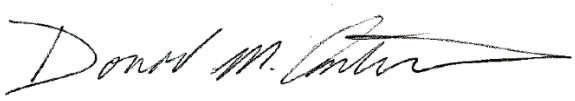
Providence
Health Plan

2024 Oregon Individual Contract

Individual & Family Dental



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PROVIDENCE HEALTH PLAN QUICK REFERENCE GUIDE

Please see our Quick Reference Guide for customer service information.

Customer Service Quick Reference Guide:

Dental plan customer service	833-212-5035 (toll-free)
Dentist directory	ProvidenceHealthPlan.com/FindADentist

Monthly Premium Payment Options

Pay online	Providence.org/PremiumPay
Pay by phone	844-791-1467 (toll-free)
Pay by mail	Providence Health Plan P.O. Box 5728 Portland, OR 97228-5728

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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 Individual & Family 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 Individual & Family 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 Individual & Family Dental Plan is provided through:
    - Dentists in the Delta Dental PPO network.
- Covered Services must be obtained from In-Network Dentists, except for a problem-focused exam or palliative care in the case of a dental emergency.
- A printable directory of In-Network Dentists in our Service Area is available at ProvidenceHealthPlan.com/FindADentist. Members without Internet access or who would like a hard copy of our dentist directory, may contact dental customer service for assistance.
- Coverage limitations and exclusions apply to certain Services, as stated in sections 3 and 4 and the Benefit Summary.
- All Covered Services are subject to the provisions, limitations, and exclusions that are specified in this Providence Individual & Family 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 Individual & Family 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 INDIVIDUAL & FAMILY DENTAL PLAN

The Providence Individual & Family 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 INDIVIDUAL & FAMILY DENTAL PLAN

Your Providence Individual & Family Dental Plan allows you to receive Covered Services from Dentists in the Delta Dental PPO network in our Service Area.

It is your responsibility to verify whether a dentist is an In-Network Dentist and whether the dental care is a Covered Service even if you have been directed or referred for care by an In-Network Dentist. Services provided Out-of-Network, including by a dentist with contracted rates with a network outside your Plan, will not be covered except in the case of a dental emergency.

If you are unsure about a dentist's participation with the Delta Dental PPO network, visit the dentist directory, available online at ProvidenceHealthPlan.com/FindADentist, before you make an appointment. You can also call dental customer service to get information about a dentist's participation with Providence Health Plan and your benefits.

Whenever you visit a Dentist:

- Bring your dental Member ID Card with you.
- 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 dental customer service at 833-212-5035 (section 2.3).

This Dental Contract is not complete without your:

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

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

For specific questions about your dental Plan, contact the dental customer service line at 833-212-5035.

Please have your dental Member ID Card available when you call.

For questions about myProvidence, contact Providence Customer Service:

- 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 at myProvidence.org. A myProvidence account enables you to view your personal health plan information, view claims history and benefit payment information, and access other health and wellness tools and services.

2.5 YOUR MEMBER ID CARD

After enrolling, you will receive a Member ID card that will include your identification number. You will need to present the card each time you receive Services. You may contact dental customer service for replacement of a lost ID card.

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, 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 ProvidenceHealthPlan.com/NOPP or by calling Providence 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 ProvidenceHealthPlan.com/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 selected 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.

Dentists in the Delta Dental PPO network contract to provide dental care to Members. You must choose an In-Network Dentist from the dentist directory (available on myProvidence). All of the claims paperwork will be handled between the dental Plan and the dentist's office. For travelers outside Oregon, the Plan's affiliation with Delta Dental Plans Association provides offices and/or contacts in every state.

For Services to be covered, you must receive Services from In-Network Dentists. It is your responsibility to verify whether 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 Established Patients with Dentists

If you and your family already see a dentist, you may want to check the dentist directory to see if your dentist is an In-Network Dentist. If your dentist is In-Network, provide their office with the information on your dental Member ID card.

3.1.2 Selecting a New In-Network Dentist

We recommend that you choose an In-Network Dentist from the dentist directory, available on myProvidence, for each covered Family Member. Call the dentist's office to make sure they are 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, provide them with the information on your dental Member ID card. On your first visit, make a list of questions 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?

3.1.3 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.

3.2 SERVICES PROVIDED BY OUT-OF-NETWORK DENTISTS

Benefits are not available for services from an Out-of-Network Dentist. Any charges incurred Out-of-Network will be denied, except for a problem-focused exam or palliative care in the case of a dental emergency.

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

IMPORTANT NOTE: Payment of covered expenses is always limited to the Maximum Plan Allowance (MPA). Benefits will never be paid for services provided beyond the scope of a dentist's or dental care provider's license, certification or registration.

3.3 PREDETERMINATION OF BENEFITS

For expensive treatment plans, your dental Plan provides a predetermination service. The dentist may submit a predetermination request to get an estimate of what the Plan would pay. The predetermination will be processed according to the Member's current policy and returned to the dentist. You and your dentist should review the information before beginning treatment.

3.4 HOW BENEFITS ARE APPLIED

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

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

All annual or per year benefits or cost sharing accrue on a Calendar Year basis. Frequency limitations are calculated from the previous date of service or initial placement, unless otherwise specified.

3.4.1 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 & Family Deductibles:

- Services not covered by this Plan;
- Services in excess of any benefit limit and/or maximum;
- Fees in excess of Maximum Plan Allowance (MPA);
- Coinsurance specified as not applicable toward the Deductible in any Benefit Summary issued with this Plan.

3.4.2 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 Maximum Benefit: **The following out-of-pocket costs do not apply toward your Maximum Benefit:**

- Services not covered by this Plan;
- Services in excess of any benefit limit;
- Fees in excess of the MPA; and
- Deductibles, or Coinsurance amounts paid by Members for Covered Services.

4. COVERED SERVICES

The Plan covers the services listed when performed by a dentist or dental care provider (licensed denturist or licensed hygienist), and only when determined to be necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury. The Plan's dental consultants and dental director shall determine these standards.

Payment of covered expenses is always limited to the Maximum Plan Allowance (MPA). Benefits will never be paid for services provided beyond the scope of a dentist's or dental care provider's license, certification, or registration.

Covered dental services are grouped into three classes starting with preventive and diagnostic care and advancing into basic and major dental procedures. Limitations may apply to these services and are noted below. See section 4.6 for exclusions.

Covered services, when generally accepted dental practices and standards determine they can be safely and effectively provided using teledentistry (audio, video, or both), are covered when provided by a provider using such telephone or internet conferencing. The application and technology used must meet all state and federal standards for privacy and security of protected health information.

All services must be provided by an In-Network (Delta Dental PPO network) Dentist to be eligible for benefits. Services provided Out-of-Network, including by a dentist in the Delta Dental Premier network, will not be covered except in the case of a dental emergency.

Benefits and Plan provisions such as Deductibles, 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.

4.1 CLASS I PREVENTIVE AND DIAGNOSTIC SERVICES

This Plan provides coverage for these Class I preventive and diagnostic services:

- Routine or comprehensive exams (including problem-focused comprehensive exams) once in a 6-month period.
- Limited exams or re-evaluations are covered twice per Calendar Year.
- Prophylaxis (cleaning), including periodontal maintenance, once every 6 months; 2 additional periodontal maintenance cleanings are covered for Members with periodontal disease.
- Adult prophylaxis is only covered for Members age 12 and over. Child prophylaxis is covered for Members under age 12.
- Only the following X-rays are covered: Complete series of panoramic once every 5 years, one set of bitewing X-rays every 12 months, periapical, and occlusal.
- Separate charges for review of a proposed treatment plan or for diagnostic aids (for example, study models and certain lab tests) are not covered.
- Topical application of fluoride once every 6 months for Members under age 19. For Members age 19 and over, topical application of fluoride is covered once in any 12-month period if there is recent history of periodontal surgery or high risk of decay due

to medical disease or chemotherapy or similar type of treatment (poor diet or oral hygiene does not constitute a medical disease).
- Interim caries arresting medicament application is covered twice per tooth per year.
- Sealants benefits are limited to the unrestored occlusal surfaces of permanent molars. Benefits will be limited to one sealant per tooth during any 5-year period, except for evidence of clinical failure.

4.2 CLASS II BASIC SERVICES

The Plan provides coverage for these Class II Basic Services:

- Space maintainers are covered once per space:
    - Space maintainers for primary anterior teeth or missing permanent teeth or for Members age 19 or over are not covered.
- Restorative fillings:
    - Not covered if within 2 months of interim caries arresting medicament application.
    - Inlays are an optional service; an alternate benefit of a composite filling will be provided.

4.3 CLASS III MAJOR RESTORATIVE SERVICES

The Plan provides coverage for these Class II Major Restorative Services:

- Oral surgery (extractions and other minor procedures):
    - A separate, additional charge for alveoloplasty done in conjunction with removal of teeth is not covered.
    - Surgery on larger lesions or malignant lesions is not considered minor surgery.
    - A separate charge for post-operative care done within 30 days following oral surgery is not covered; post-operative care is included in the charge of the original surgery.
    - Brush biopsy is covered once in every 6 months; benefits are limited to the sample collection and do not include coverage for pathology (lab) services.
- Cast restorations, such as crowns, onlays, or lab veneers, necessary to restore decayed or broken teeth to a state of functional acceptability:
    - Cast restorations (including pontics) are covered once in a 7-year period on any tooth.
    - Cast restorations are not eligible for coverage within 2 months of interim caries arresting medicament application. Repair of a cast restoration within 2 years of the original cast restoration is not eligible for additional coverage.
    - One crown per tooth every 7 years.
    - Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars; coverage is limited to gold without porcelain, and the Member is responsible for paying the difference.
    - If a tooth can be restored with a material such as composite, but another type of restoration is selected, covered expense will be limited to the cost of composite. Crowns are only a benefit if the tooth cannot be restored by a routine filling.
    - Re-cement or re-bond of a crown, inlay, or veneer by the same dentist is limited to once per lifetime.
- Endodontic services for treatment of teeth with diseased or damaged nerves (for example, pulpal therapy and root canal filling):
    - A separate charge for cultures is not covered.

    - A separate charge for pulp removal done with a root canal or root repair is not covered.
    - A separate charge for pulp capping is not covered.
    - Retreatment of the same tooth by the same dentist within a 2-year period of a root canal is not eligible for additional coverage; the retreatment is included in the charge for the original care.
    - A subsequent retrograde filling by the same dentist within a 2-year period of the initial retrograde filling is not covered.
- Periodontic services for treatment of diseases of the gums and supporting structures of the teeth:
    - Periodontal scaling and root planing is limited to once per quadrant in any 2-year period.
    - Periodontal maintenance is covered under Class I — Preventive and Diagnostic Services.
    - A separate charge for post-operative care done within 3 months following periodontal surgery is not covered.
    - Osseous surgery is covered for a maximum of 2 quadrants per visit.
    - Bone replacement grafts are covered once per quadrant in a 3-year period.
    - Additional periodontal surgical procedures by the same dentist to the same site within a 3-year period of an initial periodontal surgery are not covered.
    - Full mouth debridement is limited to once in a 2-year period, and only if there has been no cleaning (prophylaxis, periodontal maintenance) within a 2-year period.
- Stainless steel crowns and crown preparations
    - Replacement of a stainless steel crown by the same dentist within two years of placement is not covered. The replacement is included in the charge for the original crown
    - Crown buildups are included in the crown restoration cost; a buildup will be a benefit only if necessary for tooth retention
    - Prefabricated and indirectly fabricated post and core in addition to a crown are only covered when less than half of the coronal (above the gum) tooth structure remains
- Denture work (including partial and complete dentures and denture relines) and bridge work:
    - A bridge or a full or partial denture will be covered once in a 7-year period and only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the last 7 years.
    - Full, immediate, and overdentures: If personalized or specialized techniques are used, the covered amount will be limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.
    - Partial dentures: A temporary (interim) partial denture is only a benefit when placed within 2 months of the extraction of an anterior tooth or for missing anterior permanent teeth of Members age 16 or under. If a specialized or precision device is used, covered expense will be limited to the cost of a standard cast partial denture. No payment is provided for cast restorations for partial denture retainer teeth unless the tooth requires a cast restoration due to being decayed or broken.
    - Denture adjustments, repairs and relines: A separate, additional charge for denture adjustments, repairs and relines done within 6 months after the initial placement is not covered. Subsequent relines will be covered once per

denture in a 12-month period. Subsequent adjustments are limited to 2 adjustments per denture in a 12-month period.
    - Denture rebase is covered only if a reline may not adequately solve the problem. A rebase is limited to once in a 12-month period.
    - Tissue conditioning is covered no more than twice per denture in a 36-month period.
    - Dentures are not covered for Members under age 16.
- Repair of an existing prosthetic device.
- Surgical stent in conjunction with a covered surgical procedure.
- Surgical placement or removal of implants, or related services, are not covered. The Plan will cover:
    - The final crown and abutment over a single implant (limited to once per tooth or tooth space over the lifetime of the implant).
    - Provide an alternate benefit per arch of a full or partial denture for the final prosthetic when the implant is placed to support a prosthetic device.
    - This benefit or alternate benefit is not provided if the tooth received a cast restoration or prosthodontic benefit within the previous 7 years.
- The re-cement or re-bond of an implant or abutment supported crown or fixed partial denture is limited to once in a 12-month period.
- Athletic mouthguards are covered once every 12 months for Members under age 16 and once every 24 months for Members age 16 and over:
    - Over-the-counter mouthguards are not covered
- Occlusal guard (nightguard) covered up to $200 every five years. Repair or reline and adjustment is covered once every 12 months.
- Anesthesia services are covered when necessary due to concurrent medical conditions or in conjunction with covered surgical procedures performed in a dental office.
- Translation or sign language service is included in the fees for overall patient management and is not covered as a separate benefit.

4.4 EXCLUSION PERIOD AND PRIOR COVERAGE

Class II services are subject to a 6-month exclusion period and Class III services are subject to a 12-month exclusion period. The exclusion period will be waived if the Member provides evidence of 12 continuous months of prior dental coverage with no more than a 90-day break in coverage from the end of the old policy to the effective date of this Policy. To qualify, the previous plan must have provided coverage for standard dental services as determined by the Plan.

4.5 ALTERNATIVE SERVICES

If a more expensive treatment than is functionally adequate is performed, the Plan will pay the applicable percentage of the MPA for the least costly treatment. You will be responsible for the remainder of the dentist's fee.

4.6 EXCLUDED SERVICES

The following services, procedures, and conditions are not covered, even if otherwise Dentally Necessary; they relate to a condition that is otherwise covered by the Plan; or recommended, referred, or provided by a dentist or dental care provider.

- Analgesics (substances used for pain relief)

- Anesthesia or sedation (local anesthetics, nitrous oxide, general anesthesia, and/or IV sedation), except as stated in section 4.2
- Behavior management (additional services, time, or assistance to control the actions of a Member)
- Benefits not stated (services or supplies not specifically described in this policy as Covered Services)
- Congenital or developmental malformations, including treatment of cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasia and fluorosis (discoloration of teeth)
- Coping (a thin covering over the visible part of a tooth, usually without anatomic conformity)
- Cosmetic services (services and supplies for the primary purpose of improving or changing appearance, such as tooth bleaching and enamel microabrasion)
- Duplication and interpretation of X-rays or records
- Facility fees, including additional fees charged by the dentist for hospital, extended care facility, or home care treatment
- Gnathologic recordings (services to observe the relationship of opposing teeth, including occlusion analysis)
- Hypnosis
- Illegal acts (services and supplies for treatment of an injury or condition caused by or arising directly from a Member's illegal act, including any expense caused by or arising out of illegal acts related to riot, declared or undeclared war, including civil war, martial law, insurrection, revolution, invasion, bombardment, or any use of military force or usurped power by any government, military, or other authority)
- Implants (see section 4.3 for alternative benefits)
- Inmates (services and supplies a Member receives while in the custody of any state or federal law enforcement authorities or while in jail or prison)
- Instructions or training, including tobacco cessation counseling, plaque control and oral hygiene, or dietary instruction
- Investigational procedures, including expenses incidental to or incurred as a direct consequence of such procedures
- Localized delivery of antimicrobial agents (time released antibiotics to remove bacteria from below the gumline)
- Maxillofacial prosthetics (except for surgical stents as stated in section 4.3)
- Medications
- Missed appointment charges
- Never events (services and supplies related to never events, which are events that should never happen while receiving services in a dental office, including removing a non-diseased tooth structure or performing a procedure on the wrong patient or wrong tooth)
- Orthodontia
- Over the counter, including athletic mouth guards and night guards
- Periodontal charting (the measuring and recording of the space between a tooth and the gum tissue)
- Precision attachments (devices to stabilize or retain a prosthesis when seated in the mouth)

- Rebuilding or maintaining chewing surfaces (misalignment or malocclusion) or stabilizing teeth, including services only to prevent wear or protect worn or cracked teeth, except occlusal or athletic mouthguards as provided for in section 4.3
    - Excluded services include increasing vertical dimension, equilibration and periodontal splinting
- Self-treatment (services you provide yourself)
- Service-related conditions (treatment of any condition caused by or arising out of your service in the armed forces of any country or as a military contractor or from an insurrection or war, unless not covered by your military or veteran coverage)
- Services on tongue, lip, or cheek
- Services or supplies otherwise available, including those services or supplies:
    - Compensable under workers' compensation or Employer's liability laws
    - Provided by any city, county, state or federal law, except for Medicaid coverage
    - Provided without cost to the Member by any municipality, county or other political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under the Plan
- Taxes
- Teledentistry fees (a separate charge for teledentistry is not covered; teledentistry is covered in the normal charge for the service)
- Temporomandibular joint (TMJ), including treatment of any disturbance of the TMJ
- Third-party liability claims (services and supplies for treatment of illness or injury for which a third party is or may be responsible, to the extent of any recovery received from or on behalf of the third party)
- Treatment after coverage terminates, except for cast restorations and prosthodontic services that were ordered and fitted while still eligible, and then only if such items are cemented within 31 days after your eligibility ends
- Treatment before coverage begins
- Treatment not Dentally Necessary, including treatments:
    - Not established as necessary for the treatment or prevention of a dental injury or disease otherwise covered under the Plan
    - That are inappropriate with regard to standards of good dental practice
    - With poor prognosis
- Treatment of closed fractures

5. CLAIMS ADMINISTRATION AND PAYMENT

5.1 SUBMISSION AND PAYMENT OF CLAIMS

5.1.1. Claim Submission

A claim is not payable until the service or supply has actually been received. In no event, except absence of legal capacity, is a claim valid if submitted later than 12 months from the date the expense was incurred. Please send all claims to:

Dental Processing Center, Inc.
P.O. Box 40384
Portland, OR 97240-0384

5.1.2 Explanation of Benefits (EOB)

We will report its action on a claim by providing a document called an Explanation of Benefits (EOB). You are encouraged to access your EOBs electronically on myProvidence. The Plan may pay claims, deny them, or apply the allowable expense toward satisfying the deductible. If all or part of a claim is denied, the reason will be stated in the EOB.

If you do not receive an EOB or an email indicating that an EOB is available within a few weeks of the date of service, this may indicate that the Plan has not received the claim. To be eligible for reimbursement, claims must be received within the claim submission period explained in section 5.1.1.

5.1.3 Claim Inquiries

Customer Service can answer questions about how to file a claim, the status of a pending claim, or any action taken on a claim. We will respond to an inquiry within 30 days of receipt.

5.1.4 Time Frames for Processing Claims

If a claim is denied, we will send an EOB explaining the denial within 30 days after receiving the claim. If additional time is needed to process the claim for reasons beyond our control, a notice of delay will be sent to the Member explaining those reasons within 30 days after they receive the claim.

5.2 BENEFITS AVAILABLE FROM OTHER SOURCES

Sometimes dental expenses may be the responsibility of someone other than the Plan.

5.2.1 Coordination of Benefits (COB)

Coordination of benefits applies when you have dental coverage under more than one plan.

If you are covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, and then any other plans pay. The order of benefit determination rules govern the order in which each plan will pay a claim for benefits.

Order of Benefit Determination (Which Plan Pays First?)
The first of the following rules that applies will govern:

a. Non-dependent/Dependent. If a plan covers the Member as other than a dependent (e.g., an employee, member of an organization, primary insured, or retiree), then that plan will determine its benefits before a plan that covers the Member as a dependent. 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.
b. Dependent Child/Parents Married or Living Together. If the Member is a dependent child whose parents are married or are living together whether or not they have ever been married or domestic partners, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan. (This is called the birthday rule.)
c. Dependent Child/Parents Separated or Divorced or Not Living Together. If the Member is a dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married or domestic partners, then the following rules apply:
    i. If a court decree states that one of the parents is responsible for the healthcare expenses of the child, 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 healthcare expenses of the child, or that the parents have joint custody without specifying that one parent is responsible, the birthday rule described above applies.
    iii. If there is not a court decree allocating responsibility for the child's healthcare expenses, the order of benefits is as follows: The plan covering the
        A. Custodial parent
        B. Spouse or domestic partner of the custodial parent
        C. Non-custodial parent
        D. Spouse or domestic partner of the non-custodial parent
d. Dependent Child Covered by Individual Other than Parent. For a dependent child covered under more than one plan of persons who are not the parents of the child, the first applicable provision (b or c) above shall determine the order of benefits as if those persons were the parents of the child.
e. Dependent Child Covered by Parent and Spouse/Domestic Partner. For a dependent child covered under the plans of both a parent and a spouse or domestic partner, the length of coverage provision below shall determine the order of benefits. If coverage under either or both parents' plans and the spouse's/domestic partner's plan began on the same day, the birthday rule will apply.
f. Active/Retired or Laid Off Employee. The plan that covers a Member as an active employee (i.e., one who is neither laid off nor retired), or as that employee's dependent, determines its benefits before those of a plan that covers the Member as a laid off or retired employee or as that employee's dependent. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.
g. COBRA or State Continuation Coverage. If a Member whose coverage is provided under 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, member

of an organization, primary insured, or retiree or as a dependent of the same, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.

h. **Longer/Shorter Length of Coverage**. The plan that covered a Member longer is the primary plan and the plan that covered the Member for the shorter period of time is the secondary plan.
i. **None of the Above**. If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid if it had been the primary plan.

How COB Works

The **primary plan** (the plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.

The **secondary plan** (the plan that pays benefits after the primary plan) will reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

This Plan will coordinate with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in OAR 836-020-0770 to 836-020-0805 (non-complying plan) on the following basis:

a. If this Plan is primary, it will provide its benefits first.
b. If this Plan is secondary and the non-complying plan does not provide its primary payment information within a reasonable time after it is requested to do so, this Plan will assume that the benefits of the non-complying plan are identical to this Plan's benefits. This Plan will provide its benefits first, but the amount of the benefits payable shall be determined as if this Plan were the secondary plan.
c. If the non-complying plan reduces its benefits so that the Member receives less in benefits than the Member would have received had this Plan provided its benefits as the secondary plan and the non-complying plan provided its benefits as the primary plan, then this Plan shall advance additional benefits equal to the difference between the amount that was actually paid and the amount that should have been paid if the non-complying plan had not improperly reduced its benefits. Additional payment will be limited so that this Plan will not pay any more than it would have paid if it had been the primary plan. In consideration of such an advance, this Plan shall be subrogated to all rights of the Member against the non-complying plan.

Effect on the Benefits of This Plan

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 dental coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other dental coverage.

If the primary plan is a closed panel plan and the Member uses an out-of-network provider, the secondary plan shall provide benefits as if it were the primary plan, except for emergency services or authorized referrals that are paid or provided by the primary plan.

Definitions

For purposes of section 5.2.1, the following definitions apply:

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 covered persons in a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

Plan includes:

a. Group or individual insurance contracts and group-type contracts
b. HMO (health maintenance organization) coverage
c. Coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan
d. Medicare or other government programs, other than Medicaid, and any other coverage required or provided by law
e. Other arrangements of insured or self-insured group or group-type coverage

Plan does not include:

a. Fixed indemnity coverage
b. Accident-only coverage
c. Specified disease or specified accident coverage
d. School accident coverage
e. Medicare supplement policies
f. Medicaid policies
g. Coverage under other federal governmental plans, unless permitted by law

Each contract or other arrangement for coverage described above is a separate plan. If a plan has two parts and COB rules apply to only one of the two, each of the parts is treated as a separate plan.

Complying plan is a plan that follows these COB rules.

Non-complying plan is a plan that does not comply with these COB rules.

Claim means a request that benefits of a plan be provided or paid.

Allowable expense means a dental expense, including cost sharing, that is covered at least in part by any plan covering the Member. When a plan provides benefits in the form of a service instead of cash payments, the reasonable cash value of the service will also be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the Member is not an allowable expense. In addition, any expense that a provider 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:

a. The amount of the reduction by the primary plan because a Member has not complied with the plan's requirements concerning second opinions or prior

authorization, or because the Member has a lower benefit due to not using an in-network provider

b. Any amount in excess of the highest reimbursement amount for a specific benefit, if a Member is covered by 2 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
c. Any amount in excess of the highest of the negotiated fees, if a Member is covered by two or more plans that provide benefits or services on the basis of negotiated fees
d. If a Member is covered by one plan that calculates its benefits 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 on the basis of negotiated fees, the primary plan's arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

This Plan is the part of this policy that provides benefits for healthcare expenses to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the policy providing dental benefits is separate from this Plan. A policy may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Closed panel plan is a plan that provides dental benefits to covered persons primarily in the form of services through a network of providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by an in-network provider.

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 child resides more than one half of the calendar year excluding any temporary visitation.

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 at 833-212-5035. 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.

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
- 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 post-service Grievances and Appeals within seven days of receipt and resolve within 30 days or sooner depending on the clinical urgency.

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. The 180-day timeframe applies to both Standard and Expedited appeals. Please provide us any additional information that you want us to considered in the during our 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 Providence 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;
3. The individual is not entitled to Medicare Part A and/or enrolled in Medicare Part B; and
4. 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 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 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 within 15 days after the Effective Date of Coverage, or within 30 days after the date of 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 within 15 days after the Effective Date of Coverage, or within 30 days after the date of 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);
3. The Dependent is not entitled to Medicare Part A and/or enrolled in Medicare Part B; and
4. 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 within 15 days after the Effective Date of Coverage, or within 30 days after the date of 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 within 15 days after the Effective Date of Coverage, or within 30 days after the date of 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 or 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 Individual & Family 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, coverage will be effective the first day of the month following Providence Health Plan's receipt of your completed application, upon timely receipt of your initial Premium payment.

In order for coverage to become effective, Providence Health Plan must receive your initial month's Premium in full within 15 days after the Effective Date of Coverage, or within 30 days after the date of 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 within 15 days after the Effective Date of Coverage or within 30 days after the date of 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.

7.5 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 in Child-only plans who reside within our Service Area. The Service Area for this Plan is listed in section 12.

If a Policyholder, Spouse, or Member enrolled in a Child-only plan moves outside of the Service Area, that individual will no longer be eligible for coverage under this Plan.

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 in 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.

The following Members 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 Contract:

- Enrolled Family Members who no longer meet the definition of an Eligible Family Dependent, as specified in section 11;
- Enrolled Family Members who lose coverage as a result of the death of the Policyholder.

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 Individual & Family 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.

After two years from the date of issue of this policy, no misstatements except fraudulent misstatements made by the applicant shall be used to void the policy or to deny a claim and losses after two years are covered.

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 Proof of Prior Coverage

We will provide, upon request or as required by law, proof of prior 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 change 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.

Alveoloplasty
Alveoloplasty is the surgical shaping of the bone of the upper or the lower jaw. It is performed most commonly in conjunction with the removal of a tooth or multiple teeth to have the gums heal smoothly for the placement of partial denture or denture.

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

Annual
Annual means once per Calendar Year.

Anterior
Anterior refers to teeth located at the front of the mouth.

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.

Bridge
Bridge is also called a fixed partial denture. A bridge replaces one or more missing teeth using a pontic (false tooth or teeth) permanently attached to the adjacent teeth. Retainer crowns (crowns placed on adjacent teeth) are considered part of the bridge.

Broken
A tooth is considered broken when a piece or pieces of the tooth have been completely separated from the rest of the tooth. A tooth with cracks is not considered broken.

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
Child-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
Composite is 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 are Services and supplies for the primary purpose of improving or changing appearance, such as tooth bleaching and enamel microabrasion.

Covered Service
Covered Service is a service that is specifically described as a benefit of the plan.

Debridement
Debridement is the removal of excess plaque. A periodontal 'pre-cleaning' procedure done when there is too much plaque for the dentist to perform an exam.

Deductible
See section 3.7.1.

Dental Contract
Dental Contract means the provisions of this Providence Individual & Family 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.

Dentally Necessary
Dentally Necessary means services that:

a. Are established as necessary for the treatment or prevention of a dental injury or disease otherwise covered under the Plan
b. Are appropriate with regard to standards of good dental practice in the service area
c. Have a good prognosis

d. Are not more costly than the alternative supplies or levels of service that can be safely provided. For example, coverage would not be allowed for a crown when a filling would be adequate to restore the tooth appropriately

Dentist
Dentist means a licensed dentist operating within the scope of their license as required under law within the state of practice.

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 in a Child-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; and
2. Incapable of self-sustaining employment prior to the limiting age.

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.

Emergency Services

Emergency Services means services for a dental condition manifesting itself by acute symptoms of sufficient severity requiring immediate treatment. Includes services to treat the following conditions: acute infection, acute abscess, severe tooth pain, unusual swelling of the face or gums or a knocked out tooth.

Endorsement

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

Exclusion Period

Exclusion Period is a period of time during which specified treatments or services are excluded from coverage.

Family Member

Family Member means an Eligible Family Dependent who is properly enrolled in and entitled to Services under the Dental Contract. A Child-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 or Dental Provider

An In-Network Dentist or Dental Provider is a licensed dentist who contracts in the Delta Dental PPO network to provide care to Members.

Investigational

Investigational 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 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 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 Investigational and will make this available for review upon request.

Limited Exam
Limited Exam is an examination of a specific oral health problem or complaint.

Maximum Plan Allowance (MPA)
MPA is the maximum amount that the Plan will reimburse providers. The MPA is based on a PPO Fee Schedule or a contracted rate. If you go to an Out-of-Network Dentist who has contracted rates with the Delta Dental Premier network, you will not be balance billed for charges above the MPA. When using other Out-of-Network Dentists who do not have contracted rates with our dental network provider, the Plan will reimburse the provider at the MPA, and any amount above the MPA is your responsibility.

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. Where this book refers to "you" or "your", it is referring to a Member.

Out-of-Network
Out-of-Network means a dentist that is not contracted with the Delta Dental PPO network , and the services provided by that dentist.

Out-of-Network Dentist or Dental Provider
An Out-of-Network Dentist is a licensed dental provider who has not contracted in the Delta Dental PPO network. Out-of-Network dental providers include dentists in the Delta Dental Premier network, who have contracted rates with a network outside your Plan.

Periodontal Maintenance
Periodontal Maintenance is a periodontal procedure for Members who have previously been treated for periodontal disease. In addition to cleaning the visible surfaces of the teeth (as in prophylaxis) surfaces below the gum-line are also cleaned. This is a more comprehensive service than a regular cleaning (prophylaxis).

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

Plan
The Plan is the individual dental insurance plan insured under the terms of this policy between you and Providence Health Plan.

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.

Pontic
Pontic is an artificial tooth that replaces a missing tooth and is part of a bridge.

Posterior
Posterior refers to teeth located toward the back of the mouth.

PPO Fee Schedule
PPO Fee Schedule is the amount negotiated between the Plan and a dentist contracted in the Delta Dental PPO network.

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 is 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.

Reline
Reline means the process of resurfacing the tissue side of a denture with new base material.

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

Retainer
Retainer is a tooth used to support a prosthetic device (bridges, partial dentures, or overdentures). Also see Implant Abutment.

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.

Veneer
Veneer is a layer of tooth-colored material attached to the surface of an anterior tooth to repair chips or cracks, fix gaps and change the shape and size of teeth. A **chairside veneer** is a restoration created in the dentist's office. A **laboratory veneer** is a restoration that is created (cast) at a laboratory. Chairside and laboratory veneers may be paid at different benefit levels.

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, sexual orientation, religion, gender identity, marital status 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, sexual orientation, religion, gender identity, marital status or sex.

Providence Health Plan and Providence Health Assurance:

- Provides 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)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, you can call us at 503-574-7500 or 1-800-878-4445 (TTY: 711).

If you believe that Providence Health Plan and Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status 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
E-mail: PHPAppealsandGrievances@providence.org

If you need help filing a grievance, call us at 503-574-7500 or 1-800-878-4445 (TTY: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.

Members of Oregon Plans may file a complaint with the Division of Financial Regulation at 1-888-877-4894 or visit https://dfr.oregon.gov/Pages/index.aspx.

13.2 LANGUAGE ACCESS INFORMATION

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-898-8174 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-898-8174 (TTY: 711).

Russian: ВНИМАНИЕ: Если Вы говорите по-русски, то Вам доступны услуги бесплатной языковой поддержки. Звоните 1-800-898-8174 (телетайп: 711).

Vietnamese: CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-800-898-8174 (TTY: 711).

Traditional Chinese: 注意：如果您說中文， 您可以免費獲得語言支援服務。請致電 1-800-898-8174 (TTY: 711)。

Kushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-898-8174 (TTY: 711).

Farsi:
توجه :اگر به زبان فارسی صحبت میکنید، تسهیلات زبا ی ن به صورت رایگان به شما ارائه میشود .با 1-800-898-8174 (TTY: 711) تماس بگ ریید.

Ukrainian: УВАГА! Якщо Ви розмовляєте українською мовою, для Вас доступні безкоштовні послуги мовної підтримки. Телефонуйте за номером 1-800-898-8174 (телетайп: 711).

Japanese: お知らせ: 日本語での通話をご希望の場合、言語支援サービスを無料でご利用いただけます。1-800-898-8174 (TTY: 711) まで、お電話ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-898-8174(TTY: 711) 번으로 전화해 주십시오

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंले दनम्न भाषा सहायता सेवाहरू दन:शुल्क रूपमा उपलब्ध छन् । 1-800-898-8174 (TTY: 711) मा फोन गनुहोस् ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii gratuite de asistență lingvistică. Sunați 1-800-898-8174 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Rufnummer: 1-800-898-8174 (TTY: 711).

Hmong: LUS CEEB TOOM: Yog tias koj hais lus Hmoob, cov kev pab txhais lus, muaj kev pab dawb rau koj. Hu rau 1-800-898-8174 (TTY: 711).

Cambodian: កំណត់សម្គាល់៖ ប ើសិនជាអ្នកនិយាយភាសាម៉ែន អាចម្តងបសវាជំនួយខ្នកភាសាបោយមិនគិតថ្លៃពីបោកអ្នក។ សូមបៅទូរស័ពទបលម 1-800-898-8174 (TTY: 711)។

Laotian: ເຊີນຊາບ: ຖ້າວ່າທ່ານເວ ້າພາສາລາວ, ຈະມີການຊ່ວຍເຫ ຼືອ ດ້ ານພາສາ ໂດຍບ ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ 1-800-898-8174 (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: 711), 8 a.m. to 5 p.m. (Pacific Time) Monday through Friday.

ProvidenceHealthPlan.com

Providence Health & Services, a nonprofit health system, is an equal opportunity organization in the provision of health care services and employment opportunities.

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