# TABLE OF CONTENTS

1. INTRODUCTION .................................................................................................................. 1

2. WELCOME TO THE PROVIDENCE PROGRESSIVE DENTAL PLAN .......................... 2
   2.1 YOUR PROVIDENCE PROGRESSIVE DENTAL PLAN ........................................... 2
   2.2 DENTAL CONTRACT ............................................................................................... 2
   2.3 CUSTOMER SERVICE ............................................................................................ 3
   2.4 REGISTERING FOR A MyPROVIDENCE ACCOUNT ............................................. 3
   2.5 YOUR MEMBER ID CARD ...................................................................................... 3
   2.6 PRIVACY OF MEMBER INFORMATION .............................................................. 4

3. HOW TO USE YOUR PLAN ............................................................................................ 5
   3.1 NETWORK DENTIST ............................................................................................... 5
      3.1.1 Choosing a Network Dentist ........................................................................... 5
      3.1.2 Established Patients with Dentist .................................................................. 5
      3.1.3 Selecting a New Dental Provider ................................................................... 5
      3.1.4 Changing Your Network Dentist ................................................................... 5
   3.2 SERVICES PROVIDED BY OUT-OF-NETWORK DENTISTS .................................. 6
   3.3 PREDETERMINATION OF BENEFITS ................................................................. 7
   3.4 DENTAL COST MANAGEMENT ............................................................................ 8
      3.4.1 Coverage of New Technology and New Application of Existing Technology .... 8
   3.5 DENTALLY NECESSARY SERVICES .................................................................... 8
   3.6 HOW BENEFITS ARE APPLIED .......................................................................... 9
   3.7 DEDUCTIBLES AND MAXIMUM BENEFIT ......................................................... 9
      3.7.1 Understanding the Deductible ....................................................................... 9
      3.7.2 Understanding the Maximum Benefit ............................................................ 9

4. COVERED SERVICES .................................................................................................... 10
   4.1 CLASS I PREVENTIVE SERVICES ....................................................................... 10
   4.2 CLASS II BASIC SERVICES ................................................................................ 10
   4.3 CLASS III MAJOR RESTORATIVE SERVICES .................................................... 10
   4.4 EXCLUDED SERVICES .......................................................................................... 11
   4.5 GENERAL EXCLUSIONS ..................................................................................... 12

5. CLAIMS ADMINISTRATION ......................................................................................... 14
   5.1 CLAIMS PAYMENT ............................................................................................... 14
      5.1.1 Timely Submission of Claims ....................................................................... 15
      5.1.2 Right of Recovery .......................................................................................... 15
   5.2 COORDINATION OF BENEFITS ........................................................................ 15
      5.2.1 Definitions Relating to Coordination of Benefits .......................................... 15
      5.2.2 Order of Benefit Determination Rules .......................................................... 17
      5.2.3 Effect on the Benefits of This Plan ................................................................. 18
      5.2.4 Right to Receive and Release Needed Information ....................................... 19
      5.2.5 Facility of Payment ....................................................................................... 19
      5.2.6 Right of Recovery ........................................................................................ 19
5.3 Third-Party Liability/Subrogation

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

5.3.2 Proceeds of Settlement or Recovery

5.3.3 Suspension of Benefits and Reimbursement

6. PROBLEM RESOLUTION

6.1 INFORMAL PROBLEM RESOLUTION

6.2 MEMBER GRIEVANCE AND APPEAL

6.2.1 Your Grievance and Appeal Rights

6.2.2 Internal Grievance or Appeal

6.2.3 How to Submit Grievances or Appeals and Request Appeal Documents

6.2.4 Assistance Outside of Providence Health Plan

7. ELIGIBILITY AND ENROLLMENT

7.1 POLICYHOLDER ELIGIBILITY AND ENROLLMENT

7.1.1 Eligibility Requirements

7.1.2 Open Enrollment

7.1.3 Effective Date of Coverage

7.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

7.2.1 Eligibility Requirements

7.2.2 Enrollment and Effective Date of Coverage

7.3 NEWBORN AND NEWLY ADOPTED CHILDREN ELIGIBILITY AND ENROLLMENT

7.4 SPECIAL ENROLLMENT

7.4.1 Enrollment and Effective Date of Coverage

8. PREMIUMS, RENEWAL, REVISION, TERMINATION AND RESCISSION

8.1 PREMIUMS

8.1.1 Premium Billing Information

8.1.2 Changes in Premium Charges

8.1.3 Premium Payment Due Date

8.2 RENEWAL AND REVISION

8.3 TERMINATION

8.3.1 Termination Date

8.3.2 Disenrollment from this Dental Contract

8.3.3 Termination and Rescission of Coverage Due to Fraud or Abuse

8.3.4 Non-Liability After Termination

8.3.5 Notice of Creditable Coverage

9. MEMBER RIGHTS AND RESPONSIBILITIES

9.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES

10. GENERAL PROVISIONS

10.1 AMENDMENT OF THE DENTAL CONTRACT

10.2 BINDING EFFECT

10.3 CIRCUMSTANCES BEYOND THE CONTROL OF PROVIDENCE HEALTH PLAN

10.4 CHOICE OF STATE LAW

10.5 DUPLICATING PROVISIONS

10.6 DUTY TO COOPERATE AND TO PROVIDE RELEVANT INFORMATION

10.7 HOLD HARMLESS
10.8 INTEGRATION .................................................................................................................. 34
10.9 LEGAL ACTION .................................................................................................................. 34
10.10 MEMBER RESPONSIBILITY ......................................................................................... 34
10.11 MEMBER ID CARD ........................................................................................................ 34
10.12 NON-TRANSFERABILITY OF BENEFITS .................................................................... 34
10.13 NONWAIVER .................................................................................................................. 34
10.14 NO RECOURSE FOR ACTS OF PROVIDERS ............................................................... 34
10.15 NOTICE .......................................................................................................................... 34
10.16 PROFESSIONAL REVIEW AND RIGHT TO EXAMINE RECORDS ............................ 35
10.17 PRORATION OF BENEFITS ....................................................................................... 35
10.18 SEVERABILITY .............................................................................................................. 35
10.19 SUGGESTIONS ............................................................................................................. 35
10.20 WORKERS’ COMPENSATION INSURANCE ............................................................... 35

11. DEFINITIONS .................................................................................................................. 36
12. SERVICE AREA ................................................................................................................ 42
1. INTRODUCTION

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

- Some capitalized terms have special meanings. Please see section 11, Definitions.
- In this handbook, Providence Health Plan is referred to as “we,” “us” or “our.” Members enrolled under this Providence Progressive Dental Plan are referred to as “you” or “your.”
- If after examining this Contract you are not satisfied with it for any reason, you may cancel this policy within 10 days of receipt. Your decision to cancel this policy must be provided to us in writing within the 10 day period, and we will provide a full refund of your premium and consider the policy void and never effective.
- Coverage under this Providence Progressive Dental Plan is provided through:
  - Our Network Dental Providers located in our Service Area; and
  - Out-of-Network Dental Providers.
- With a Providence Progressive Dental Plan, you will generally have lower out-of-pocket expenses when you obtain Covered Services from Network Dental Providers. You may, however, obtain most Covered Services from Out-of-Network Dental Providers, but that option will result in higher out-of-pocket expenses. Please see section 3 and your Benefit Summary for additional information.
- More extensive care (fillings, dentures, crowns, root canals, periodontal care, oral surgery, etc.) is covered at increasing levels the more years you are covered under this Plan, progressing through years one, two and three. After year three, the coverage level will remain the same.
- A printable directory of Network Dental Providers in our Service Area is available at www.ProvidenceHealthPlan.com. Members without Internet access or who would like a hard copy of our Provider Directory may contact Customer Service for assistance. NOTE: Printed provider directories are updated only once each year and may not contain the most up-to-date information.
- Covered Services in excess of $300 require an approved Predetermination, as specified in section 3.3.
- 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 Progressive Dental Plan. You should read the provisions, limitation and exclusions before seeking Covered Services because not all dental services are covered by this Plan.
- The Group Contract for this Providence Progressive Dental Plan consists of this Dental Contract plus the Dental Benefit Summary, any Endorsements and amendments that accompany these documents, and those policies maintained by Providence Health Plan which clarify any of these documents. In the event of any conflict between these documents, they are to be interpreted in the following order of priority: (1) Endorsements and amendments, (2) Dental Contract, (3) Dental Benefit Summary, and (4) applicable Providence Health Plan policies.
2. WELCOME TO THE PROVIDENCE PROGRESSIVE DENTAL PLAN

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

2.1 YOUR PROVIDENCE PROGRESSIVE DENTAL PLAN

Your Providence Progressive Dental Plan allows you to receive Covered Services from Network Dentists through what is called your In-Network benefit. You also have the option to receive most Covered Services from Out-of-Network Dentists through what is called your Out-of-Network benefit. Generally, your out-of-pocket costs will be less when you receive Covered Services from Network Dentists. Also, Network Providers will work with us to Predetermine treatment. If you receive Covered Services from Out-of-Network Providers, it is your responsibility to make sure the Services listed in section 3.3 are Predetermined by us before treatment is received.

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

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

Whenever you visit a Dentist:
- Bring your Providence Health Plan Member ID Card with you.
- Be prepared to make a Copayment at the time of visit if the office visit is subject to a Copayment.
- If your dental Covered Services are subject to a Coinsurance (a percentage of the amount billed for Services), your providers 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 providers may send you a bill for what you owe. Be sure to check with your provider’s office regarding payment policies prior to receiving services.

2.2 DENTAL CONTRACT

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

This Dental Contract is not complete without your:
- Progressive Dental Benefit Summary and any other Benefit Summary documents. These documents are available at www.ProvidenceHealthPlan.com when you register for a myProvidence account as explained in section 2.4. Benefit Summaries detail your Copayments and Coinsurance for Covered Services and also provide important information about your Benefits.
- Provider Directory which lists Network Providers, available online at www.ProvidenceHealthPlan.com. If you do not have Internet access, please call Customer Service or check with your Employer’s human resource department to obtain a hard copy of the directory.

If you need more detailed information for a specific problem or situation, contact your Employer or 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 health 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 health care or service.

Contacting Providence Customer Service

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

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

You may **access claims and benefit information 24 hours a day, seven days a week** through our automated voice-recognition phone as well as online through your myProvidence account.

2.4 REGISTERING FOR A MyPROVIDENCE ACCOUNT

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

2.5 YOUR MEMBER ID CARD

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

- Your Member number
- Important phone numbers

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

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

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

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

- Visit your dental provider or facility.
- Register online for your myProvidence account.
- Call or correspond with Customer Service.
2.6 PRIVACY OF MEMBER INFORMATION

Providence Health Plan respects the privacy of our Members and takes great care to determine when it is appropriate to share your personal health information, in accordance with federal and state privacy laws. We use protected health information and may share it with others as part of your treatment, payment for your treatment, and our business operations.

The following are ways we may use or share information about you, consistent with law:

- We will use the information to administer your benefits and help pay your dental bills that have been submitted to us for payment.
- We may share your information with your dentists to help them provide dental care to you.
- We may use or share your information with others to help manage your dental care.
- We may share your information with individuals who perform business functions for us. We will only share your information if there is a business need to do so and if our business partner agrees to protect the information.
- We may use your information to provide you with information about alternative dental treatments or about dental related products and services that you may be interested in.

We make every effort to release only the amount of information necessary to meet any release requirement and only release information on a need to know basis. Also, wherever feasible, identifiable information is removed from any information shared.

To secure the confidentiality of your information, we have procedures in place which you can review at www.ProvidenceHealthPlan.com/privacy.

When Member information is used in health studies, identifiable information is not released. All Member-specific information has identifying information removed, and aggregated data are used as early in the measurement process as possible. The privacy of our Members is completely protected.

Our agreements with Network Providers contain confidentiality provisions that require providers treat your personal health information with the same care.

You have the right to ask us to restrict how we use or disclose your information for treatment, payment or health care operations. You also have the right to ask us to restrict information we may give to persons involved in your care. While we may honor your request for restrictions, we are not required to agree to these restrictions. You also have the right to register a complaint if you believe your privacy is compromised in any manner.

Members may request to see their dental records. Call your dentist’s office to ask how to schedule a visit for this purpose.

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 www.ProvidenceHealthPlan.com/privacy or by calling Customer Service.

Appointment of Authorized Representative

You are entitled to appoint an individual to act as your authorized representative to pursue any claim you have for benefits. To ensure privacy and to address other issues, Providence’s policy on Appointment of Authorized Member Representatives, and the form for doing so, may be accessed through our website at www.ProvidenceHealthPlan.com. 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 represents a dental service provider 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 your Employer has elected and the kinds of Services and providers 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 NETWORK DENTIST

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

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

3.1.1 Choosing a Network Dentist

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

Advantages of Using a Network Dentist

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

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

3.1.2 Established Patients with Dentist

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

3.1.3 Selecting a New Dental Provider

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

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

3.1.4 Changing Your Network Dentist

You are encouraged to establish an ongoing relationship with your Network Dentist. If you decide to change your Network Dentist, please remember to have your dental records transferred to your new Network Dentist.
3.2 SERVICES PROVIDED BY OUT-OF-NETWORK DENTISTS

You may choose to receive Covered Services from Out-of-Network Dentists using your Out-of-Network benefit.

Benefits for Covered Services by Out-of-Network Dentists will be provided as shown in the Benefit Summary. See section 3.3 Predetermination requirements.

**Generally, when you receive Services from Out-of-Network Dentists, your Copayments and Coinsurance will be higher than when you see Network Dentists.**

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

**Payment for Out-of-Network Dentists (UCR)**

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

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

<table>
<thead>
<tr>
<th>Item</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s standard charges</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Allowable charges under this Plan</td>
<td>$80 (contracted)</td>
<td>$80 (if that is UCR)</td>
</tr>
<tr>
<td>Plan benefits (for this example only)</td>
<td>$64 (if 80% benefit)</td>
<td>$56 (if 70% benefit)</td>
</tr>
<tr>
<td>Balance you owe</td>
<td>$16</td>
<td>$24</td>
</tr>
<tr>
<td>Additional amount that the provider may bill to you</td>
<td>$-0-</td>
<td>$20 ($100 minus $80)</td>
</tr>
<tr>
<td>Total amount you would pay</td>
<td>$16</td>
<td>$44 ($24 plus $20)</td>
</tr>
</tbody>
</table>

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

If the charge for treatment is expected to exceed $300, the Plan requires the Dentist to submit a treatment plan prior to initiating services. The Plan may request x-rays, periodontal charting or other dental records to evaluate the Predetermination request. The proposed services will be reviewed and a Predetermination will be issued to the Member or Dentist. The Predetermination is not a guarantee of coverage and does not supersede other specific provisions of this Plan regarding coverage, limitations, exclusions and Dental Necessity. Predetermination is considered valid for 180 days.

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

**Services received from Network Dentists:**
When Services are received from a Network Dentist, the Network Dentist is responsible for obtaining Predetermination.

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

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

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

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

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

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

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

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

3.4.1 Coverage of New Technology and New Application of Existing Technology

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

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

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

3.5 DENTALLY NECESSARY SERVICES

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

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

3.6 HOW BENEFITS ARE APPLIED

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

1. The Deductible;
2. The Copayment or Coinsurance amount; and
3. The benefit limits and/or maximums.
3.7 DEDUCTIBLES AND MAXIMUM BENEFIT

Dental Plans have In-Network and Out-of-Network Deductibles and a Maximum Benefit, as stated in your Benefit Summary.

3.7.1 Understanding the Deductible

The Deductible is the dollar amount shown in the Benefit Summary that a Member is 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 In-Network preventive care, are covered without a Deductible. Please see your Benefit Summary for information about these Services.

Common In-Network and Out-of-Network Deductible: Your Plan has an In-Network and an Out-of-Network Common Deductible, as listed in your Benefit Summary. The Common Deductibles can be met by using In-Network or Out-of-Network benefits, or a combination of both.

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

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

3.7.2 Understanding the Maximum Benefit

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

Common In-Network and Out-of-Network Maximum Benefit: Your Plan has a Common In-Network and Out-of-Network Maximum Benefit, as listed in your Benefit Summary. The Common Maximum Benefit is met by payments this Dental Plan makes for In-Network and Out-of-Network Covered Services.

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

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

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

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

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

4.1 CLASS I PREVENTIVE SERVICES

This Plan provides coverage for the preventive services listed below.

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

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

- Two evaluations per Calendar Year including a maximum of one comprehensive evaluation per 36 months.
- One emergency or problem focused exam (D0140) per Calendar Year.
- Two prophylaxes (cleaning, scaling and polishing teeth) per Calendar Year.
- Bitewing x-rays, two per Calendar Year.
- One topical fluoride per Calendar year, age 16 and under.
- One sealant per tooth per lifetime, age 16 and under (limited to permanent first and second molars).
- Space maintainers to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment).
- Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service).

4.2 CLASS II BASIC SERVICES

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

- Simple extraction of teeth.
- Amalgam and composite fillings excluding posterior composites (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface. restorations), per tooth, per surface every 24 months.
- Pin retention of fillings (multiple pins on the same tooth are allowable as one pin).
- Antibiotic injections administered by a Dentist.
- Periapical x-rays.
- One full mouth or panoramic x-ray per 60 months.

4.3 CLASS III MAJOR RESTORATIVE SERVICES

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

- One study model per 36 months.
- Crown build-up for non-vital teeth.
- Recementing bridges, inlays, onlays and crowns after 12 months of insertion and per 12 months per tooth thereafter.
• One repair of dentures or fixed bridgework per 24 months.
• General anesthesia and analgesia, including intravenous sedation, in conjunction with covered oral surgery or periodontal surgery.
• Restoration services, limited to:
  o Cast metal, stainless steel, porcelain/ceramic, all ceramic and resin-based composite inlay, only, or crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling.
  o Replacement of existing inlay, onlay, or crown, after seven years of the restoration initially placed or last replaced.
  o Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally.
  o Stainless steel crowns.
• Prosthetic services, limited to:
  o Initial placement of removable dentures or fixed bridges.
  o Replacement of removable dentures or fixed bridges that cannot be repaired after seven years from the date of last placement.
  o Addition of teeth to existing partial denture.
  o One relining or rebasing of existing removable dentures per 24 months (only after 24 months from date of last placement, unless an immediate prosthesis replacing at least three teeth).
• Oral surgery, including postoperative care for:
  o Removal of teeth, including impacted teeth.
  o Extraction of tooth root.
  o Alveolectomy, alveoplasty, and frenectomy.
  o Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy.
  o Reimplantation or transplantation of a natural tooth.
  o Excision of a tumor or cyst and incision and drainage of an abscess or cyst.
• Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
  o Root canal therapy (not covered if pulp chamber was opened before effective date of coverage).
  o Pulpotomy.
  o Apicoectomy.
  o Retrograde fillings, per root per lifetime.
• Periodontic services, limited to:
  o Two periodontal maintenance visits, following surgery per Calendar Year (D4341 is not considered surgery).
  o One scaling and root planing per quadrant (D4341 or D4342) per 24 months from age 21.
  o Occlusal adjustment performed with covered surgery.
  o Gingivectomy.
  o Osseous surgery including flap entry and closure.
  o One pedicle or free soft tissue graft per site per lifetime.
  o One appliance (night guards) per five years within six months of osseous surgery.
  o One full mouth debridement per lifetime.

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

4.5 GENERAL EXCLUSIONS

General Exclusions:

We do not cover Services and supplies which:
• Are not provided;
• Are provided without charge or for which you would not be required to pay if you did not have this coverage;
• Are received before the Effective Date of Coverage;
• Are not listed as a Covered Service or relate to complications resulting from a Non-Covered Service;
• Are not furnished by a Qualified Dentist;
• Are provided by or payable under any plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law;
• Are provided while you are confined in a Hospital or institution owned or operated by the United States Government or any of its agencies, except to the extent provided by 38 U. S. C. § 1729 as it relates to non-military Services provided at a Veterans Administration Hospital or facility;
• Are provided while you are in the custody of any law enforcement authorities or while incarcerated;
• Are self-administered, are prescribed by you for your own benefit, or are provided or prescribed by a person who resides in your home or is a member of your family. “Member of your family” for this purpose means any person who could possibly inherit from you under the intestate succession law of any state, plus any in-law, step relative, foster parent, or domestic partner of you or of any such person;
• Are provided for convenience, educational or vocational purposes including, but not limited to, videos and books, educational programs to which drivers are referred by the judicial system, and volunteer mutual support groups;
• Are performed in association with a Service that is not covered under this Plan;
• Are provided for any injury or illness that is sustained by any Member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers’ Compensation Act or similar law is required for the Member. This exclusion also applies to injuries and illnesses that are the subject of a disputed claim settlement or claim disposition agreement under a Workers’ Compensation Act or similar law. This exclusion does not apply to Members who are exempt under any Workers’ Compensation Act or similar law;
• Are payable under any automobile medical, personal injury protection, automobile no-fault, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance makes benefits or Services available to you, whether or not you make application for such benefits or Services and whether or not you are refused payment for failure to satisfy any term of such coverage. If such coverage is required by law and you unlawfully fail to obtain it, benefits will be deemed to have been payable to the extent of that requirement. This exclusion also applies to charges applied to the deductible of such contract or insurance. Any benefits or Services provided under this Plan that are subject to this exclusion are provided solely to assist you and such assistance does not waive our right to reimbursement or subrogation as specified in section 5.3. This exclusion also applies to Services and supplies after you have received proceeds from a settlement as specified in section 5.3.3;
• Are provided for treatment or testing required by a third party or court of law which is not Dentally Necessary;
• Are Experimental/Investigational;
• Are determined by us not to be Dentally Necessary for diagnosis and treatment of a dental condition;
• Have not been Predetermined as required by this Plan;
• Relate to any condition sustained by a Member as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Member, if such Member is convicted of a crime on account of such illegal engagement or act. For purposes of this exclusion, “illegal” means any engagement or act that would constitute a felony or misdemeanor punishable by up to a year’s imprisonment under applicable law if such Member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or a medical condition (i.e., a physical or mental health condition); and
• Relate to a civil revolution, riot, duty as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.

We do not cover:
• Charges that are in excess of Usual, Customary and Reasonable (UCR) costs;
• “Telephone visits” by a physician or “environment intervention” or “consultation” by telephone for which a charge is made to the patient;
• “Get acquainted” visits without physical assessment or diagnostic or therapeutic intervention provided and online treatment sessions;
• Missed appointments;
• Transportation or travel time, food, lodging accommodations and communication expenses;
• Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
• Any vitamins, dietary supplements, and other non-prescription supplements, except as required by federal or Oregon state law;
• Sales taxes, handling fees and similar surcharges, as explained in the definition of UCR.
5. CLAIMS ADMINISTRATION

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

5.1 CLAIMS PAYMENT

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

Explaination of Benefits (EOB)

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

Time Frames for Processing Claims

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

Claims Involving Predetermination (Pre-Service Claims)

- **For services that do not involve urgent dental conditions:** Providence Health Plan will notify your provider or you of its decision within two business days after the Predetermination request is received. If additional information is needed to process the request, Providence Health Plan will notify the provider and the provider will have 45 days to submit the additional information. Within two days of receipt of the additional information, Providence Health Plan will complete its review and notify your provider or you of its decision. If the information is not received within 45 days, the request will be denied.

- **For services that involve urgent dental conditions:** Providence Health Plan will notify your provider or you of its decision within 72 hours after the Predetermination request is received. If Providence Health Plan needs additional information to complete its review, it will notify the requesting provider or you within 24 hours after the request is received. The requesting provider or you will then have 48 hours to submit the additional information. Providence Health Plan will complete its review and notify the requesting provider or you of its decision by the earlier of (a) 48 hours after the additional information is received or, (b) if no additional information is provided, 48 hours after the additional information was due.

Claims Involving Concurrent Care Decisions

If an ongoing course of treatment for you has been approved by Providence Health Plan and it then determines through its dental cost management procedures to reduce or terminate that course of treatment, you will be provided with advance notice of that decision. You may request a reconsideration of that decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. Providence Health Plan will then notify you of its reconsideration decision within 24 hours after your request is received.
5.1.1 Timely Submission of Claims
We will make no payments for claims received more than 365 days after the date of Service. Exceptions may be made if we receive documentation that you lacked legal capacity during that period. Payment of claims submitted by the Oregon state Medicaid agency or a prepaid managed care health services organization described in ORS 414.651 (i.e., a Coordinated Care Organization) will be made in accordance with ORS 743.847, which establishes payment requirements for claims submitted by the Oregon state Medicaid agency.

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

Dental Benefit claims should be submitted to:

Providence Health Plan
251 18th Street South, Suite 900
Arlington, VA 22202

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

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

5.2.1 Definitions Relating to Coordination of Benefits

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

1. Plan includes: group and individual health insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law and group and individual insurance contracts and Subscriber contracts that pay or reimburse for the cost of dental care.

2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare Supplement policies; Medicaid policies; or coverage under any federal governmental plans, unless permitted by law.

Each contract for coverage listed under (1) or (2) above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.
This Plan
This Plan means, as used in this COB section, the part of this contract providing health care benefits to which this COB section applies and which may be reduced because of the benefits of other plans. Any other part of this contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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

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

Allowable expense
Allowable expense means a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering a Member. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering a Member is not an Allowable expense. In addition, any expense that a 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:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

2. If the Member is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

3. If the Member is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

4. If the Member is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan’s payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan’s payment arrangement and if the provider’s contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

5. The amount of any benefit reduction by the Primary plan because the Member has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

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

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

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

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Plan.

B. 

1. Except as provided in Paragraph (2) below, a Plan that does not contain a COB provision that is consistent with the State of Oregon’s COB regulations is always primary unless the provisions of both Plans state that the complying Plan is primary.

2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

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

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

1. Non-Dependent or Dependent. The Plan that covers a Member other than as a Dependent, for example, as an employee, Subscriber or retiree is the Primary plan and the Plan that covers the Member as a Dependent is the Secondary plan. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the Member as a Dependent; and primary to the Plan covering the Member as other than a Dependent (e.g., a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Member as an employee, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Member is a Dependent child covered by more than one Plan the order of benefits is determined as follows:

   a) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

      i. The Plan of the parent whose birthday falls earlier in the Calendar Year is the Primary plan; or

      ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

   b) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

      i. If a court decree states that one of the parents is responsible for the Dependent child’s health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

      ii. If a court decree states that both parents are responsible for the Dependent child’s health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

      iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
iv. If there is no court decree allocating responsibility for the Dependent child’s health care expenses or health care coverage, the order of benefits for the Dependent child are as follows:

- The Plan covering the Custodial parent, first;
- The Plan covering the spouse of the Custodial parent, second;
- The Plan covering the non-custodial parent, third; and then
- The Plan covering the Dependent spouse of the non-custodial parent, last.

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

d) For a Dependent child:

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

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

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a Member as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same Member as a retired or laid-off employee is the Secondary plan. The same would hold true if a Member is a Dependent of an active employee and that same Member is a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a Member whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the Member as an employee, subscriber or retiree or covering the Member as a Dependent of an employee, Subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the Member the longer period of time is the Primary plan and the Plan that covered the Member the shorter period of time is the Secondary plan.

6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than we would have paid had we been the Primary plan.

5.2.3 Effect on the Benefits of This Plan

When This Plan is secondary, we may reduce our benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.
If a Member is enrolled in two or more Closed panel plans and if, for any reason, including the provision of services by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

5.2.4 Right to Receive and Release Needed Information

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

5.2.5 Facility of Payment

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

5.2.6 Right of Recovery

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

5.3 THIRD-PARTY LIABILITY/SUBROGATION

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

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

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

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

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

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

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

5.3.2 Proceeds of Settlement or Recovery

If for any reason we are not paid directly by the third party, we are entitled to reimbursement from the Member or the Member’s heirs, legal representatives, beneficiaries or relatives, and we may request refunds from the dental providers who treated the Member, in which case those providers will bill the Member for their Services. To the fullest extent permitted by law, we are entitled to the proceeds of any settlement, award, verdict, or other payment that results in a monetary recovery from a third party, whether or not responsibility is accepted or denied by the third party for the condition, whether or not such monetary recovery is described by any person as something other than a recovery of dental expenses incurred by us, and whether or not the Member is alleged to have any fault, under principles of comparative negligence or otherwise. With respect to any workers’ compensation recovery, we are entitled to the proceeds whether or not the loss is deemed to be compensable under the workers’ compensation laws. We are entitled to recover up to the full value of the benefits provided by us for the condition, calculated using our UCR charges for such Services, less our pro-rata share of the Member’s out-of-pocket expenses and attorney fees incurred in making the recovery. We are entitled to such recovery regardless of whether the Member has been fully compensated or “made whole” for the loss caused by the third party, and regardless of whether the Member has been partially compensated for such loss. We are entitled to first priority in repayment, over the Member and over any other person, for such charges.

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

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

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

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

Any settlement arising out of an injury or illness covered by this Plan will be deemed first to compensate you for your dental expenses, regardless of any allocation of proceeds in any settlement document that we have not approved in advance. In no event shall the amount reimbursed to us be less than the maximum permitted by law.
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 Network Providers or payment for Services by Out-of-Network Providers, please ask for our help. Customer Service is available to provide information and assistance. You may call us or meet with us at the phone number and address listed on your Member ID Card. If you have special needs, such as a hearing impairment, we will make efforts to accommodate your requirements. Please contact us so we may help you with whatever special needs you may have.

6.2 MEMBER GRIEVANCE AND APPEAL

Definitions:

**Adverse Benefit Determination**
An Adverse Benefit Determination means a:

- Denial of eligibility for or termination of enrollment in this Plan;
- Rescission or cancellation of coverage under this Plan;
- Imposition of a pre-existing condition exclusion, 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 consent of a Member may act on behalf of the Member.

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

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

- In writing, for an internal Appeal or an external review; or in writing or orally, for an expedited response or an expedited external review; or
- A written complaint submitted by a Member or an Authorized Representative of a Member regarding the:
  - Availability, delivery or quality of a health care service;
  - Claims payment, handling or reimbursement for health care services and, unless the Member has not submitted a request for an internal Appeal, the complaint is not disputing an Adverse Benefit Determination; or
  - Matters pertaining to the contractual relationship between a Member and Providence Health Plan.
6.2.1 Your Grievance and Appeal Rights

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

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

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

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

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

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

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

6.2.2 Internal Grievance or Appeal

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

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

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

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

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

6.2.4 Assistance Outside of Providence Health Plan

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 Advocacy Unit
P.O. Box 14480
Salem, OR 97309-0405

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

cp.ins@state.or.us (email)
http://www.oregon.gov/DCBS/insurance/-gethelp/Pages/fileacomplaint.aspx (website)

If your plan is governed by ERISA, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

If your plan is not governed by ERISA, you may contact the Department of Health and Human Services Health Insurance Assistance Team at 1-888-393-2789.
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 on this Plan. You and your Employer must provide us 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; and
2. The individual resides in our Oregon Service Area as stated in section 12; and
3. The individual has been approved by us for enrollment.

7.1.2 Open Enrollment
To request coverage, an Eligible Individual must apply with Providence Health Plan during Open Enrollment. All applications must be submitted by the last day of the Open Enrollment period.

- Plan Year 2017 and 2018: November 1, 2016 through January 31st of the coverage year.
- Plan Years beginning 2019 and after: November 1 of the previous calendar year through January 31 of the current plan year.

For enrollment outside of Open Enrollment, see section 8.4 Special Enrollment.

7.1.3 Effective Date of Coverage
The Effective Date of Coverage is determined by the date Providence Health Plan receives your completed application as well as the date Providence Health Plan receives the initial Premium:

- For applications received November 1st through December 15th, coverage is effective January 1st, provided initial premium is received by January 1st.
- For applications received December 16th through January 31st:
  - For applications received the 1st of the month through the 15th of the month, coverage will be effective the first day of the following month, provided initial Premium is received by the first day of the effective month.
  - For applications received the 16th of the month through the end of the month, coverage will be effective the first day of the second following month, provided initial Premium is received by the first day of the effective month.

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 our Individual Application; and
2. The Dependent resides in our Oregon Service Area, as stated in section 12 (this requirement applies to Spouses and to individuals enrolling in Dependent-only coverage); and
3. The Dependent has been approved by us for enrollment.

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

To obtain coverage, an Eligible Family Dependent must enroll with Providence Health Plan during Open Enrollment. The Effective Date of Coverage is determined by the date Providence Health Plan receives your completed application as well as the date Providence Health Plan receives the initial Premium:

- For applications received November 1st through December 15th, coverage is effective January 1st, provided initial premium is received by January 1st.
- For applications received December 16th through January 31st:
  - For applications received the 1st of the month through the 15th of the month, coverage will be effective the first day of the following month, provided initial Premium is received by the first day of the effective month.
  - For applications received the 16th of the month through the end of the month, coverage will be effective the first day of the second following month, provided initial Premium is received by the first day of the effective month.

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

7.3 NEWBORN AND NEWLY ADOPTED CHILDREN ELIGIBILITY AND ENROLLMENT

A newborn or newly adopted 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 if the newborn or newly adopted child is enrolled and the additional Premium is paid to us within 60 days of the date of birth or placement for adoption. 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 8.2.

7.4 SPECIAL ENROLLMENT

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

Qualifying Events:

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 person’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 person’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 person 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 or placement for adoption.

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.

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, you must submit an application for coverage to Providence Health Plan within 60 days of the Qualifying Event. The Effective Date of Coverage is determined by the Qualifying Event as well as Providence Health Plan’s receipt of the application and initial Premium:

• When the Qualifying Event is birth, adoption, or placement for adoption or foster care; coverage will be effective from date of birth, adoption, or placement for adoption or foster care, provided the application and initial Premium is received within 60 days of birth, adoption, or placement.

• For all other Qualifying Events:
   o If the application is received the 1st of the month through the 15th of the month, coverage will be effective the first day of the following month, provided initial Premium is received by the first day of the effective month.
   o If the application is received the 16th of the month through the end of the month, coverage will be effective the first day of the second following month, provided initial Premium is received by the first day of the effective month.

See section 7.3 for Enrollment and Effective Date of Coverage requirements for newborn and newly adopted children of existing Members.
8. PREMIUMS, RENEWAL, REVISION, TERMINATION AND REVISION

8.1 PREMIUMS

8.1.1 Premium Billing Information
We will send out Premium billing statements on a monthly basis to the Policyholder listing all Members and the amount of Premium due. If you have selected to pay by automatic credit card payment, 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 notify you 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. The Premium may be adjusted to reflect changes in your family composition. The change in Premium shall be effective on the first of the month following the change in family composition.
4. Any change in Premium resulting from an approved plan change, as provided in section 8.2, will become effective on the first day of the month that the plan change becomes effective.

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 within 10 days after the due date, 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. We reserve the right to suspend claims processing for Policyholders whose Premium is delinquent. 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 Oregon Insurance Division 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, 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 Dependent-only coverage ceases to reside in our Oregon Service Area, as described in section 12. The termination of coverage will be effective the last day of the month in which the Member resides in our Oregon Service Area.
4. Upon our discovery of fraud or intentional misrepresentation on the part of the Policyholder or Member.
5. 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.
6. 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.

7. 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 health care providers or organization of health care providers 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.

8. 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 our Members or impair our ability to meet contractual obligations.

9. In the case of a plan that delivers Covered Services through a network of Network Providers, when we no longer have any Members living, residing or working 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 Oregon 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 reside in our Oregon Service Area, as stated in section 12;
5. For a Dependent child enrolled on a Dependent-only Plan, the last day of the month in which the child ceases to reside in our Oregon 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; and
7. For a Family Member, the last day of the month in which the individual no longer qualifies as an Eligible Family Dependent.

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

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

**8.3.2 Disenrollment from this Dental Contract**

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

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

**8.3.3 Termination and Rescission of Coverage Due to Fraud or Abuse**

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

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

8.3.4 Non-Liability After Termination
Upon termination of this Dental Contract, we shall have no further liability beyond the effective date of the termination unless the Member continues, without lapse of membership, under another Providence Health Plan.

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

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

9.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES

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

Members have the right to:

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

Members have the responsibility to:

- Read and understand the information in and the terms of your Plan. We will have no liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact us. We will assist you in understanding and complying with the terms of the Plan.
- Talk openly with your provider, understand your health problem and work toward a relationship built on mutual trust and cooperation.
- Develop mutually agreed upon treatment goals with your Qualified Practitioner, to the degree possible, and follow treatment plans and instructions.
- Supply to the extent possible information 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 providers 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 providers and Services.
- Contract with providers 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 Network Providers.
- 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 providers 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 Employer 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 is 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 Network Providers 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 Network Providers 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 Network Providers for any such sums. The Employer further acknowledges that the hold harmless agreements described in this section do not prohibit Network Providers 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 the Dental Contract. Such right to benefits is nontransferable.

10.13 NONWAIVER

No delay or failure when exercising or enforcing any right under the Dental Contract shall constitute a waiver or relinquishment of that right, and no waiver or any default under this contract shall constitute or operate as a waiver of any subsequent default. No waiver of any provision of the 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 RECOUSE 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 the 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. Notice of termination of health insurance coverage will not be sent by electronic means. Any notice required of you shall be deemed sufficient if mailed by postal or electronic means to the principal office of Providence Health Plan, P.O. Box 3125, Portland, OR 97208 or via the contact link provided on our website at www.ProvidenceHealthPlan.com.
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 the 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 Member Handbook.

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

**Adverse Benefit Determination**
See section 6.

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

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

**Annual**
Annual means once per Calendar Year.

**Appeal**
See section 6

**Authorized Representative**
See section 6.

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

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

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

**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. Your Coinsurance will usually be less when you receive Covered Services from a Network Provider.

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

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

**Copayment**
Copayment means the dollar amount that you are responsible to pay to a health care provider when you receive certain Covered Services, as shown in the Benefit Summary.
Cosmetic Services
Cosmetic Services means Services or surgery performed to reshape structures of the body in order to improve your appearance or self-esteem.

Covered Service
Covered Service means a Service that is:
1. Listed as a benefit in the Benefit Summary and in section 4;
2. Dentally Necessary;
3. Not listed as an Exclusion in the Benefit Summary or in section 4; and
4. Provided to you while you are a Member and eligible for the Service under the Dental Contract.

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

Curettage
Curettage means the scraping.

Deductible
See section 3.7.1.

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

Dental Emergency
See section 3.3.

Dentally Necessary
Dentally Necessary means Services that are in the reasonable opinion of Providence Health Plan, consistent with the written criteria regarding dentally indicated Services that are maintained by us. The criteria are based on the following principles:
1. The Service is dentally indicated according to the following factors:
   a. The Service is necessary to diagnose or to meet the reasonable dental health needs of the Member;
   b. The expected dental health benefits from the Service are dentally significant and exceed the expected health risks by a significant margin;
   c. The Service is of demonstrable value and that value is superior to other Services and to the provision of no Services; and
   d. Expected dental health benefits can include:
      o Repaired or Improved functional capacity;
      o Prevention of complications; or
      o Relief of pain.
2. The Dentists recommends the Service.
3. The Service is rendered in the most cost-efficient manner and type of setting consistent with nationally recognized standards of dental care, with consideration for potential benefits and harms to the patient.
4. The Service is consistent in type, frequency and duration with scientifically based guidelines of national dental, research, or dental care coverage organizations or governmental agencies that are accepted by us.
5. The Service is the least costly of the alternative services or supplies that can be safely provided.
**Dentist**
Dentist means a doctor of dental science (DDS), a doctor of medical dentistry (DMD), or an Expanded Practice Dental Hygienist (EPDH) who is professionally licensed by the appropriate governmental agency to diagnose or treat dental conditions and who provides Covered Services within the scope of that license.

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

**Dependent**
Dependent means a person who is supported by the Subscriber, or supported by the Subscriber’s Spouse or Domestic Partner. See also Eligible Family Dependent.

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

**Director**
Director means the director of the Oregon Division of Financial Regulation.

**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 the 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 the Dental Contract commences for a Member.

**Eligible Family 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) A biological child, step-child, or legally adopted child;
   b) An unmarried grandchild for whom the Policyholder or Spouse provides at least 50% support;
   c) A child placed for adoption with the Policyholder or Spouse;
   d) 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
   e) 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 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 (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption). Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.

The limiting age for each Dependent child who is enrolled as an Eligible Family Dependent is age 26 and such Members shall become ineligible for coverage under this Contract on the last day of the month in which their 26th birthday occurs, except:
• When an Eligible Family Dependent is enrolled on a Dependent-only Plan, the limiting age is 20, and such a Member shall become ineligible for coverage under this Contract on the last day of the month in which their 21st birthday occurs.

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

A covered Dependent child who attains the limiting age remains eligible if the child is:
1. Developmentally or physically disabled;
2. Incapable of self-sustaining employment; and
3. Unmarried.

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

**Endorsement**

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

**Experimental/Investigational**

Experimental/Investigational means those Services that are determined by us not to be Dentally Necessary or accepted dental practice in the Service Area, including Services performed for research purposes. In determining whether Services are Experimental/Investigational, we will consider whether the Services are in general use in the dental community in the U.S.; whether the Services are under continued scientific testing and research; whether the Services show a demonstrable benefit for a particular illness or disease; whether they are proven to be safe and efficacious; and whether they are approved for use by appropriate governmental agencies. We determine on a case-by-case basis whether the requested Services will result in greater benefits than other generally available Services, and will not approve such a request if the Service poses a significant risk to the health and safety of the Member. We will retain documentation of the criteria used to define a Service deemed to be Experimental/Investigational and will make this available for review upon request.

**Family Member**

Family Member means an Eligible Family Dependent who is properly enrolled in and entitled to Services under the Dental Contract. A Dependent-only Family Member means an Eligible Family Dependent, of a non-enrolled Policyholder, who is under age 21 when enrollment commences in this Contract.

**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 a Network Provider.

**Ineligible Person**

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

**Maximum Benefit**

See section 3.7.2.

**Member**

Member means a Policyholder or Eligible Family Dependent, who is properly enrolled in and entitled to Services under the Dental Contract.
**Network Dentist**
Network Dentist shall means a Dentist that has contracted with the Plan to provide dental services at negotiated fees for Members of the Plan. Network Dentists are not employers of nor supervised by the Plan.

**Out-of-Network**
Out-of-Network means the level of benefits specified in the Benefit Summary for Covered Services provided by Out-of-Network Providers.

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

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

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

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

**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 one child who is under age 21, the adult person who applied for such coverage shall be deemed to be the Policyholder until such child reaches the age of 21 when this Dental Contract shall be reissued to show the 21 year old Member as the Policyholder.

**Predetermination of Benefits**
Predetermination of Benefits means a request to us or our authorizing agent by you or by a Qualified Practitioner regarding proposed services in excess of $300, for which our prior approval is required. Predetermination review will determine if the proposed service is eligible as a Covered Service or if an individual is a Member at the time of the proposed service. To facilitate our review of the Predetermination request, we may require additional information about the Member’s condition and/or the Services requested. We may also require that a Member receive further evaluation from another provider of our choosing. Predetermination is subject to the terms and provisions of the Dental Contract.

Predeterminations are not a guarantee of benefit payment unless:

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

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

**Prophylaxis**
Prophylaxis means the cleaning and polishing of teeth.
**Providence Health Plan**
Providence Health Plan means the nonprofit corporation authorized as a health care service contractor in the states of Oregon that issues the Dental Contract to the Policyholder.

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

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

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

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

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

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

**Service Area**
See section 12.

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

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

When a Service is provided by an Out-of-Network Provider, UCR charges will be determined, in Providence Health Plan’s reasonable discretion, based on the lesser of:
1. The fee a we have negotiated with Network Providers for a given Service;
2. A fee which falls within the range of usual charges for a given Service billed by most professional providers in the same locality or region who have similar training and experience;
3. A fee which is prevalent or which would not be considered excessive in a particular case because of unusual circumstances; or
4. The fee determined by comparing charges for similar Services to a regional or national database adjusted to the geographical area where the Service was performed.

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

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

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

Oregon Service Area:

All ZIP codes in all Oregon counties.
Customer Service: 503-574-7500 or 800-878-4445
Sales: 503-574-6300 or 877-245-4077
www.ProvidenceHealthPlan.com
**Non-discrimination Statement**

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

Providence Health Plan and Providence Health Assurance:

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

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

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

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

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at [https://ocrportal.hhs.gov/ocr/portal/lobby.jsf](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  
1-800-868-1019, 1-800-537-7697 (TTY)

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

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

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

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

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

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

УВАГА! Якщо ви говорите на українській мові, вам доступні безкоштовні служби перекладу. Звертайтеся за номером 1-800-878-4445 (Телетайп: 711).

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

MLHOVÁZIE: Čiže konáte slovenščina, máte k dispozici bezplatné služby překladu. Zavolejte na číslo 1-800-878-4445 (TTY: 711).

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

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


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