described as covered under two or more benefit provisions, we will pay only under the provision allowing the greater benefit. This may require us to make a recalculation based upon both the amounts already paid and the amounts due to be paid. We have NO liability for benefits other than those this Dental Contract provides.

10.6 DUTY TO COOPERATE AND TO PROVIDE RELEVANT INFORMATION

The Policyholder and all Members are required to cooperate with us in all manners reasonably related to securing any Member's rights, or our rights, under this Dental Contract, including, but not limited to, providing, upon request, all information relevant to eligibility, to coverage, to coordination of benefits, or to third-party or subrogation matters. Policyholders warrant that all information contained in applications, questionnaires, forms, or statements submitted to us to be true, correct, and complete. If any Member fails to provide information required to be provided under this Dental Contract or knowingly provides incorrect or incomplete information, then the rights of that Member and of any Family Members may be terminated, as described in section 8.3.

10.7 HOLD HARMLESS

The Policyholder acknowledges that Providence Health Plan and its In-Network Dentists have entered into contracts requiring that in the event Providence Health Plan fails to pay for Services that are covered under this Dental Contract that the In-Network Dentists shall not bill or otherwise attempt to collect from Members for any amounts owed to them under this Dental Contract by Providence Health Plan, and Members shall not be liable to In-Network Dentists for any such sums. The Policyholder further acknowledges that the hold harmless agreements described in this section do not prohibit In-Network Dentists from billing or collecting any amounts that are payable by Members under this Dental Contract, such as Copayment, Coinsurance and Deductible amounts.

10.8 INTEGRATION

The Dental Contract and any attached amendments, embodies the entire contract of the parties. There are no promises, terms, conditions or obligations other than those contained herein. The Dental Contract shall supersede all other communications, representations or agreements, either verbal or written, between the parties.

10.9 LEGAL ACTION

No civil action may be brought under state or federal law to recover benefits from the Dental Contract until receipt of a final decision under the Member Grievance and Appeal process specified in section 6.2 of the Dental Contract. Challenges to the final decision of the Grievance Committee must be brought in Oregon state court, either in your county of residence or such other county as mutually agreed upon between you and the Plan. In the alternative, you may request that the Plan agree to submit the dispute to binding arbitration before a single arbitrator under the rules of the United States Arbitration & Mediation Service in your county of residence or such other county as mutually agreed upon between you and the Plan. Any such arbitration shall be under Oregon law, in accordance with USA&M's Rules for Arbitration, and the arbitrator's decision shall be final and legally binding and judgment may be entered thereon. No such action may be brought later than three years after the Grievance Committee's decision was issued. Irrespective of whether the Grievance is appealed to a court or an arbitrator, neither party shall, under any circumstance, be liable to the other for any special, incidental, or consequential damages, or for any tort liability (including any punitive or exemplary damages), in any way related to this Dental Contract.

10.10 MEMBER RESPONSIBILITY

It is your responsibility to read and to understand the terms of this Dental Contract. We will have no liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Contract. If you have any questions or are unclear about any provision concerning this Contract, please contact us. We will assist you in understanding and complying with the terms of this Contract.

10.11 MEMBER ID CARD

The Member ID card is issued by Providence Health Plan for Member identification purposes only. It does not confer any right to Services or other benefits under this Dental Contract.

10.12 NON-TRANSFERABILITY OF BENEFITS

No person other than a Member is entitled to receive benefits under this Dental Contract. Such right to benefits is nontransferable.

10.13 NON-WAIVER

No delay or failure when exercising or enforcing any right under this Dental Contract shall constitute a waiver or relinquishment of that right, and no waiver or any default under this Dental Contract shall constitute or operate as a waiver of any subsequent default. No waiver of any provision of this Dental Contract shall be deemed to have been made unless and until such waiver has been reduced to writing and signed by the party waiving the provision.

10.14 NO RECOURSE FOR ACTS OF PROVIDERS

The Hospitals, Skilled Nursing Facilities, physicians and other persons or organizations providing Services to you do so as independent contractors. We are not liable for any claim or demand due to damages arising out of, or in any manner connected with, any injuries suffered by you while receiving such Services.

10.15 NOTICE

Any notice required of us under this Dental Contract shall be deemed to be sufficient if mailed to the Policyholder by postal or electronic means at the address appearing in the records of Providence Health Plan. The Policyholder is responsible for notifying us of any challenge in address. Policyholders who move should call Customer Service as soon as possible to provide the new address. Notice of termination of health insurance coverage will not be sent by electronic means. Any notice required of you by Providence Health Plan shall be deemed sufficient if mailed by electronic means via the contact link provided on our website at ProvidenceHealthPlan.com or postal means to the principal office of:

Providence Health Plan
P.O. Box 4327
Portland, OR 97208

10.16 PROFESSIONAL REVIEW AND RIGHT TO EXAMINE RECORDS

All Members, by acceptance of the benefits of the Dental Contract, shall be deemed to have consented to the examination of dental records for purposes of utilization review, quality assurance and peer review by Providence Health Plan or our designee.

All Members, for purposes other than utilization review, quality assurance and peer review, may be required to authorize any provider to give and discuss with us any information relating to any condition for which benefits are claimed under the Dental Contract. We may transfer this information between providers or other organizations who are treating you or performing a Service on our behalf. If you do not consent to the release of records or to discussions with providers, we will be unable to determine the proper payment of any benefits and will deny the claims accordingly. Consent to the release of records and discussion with providers is a condition of payment of any benefits. Neither the consent to, nor the actual examination of the records or discussion with providers will constitute a guarantee of payment.

10.17 PRORATION OF BENEFITS

Benefits are based on a Calendar Year. If the benefits under this Dental Contract are modified, or if you change to another Dental Contract within Providence Health Plan, the benefit limits shall be prorated accordingly.

10.18 SEVERABILITY

Invalidation of any term or provision herein by judgment or court order shall not affect any other provisions, which shall remain in full force and effect.

10.19 SUGGESTIONS

You are encouraged to make suggestions to us. Suggestions may be oral or written and should be directed to the Customer Service Team at our administrative office.

10.20 WORKERS' COMPENSATION INSURANCE

This Dental Contract is not in lieu of, and does not affect, any requirement for coverage under any Workers' Compensation Act or similar law.

11. DEFINITIONS

The following are definitions of important capitalized terms used in this Dental Contract.

Abutment
Abutment means a tooth used to support a prosthetic device, such as bridges, partials or overdentures. With an implant, an abutment is a device placed on the implant that supports the implant crown.

Adverse Benefit Determination
See section 6.

Alveolectomy
Alveolectomy means the removal of bone from the socket of a tooth.

Amalgam
Amalgam means a silver-colored material used in restoring teeth.

Annual
Annual means once per Calendar Year.

Appeal
See section 6.

Authorized Representative
See section 6.

Benefit Summary
Benefit Summary means the document with that title which is part of your Plan and which summarizes the benefit provisions under your Plan.

Calendar Year
Calendar Year means a 12-month time period beginning January 1st and ending December 31st.

Cast Restoration
Cast Restoration means crowns, inlays, onlays, and other restorations made to fit a patient's tooth that are made at a laboratory and cemented onto the tooth.

Child-only Plan
Dependent-only Plan means a Dental Contract covering only a Dependent child under 21 years of age (age 0-20 years).

Coinsurance
Coinsurance means the dollar amount that you are responsible to pay to a health care provider, after your claim has been processed by us. Your Coinsurance for a Covered Service is shown in the Benefit Summary and is a percentage of the charges for the Covered Service.

Composite Resin
Composite Resin means a tooth-colored material used in restoring teeth.

Contract Year
Contract Year means a 12-month time period starting from the effective date of the Dental Contract.

Copayment
Copayment means the dollar amount that you are responsible to pay to an In-Network Dentist when you receive certain Covered Services, as shown in the Benefit Summary.

Cosmetic Services
Cosmetic Services means Services or surgery performed to reshape structures of the body in order to improve your appearance or self-esteem.

Covered Service
Covered Service means a Service that is:

- Listed as a benefit in the Benefit Summary and in section 4;
- Dentally Necessary;
- Not listed as an Exclusion in the Benefit Summary or in section 4; and
- Provided to you while you are a Member and eligible for the Service under this Dental Contract.

Creditable Coverage
Creditable Coverage means prior health care coverage as defined in 42 U.S.C. § 300gg and includes any coverage remaining in force at the time a Member obtains new coverage. Creditable Coverage includes any group health care coverage (including the Federal Employees Health Benefits Plan and the Peace Corps), individual health care coverage, Medicare, Medicaid, TRICARE, SCHIP, Indian Health Service or tribal organization coverage, state high-risk pool coverage, or a domestic or foreign public health plan.

Curettage
Curettage means the scraping.

Deductible
See section 3.7.1.

Dental Contract
Dental Contract means the provisions of this Providence Progressive Dental Plan document, the Benefit Summary, any endorsements or amendments to those documents, and those policies maintained by Providence Health Plan which clarify any of these documents.

Dental Emergency
See section 3.3.

Dentally Necessary
Dentally Necessary means Covered Services that are in the reasonable opinion of Providence Health Plan, consistent with the written criteria regarding dentally indicated Covered Services that are maintained by us.

The criteria are based on the following principles:

1. Covered Services are determined to be Dentally Necessary if they are dental services or products that a Qualified Dentist, exercising prudent clinical judgment, would

provide to a Member for the purpose of evaluating, diagnosing, preventing or treating dental illness, injury disease or its symptoms, and that are:

a. In accordance with generally accepted standards of dental practice:
    i. Generally accepted standards of dental practice are standards that are based on credible scientific evidence published in peer reviewed dental literature generally recognized by the relevant dental community, Qualified Dentist specialty society recommendations, the view of Qualified Dentists practicing in relevant dental areas and any other relevant factors;
b. Dentally appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Member's dental condition;
c. Not primarily for the convenience of the Member or Qualified Dentist; and
d. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis, prevention or treatment of that Member's dental illness, injury or disease.

The "prudent physician" standard of Dental Necessity ensures that Qualified Dentists are able to use their expertise and exercise discretion, consistent with good dental care, in determining the Dental Necessity for dental care services to be provided each Member. Dental care services may include, but are not limited to, preventive, surgical, diagnostic tests, other dental care technologies, supplies, treatments, procedures, drug therapies or devices.

Dentist

Dentist means a doctor of dental science (DDS), a doctor of medical dentistry (DMD), or an Expanded Practice Dental Hygienist (EPDH) who is professionally licensed by the appropriate governmental agency to diagnose or treat dental conditions and who provides Covered Services within the scope of that license.

As used in this Plan, the term "Dentist" may also include an oral surgeon, endodontist, orthodontist, periodontist, pedodontist, denturist or dental hygienist so long as the services provided are Covered Services and within scope of license.

Domestic Partner

A Domestic Partner is:

- At least 18 years of age; and
- Has entered into a domestic partnership with a member of the same sex; and
- Has legally registered a Declaration of Domestic Partnership and obtained a Certificate of Registered Domestic Partnership in accordance with Oregon state law.

Note: All provisions of this Dental Contract that apply to a Spouse shall apply to a Domestic Partner.

Effective Date of Coverage

Effective Date of Coverage means the date upon which coverage under this Dental Contract commences for a Member.

Eligible Family Dependent (Dependent)

Eligible Family Dependent means:

1. The legally recognized Spouse or Domestic Partner of a Policyholder;

2. In relation to a Policyholder, the following individuals:
    - A biological child, step-child, legally adopted child, or legally fostered child;
    - An unmarried grandchild for whom the Policyholder or Spouse provides at least 50% support;
    - A child placed for adoption or foster care with the Policyholder or Spouse;
    - An unmarried individual for whom the Policyholder or Spouse is a legal guardian and for whom the Policyholder or Spouse provides at least 50% support; and
    - A child for whom the Policyholder or Spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law.

Placement for adoption or foster care means the assumption and retention by a Policyholder or Spouse, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child or foster care (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption or foster care). Upon any termination of such legal obligations the placement for adoption or foster care shall be deemed to have terminated.

The limiting age for each Dependent child who is enrolled as an Eligible Family Dependent is age 26 and such Members shall become ineligible for coverage under this Contract on the last day of the month in which their 26th birthday occurs, except:

- When an Eligible Family Dependent is enrolled on a Dependent-only Plan, the limiting age is 20, and such a Member shall become ineligible for coverage under this Contract on the last day of the month in which their 21st birthday occurs.

Enrolled Eligible Family Dependents who become ineligible for coverage under this Contract may be eligible to continue coverage under a separate Dental Contract.

A covered Dependent child who attains the limiting age remains eligible if the child is:

1. Developmentally or physically disabled;
2. Incapable of self-sustaining employment prior to the limiting age; and
3. Unmarried.

Proof of incapacity must be provided to us upon enrollment. For Eligible Family Dependents who become incapacitated while covered under the Dental Contract, proof of incapacity must be provided within 60 days of reaching the Dependent child limiting age. Thereafter, we may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to us, the individual's coverage will not continue beyond the last date of eligibility.

Endorsement

Endorsement means a document that amends and is part of the Dental Contract.

Experimental/Investigational

Experimental/Investigational (E/I) means Services for which current, prevailing, evidence-based, peer-reviewed dental literature does not demonstrate the safety and effectiveness of the Service for treating or diagnosing the condition or illness for which its use is proposed. In determining whether Services are Experimental/Investigational the Plan considers a variety of criteria, which include, but are not limited to, whether the Services are:

- Approved by the appropriate governmental regulatory body;

- Subject to review and approval of an institutional review board (IRB) or are currently offered through an approved clinical trial;
- Offered through an accredited and proficient dentist in the United States;
- Reviewed and supported by national professional dental societies;
- Address the condition, injury, or complaint of the Member and show a demonstrable benefit for a particular illness or disease;
- Proven to be safe and efficacious; and
- Pose a significant risk to the health and safety of the Member.

The experimental/investigational status of a Service may be determined on a case-by-case basis. We will retain documentation of the criteria used to define a Service as Experimental/Investigational and will make this available for review upon request.

Family Member
Family Member means an Eligible Family Dependent who is properly enrolled in and entitled to Services under the Dental Contract. A Dependent-only Family Member means an Eligible Family Dependent, of a non-enrolled Policyholder.

Grievance
See section 6.

In-Network
In-Network means the level of benefits specified in the Benefit Summary for Covered Services that are provided by an In-Network Dentist.

In-Network Dentist
In-Network Dentist shall mean those independent licensed dentists and licensed expanded practice dental hygienists who have contracted with the Plan to provide dental Services at negotiated fees for Members of the Plan. In-Network Dentists are not employers of nor supervised by the Plan.

Ineligible Person
Ineligible Person means any person who does not qualify as a Member under the Dental Contract.

Maximum Benefit
See section 3.7.2.

Member
Member means a Policyholder or Eligible Family Dependent, who is properly enrolled in and entitled to Services under the Dental Contract.

Out-of-Network
Out-of-Network means a dentist that is not contracted with the Plan, and any services received from a non-contracted dentist.

Out-of-Network Dentist
Out-of-Network Dentist means a Dentist that does not have a written agreement with Providence Health Plan to participate as a Dentist for this Plan.

Outpatient Surgical Facility

Outpatient Surgical Facility means any licensed public or private establishment that has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient surgery. It does NOT provide Services or accommodations for patients to stay overnight.

Periodontal Maintenance

Periodontal Maintenance means a periodontal procedure for patients who have previously been treated for periodontal disease. In addition to cleaning the visible surfaces of the teeth, surfaces below the gum line are cleaned.

Periodontal Scaling and Root Planing

Periodontal Scaling and Root Planing means the removal of plaque and calculus deposits from the root surface under the gum line.

Plan Year

Plan Year means the 12-month period for which Premium rates for this Contract have been approved by the Director. The Plan Year begins on January 1.

Policyholder

Policyholder means the person to whom this Dental Contract has been issued. A policyholder shall be age 18 or older. If enrollment under this Dental Contract consists solely of children under the age of 21, the adult person who applied for such coverage shall be deemed to be the Policyholder.

Predetermination of Benefits

Predetermination of Benefits means a request to us or our authorizing agent by you or by a Qualified Practitioner regarding proposed Class II and Class III services except restorative fillings, for which our prior approval is required. Predetermination review will determine if the proposed service is eligible as a Covered Service or if an individual is a Member at the time of the proposed service. To facilitate our review of the Predetermination request, we may require additional information about the Member's condition and/or the Services requested. We may also require that a Member receive further evaluation from another dentist of our choosing. Predetermination is subject to the terms and provisions of the Dental Contract.

Predeterminations are not a guarantee of benefit payment unless:

- A determination that relates to benefit coverage and Dental Necessity is obtained no more than 180 days prior to the date of the service; or
- A determination that relates to eligibility is obtained no more than five business days prior to the date of the Service.

Premium

Premium means the monthly rates set by us and approved by the Oregon Division of Financial Regulation as consideration for benefits offered under the Dental Contract. Premium rates are subject to change at the beginning of each Calendar Year.

Prophylaxis

Prophylaxis means the cleaning and polishing of teeth.

Providence Health Plan
Providence Health Plan means the nonprofit corporation authorized as a health care service contractor in the states of Oregon that issues this Dental Contract to the Policyholder.

Pulpotomy
Pulpotomy means the removal of a portion of the pulp, including the diseased aspect, with the intent of maintaining the vitality of the remaining pulpal tissue by means of a therapeutic dressing.

Qualified Treatment Facility
Qualified Treatment Facility means a facility, institution or clinic duly licensed by the appropriate governmental agency, which is primarily established and operating within the lawful scope of its license.

Rate Summary
Rate Summary means the document with that title which is part of this Dental Contract and which summarizes the Premium provisions under this Dental Contract.

Reconstructive Surgery
Reconstructive Surgery means surgery that restores features damaged as a result of injury or illness or to correct a congenital deformity or anomaly that results in functional impairment.

Restoration
Restoration means the treatment that repairs a broken or decayed tooth. Restorations include, but are not limited to, filings and crowns.

Service
Service means a health care related procedure, surgery, consultation, advice, diagnosis, referral, treatment, supply, medication, prescription drug, device or technology that is provided to a Member by a Qualified Practitioner.

Service Area
See section 12.

Spouse
Spouse means an individual who is legally married to the Policyholder in accordance with the laws of the country or state of celebration.

Usual, Customary and Reasonable (UCR)
When a Service is provided by an In-Network Dentist, UCR means charges based on the fee that we have negotiated with In-Network Dentists for that Service. UCR charges will never be less than our negotiated fees.

When a Service is provided by an Out-of-Network Dentist, UCR charges will be determined, in Providence Health Plan's reasonable discretion, based on the lesser of:

1. The fee we have negotiated with In-Network Dentists for a given Service;
2. A fee which falls within the range of usual charges for a given Service billed by most professional dentists in the same locality or region who have similar training and experience;
3. A fee which is based upon a percentage of the Medicare allowable amount;

4. A fee which is prevalent or which would not be considered excessive in a particular case because of unusual circumstances; or
5. The fee determined by comparing charges for similar Services to a regional or national database adjusted to the geographical area where the Service was performed.

UCR charges do not include sales taxes, handling fees and similar surcharges and such taxes, fees and surcharges are not covered expenses.

12. SERVICE AREA

Service Area means the geographic area in Oregon within which the Policyholder, the Spouse or the Child-only Member must physically reside in order to be eligible for coverage under this Dental Contract.

In-Network Dentists are located within the Service Area, as well as outside of the Service Area through our national network.

Service Areas include:

All ZIP codes in Oregon.

13. NON-DISCRIMINATION AND LANGUAGE ACCESS

13.1 NON-DISCRIMINATION STATEMENT

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html.*

13.2 LANGUAGE ACCESS INFORMATION

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: TTY: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-878-4445 (TTY: 711)។

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما بگیرید تماس با 1-800-878-4445 (TTY: 711) می باشد.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)

PROVIDENCE
Health Plan

Our Mission

As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

Our Values

Compassion | Dignity | Justice | Excellence | Integrity

Questions? We're here to help.

Speak to one of our Customer Service representatives at 503-574-7500 or 800-878-4445 (TTY: 771), 8 a.m. to 5 p.m. (Pacific Time) Monday through Friday.

ProvidenceHealthPlan.com

Providence Health & Services, a not-for-profit health system, is an equal opportunity organization in the provision of health care services and employment opportunities.

PIC-OR 0122 IND DENT CTR