LifeMap Assurance Company®
200 SW Market Street
P.O. Box 1271, M/S E8L
Portland, OR 97207
(800)794-5390

INDIVIDUAL EXCLUSIVE PROVIDER ORGANIZATION DENTAL 16 INSURANCE FOR OREGON INDIVIDUALS AND FAMILIES

This Outline of Coverage is designed to give you a very brief description of the important features of the policy.

PLEASE READ YOUR POLICY CAREFULLY

This outline of coverage provides a very brief description of the important features of the Policy. Please note that this outline is not intended to be a part of the insurance contract. Only the actual policy provisions are final and binding. Please refer to the Policy for a detailed description of the rights and obligations of both you and LifeMap Assurance Company.

Dental care is a vital part of maintaining and improving overall health for both children and adults. Dental disease is chronic, progressive and, at times, painful. It is also highly preventable and maintainable with routine care. Routine dental care is essential for a healthy lifestyle which is why LifeMap's Individual Exclusive Provider Organization Dental plan is available to you and your family.

How the Policy Works

Under this individual dental plan, your dental care is coordinated to ensure that your expenses stay as low as possible through cost-effective dental care and an emphasis on prevention to help avoid more costly care later.

With LifeMap's Individual Exclusive Provider Organization Dental plan, you'll work with Participating Providers to maintain your oral health and enhance your overall health through routine exams and other preventive care. In order to take advantage of the benefits of this plan, you must receive your dental care from a Participating Provider.

For the purposes of this plan, Participating Providers include Willamette Dental Group, P.C. and the providers who are employed by or are under contract with Willamette Dental Group, P.C.

Scheduling Appointments

Scheduling an appointment is simple. Please contact the Participating Provider's Appointment Center at 1.855.4DENTAL for information regarding the next available appointment that meets your scheduling needs.

You are free to select your Willamette Dental Group dentist and whichever location is best for you. You can find office locations and driving directions at www.willamettedental.com. Most Participating Provider offices are open Monday through Friday and select Saturdays. The length of wait-time for an appointment may vary based on choice of provider, dental office location, appointment type and desired day or time of appointment.

If you are unable to keep an appointment, please call the Appointment Center as soon as your plans change to reschedule your dental appointment.

OUTLINE OF COVERAGE

Eligibility
Eligible Dependents include your Spouse and you or your Spouse's Dependent Children under age 26.

Benefits
The Member is responsible for payment of the Visit Charge and any applicable Service Copays at the time of treatment. Please see the Schedule of Covered Services and Copays in the Policy for a complete description of the Covered Services provided by the Policy and the applicable Service Copays.

Visit Charge
The dollar amount that is the Member's responsibility to pay for each visit to a Participating Provider. All Visit Charges are paid directly to the Participating Provider at the time of the visit. In addition to the Visit Charge, the Member may be responsible to pay a Service Copay for procedures as specified in the Schedule of Covered Services and Copays.

Service Copay
The amount that will be the Member's responsibility to pay for each Covered Service received under the Policy as specified in the Schedule of Covered Services and Copays. All Service Copays amounts are paid directly to the Participating Provider at the time of the visit. The Service Copay is flat dollar amount in addition to the Visit Charge.

Summary of Benefits

Benefit Waiting Period

No Benefit Waiting Period for Diagnostic, Preventive or most Restorative Services.

6 month Benefit Waiting Period for all Orthodontic Services, Inlay/Onlay Restorative Services and some Major Services, including Permanent Crowns and some Prosthetic Services.

See the Schedule of Covered Services and Copays in the Policy for more information.

Annual Maximum

No Annual Maximum

Deductible

No Deductible

Visit Charge

$35 per visit

Service Copay

A summary of Covered Services and Service Copay amounts is included in this Outline of Coverage.

For a complete list of the Covered Services and the applicable Service Copay amount, please see the Schedule of Covered Services and Copays in the Policy.

SUMMARY OF COVERED SERVICES AND COPAYS

This is a brief summary of Benefits. For full coverage provisions including a complete list of Covered Services and Exclusions, please refer to the Policy.

	COPAYS
General or Specialty Office Visit	You pay $35 Copay per visit
DIAGNOSTIC AND PREVENTIVE SERVICES	
Routine and Emergency Exams	Covered with the Office Visit Copay
X-rays	Covered with the Office Visit Copay
Teeth Cleaning	Covered with the Office Visit Copay
Fluoride Treatment	Covered with the Office Visit Copay
Sealants (per Tooth)	Covered with the Office Visit Copay
Periodontal Charting and Evaluation	Covered with the Office Visit Copay
RESTORATIVE DENTISTRY	
Fillings (Amalgam)	You pay a $45 Copay
Porcelain-Metal Crown	You pay a $500 Copay [1]
PROSTHODONTICS	
Complete Upper or Lower Denture	You pay a $600 Copay [1]
Bridge (per Tooth)	You pay a $500 Copay [1]
ENDODONTICS AND PERIODONTICS	
Root Canal Therapy – Anterior	You pay a $225 Copay
Root Canal Therapy – Bicuspid	You pay a $325 Copay
Root Canal Therapy – Molar	You pay a $425 Copay
Osseous Surgery (per Quadrant)	You pay a $325 Copay
Root Planing (Per Quadrant)	You pay a $100 Copay
ORAL SURGERY	
Routine Extraction (Single Tooth)	You pay a $75 Copay
Surgical Extraction	You pay a $190 Copay
ORTHODONTIA TREATMENT	
Pre-Orthodontia Treatment	You pay a $150 Copay [1, 2]
Comprehensive Orthodontia Treatment	You pay a $3,000 Copay [1]
MISCELLANEOUS	
Local Anesthesia	Covered with the Office Visit Copay
Dental Lab Fees	Covered with the Office Visit Copay
Nitrous Oxide	You pay a $40 Copay
Out of Area Emergency Care Reimbursement	You pay charges in excess of $100

[1] Benefit available after a six-month Benefit Waiting Period.

[2] Applies toward Comprehensive Orthodontia Copay if Member accepts treatment plan.

Optional Vision Benefits Rider

You may elect to include Vision Benefits along with your dental coverage. The Vision Benefit reimburses up to $150 per member for vision exams and/or hardware every 24 months.

EXCLUSIONS

Your Policy does not cover:

- **Aesthetic Dental Procedures** and complications arising out of such services
- **Benefits not stated**
- **Charges by any person other than a Participating Provider**, except as otherwise indicated in the Policy
- **Cosmetic/Reconstructive Services and Supplies** (certain exceptions apply)
- **Coverage available under any federal, state, or other governmental program**, except where required by law
- **Dental services which are not Necessary Dental Services**
- **Diagnostic Casts or Study Models**
- **Endodontics**, **bridges, crowns, and other prosthetic devices or services** if treatment was started or ordered prior to the Member's effective date or delivered more than 60 days after the Member's coverage under the Policy has terminated.
- **Excision of a tumor; biopsy of soft or hard tissue; removal of a cyst**
- **Experimental/Investigational** treatments, procedures, services and supplies
- **Extraction of permanent teeth** for tooth guidance procedures; procedures for tooth movement
- **Full-mouth reconstruction**
- **General Anesthesia**
- **Habit-breaking or Stress-Breaking Appliances**
- **Hospitalization** for dentistry
- **Maxillofacial prosthetic services**
- **Medication and Supply Charges**
- **Military Service-Related Conditions**
- **Motor Vehicle Coverage and Other Insurance Liability**
- **Non-Direct Patient Care**
- **Occlusal Treatment** including complete occlusal adjustments and occlusal guards
- **Personalized restorations, precision attachments, and special techniques**
- **Repair or replacement of lost, stolen, or broken items**
- **Replacement of sound restorations**
- **Services and supplies for treatment of an illness or injury caused by Riot, Rebellion, War and Illegal Acts**
- **Services for accidental injury to natural teeth that are provided more than 12 months after the date of the accident**
- **Services or supplies and related exams or consultations that are not within the prescribed treatment plan** and/or are not recommended and approved by a Participating Provider
- **Services or supplies where there is no evidence of pathology, dysfunction, or disease**
- **Temporomandibular Joint (TMJ) Dysfunction Treatment**
- **Transseptal fiberotomy**
- **Treatment started prior to the Member's Effective Date under the Policy or completed after the Policy terminates**
- **Work-Related Injuries**

INDIVIDUAL INCENTIVE 10 DENTAL INSURANCE
OUTLINE OF COVERAGE

ELIGIBILITY
Eligible Dependents include your Spouse and your unmarried Dependent Children under age 26.

DEDUCTIBLES
An annual $50 Deductible applies individually to each member before benefits are paid, except that the Deductible is waived for cleanings and exams covered under Preventive Dental Services in the Policy.

WAITING PERIOD
This policy does not have a Benefit Waiting Period for Preventive Dental Services. There is a 6 month Benefit Waiting Period for Restorative Dental Services and a 12 month Benefit Waiting Period for Major Dental Services. The Benefit Waiting Period is the continuous length of time a member must be covered under the Policy before becoming eligible for benefits.

COINSURANCE
After the annual Deductible is met, we pay a percentage of the Allowed Amount as shown below.

	LEVEL 1	LEVEL 2	LEVEL 3
Preventive Dental Services	80%	90%	100%
Restorative Dental Services	60%	70%	80%
Major Dental Services	30%*	40%	50%

* There is a 12 month Benefit Waiting Period for Major Dental Services. The 30% Coinsurance for Major Dental Services shown under benefit level 1 is only payable if a member fails to receive the required cleaning and oral evaluation during the first benefit year, and thus benefits remain at level 1 during the second benefit year or thereafter.

BENEFIT MAXIMUM
The maximum benefit payable each year per member is shown below.

LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
$750	$1,000	$1,250	$1,500

Please note that the benefit levels will increase on the anniversary date of the Policy only if the member receives at least one dental cleaning and one periodic or comprehensive oral evaluation during the prior benefit year. In no event will the benefit level increase by more than one level each benefit year.

COVERED SERVICES

Covered Services are those services or supplies that are required to prevent, diagnose, or treat diseases or conditions of the teeth and supporting tissues and are Dentally Appropriate. These services must be performed by a Dentist or other provider practicing within the scope of his or her license.

Subject to the limitations and conditions described in the Policy, the following will be considered covered services under your policy:

Preventive Dental Services

- **Cleanings** allowed two per benefit year (In no Benefit Year will any Member be entitled to more than 2 cleanings whether cleanings or periodontal maintenance. Please note: periodontal maintenance is covered under Major Dental Services)
- **Oral exams** allowed two per benefit year)
- **Fluoride Treatment** allowed two applications per benefit year for members age 17 and under
- **X-rays** bitewings: allowed one set limited to twice per benefit year; panoramic and full mouth series: limited to once every three years
- **Sealants** allowed for permanent bicuspid and molars for members age 17 and under
- **Space Maintainers** allowed for members age 11 and under

Restorative Dental Services

- **Fillings** composite and amalgam
- **Emergency treatment** for pain relief only
- **Oral surgery** including surgical extractions, removal of teeth, biopsies and incision and drainage
- **General anesthesia or intravenous sedation** allowed for surgical extractions of teeth or to safeguard the Member’s health
- **Direct pulp capping**

Major Dental Services

- **Crowns or onlays and related services**
- **Bridges (fixed partial dentures)** limited to one in a 7-year period
- **Dentures (full or partial) and related services**
- **Endosteal Implants and related services** implants are limited to 4 per lifetime per member
- **Endodontics** including root canal treatment, pulpotomy, apicoectomy
- **Periodontal Maintenance** allowed two per benefit year (In no Benefit Year will any Member be entitled to more than 2 cleanings whether periodontal maintenance or cleaning)
- **Gingivectomy and gingivoplasty** allowed once every three years per quadrant
- **Osseous and mucogingival surgery** allowed once every five years per quadrant
- **Debridement** allowed once every 3 years
- **Scaling and root planing** allowed once every two years per quadrant

Replacement of prosthetics is limited to once in a seven year period from the date of the most recent placement.

OPTIONAL VISION BENEFITS RIDER

You may elect to include Vision Benefits along with your dental coverage. The Optional Vision Benefit reimburses up to $150 per member for vision examinations and/or hardware every 24 months.

EXCLUSIONS

Your Policy does not cover:

- Additional procedures to construct new crown under existing partial denture framework
- Aesthetic Dental Procedures including bleaching of teeth and labial veneers
- Application of desensitizing resin for cervical and/or root surface
- Collection of cultures and specimens
- Connector bar or stress breaker
- Cosmetic/Reconstructive Services and Supplies (certain exceptions apply)
- Diagnostic casts or study models
- Duplicate x-rays
- Experimental/Investigational treatments, procedures and services and supplies
- Endodontic endosseous implants
- Expenses payable by motor vehicle insurance or other liability insurance coverage
- Exfoliate cytology sample collection or brush biopsy
- Fees, Taxes, Interest
- Gold foil restorations
- Home Visits
- Hospitalization for dentistry
- Implant maintenance procedures, including: removal of prosthesis, cleansing of prosthesis and abutments, reinsertion of prosthesis
- Incision and drainage of abscess extraoral soft tissue, complicated or non-complicated
- Indirect pulp capping
- Interim partial or complete dentures
- Local anesthesia, sterilization, and supplies billed as separate charges (these procedures are considered inclusive of billed procedures)
- Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue per tooth
- Maxillofacial prosthetic procedures
- Military Service Related Conditions: Any condition resulting from military service in the armed forces of any country
- Modification of removable prosthesis following implant surgery
- Nitrous oxide
- Non-direct patient care
- Occlusal analysis, adjustments and guards
- Oral/facial photographic images
- Orthodontic services, including craniomandibular orthopedic treatment; procedures for tooth movement, regardless of purpose; correction of malocclusion; preventive orthodontic procedures; and other orthodontic treatment
- Pediatric dentures
- Pin retention in addition to restoration
- Precision attachments
- Prescription drugs, including take home prescription drugs, pre-medications, therapeutic drug injections, or supplies
- Provisional splinting
- Pulp vitality tests
- Radical resection of maxilla or mandible

EXCLUSIONS *(cont.)*

- Radiographic/surgical implant index
- Removal of nonodontogenic cyst, tumor or lesion
- Replacement of lost, stolen or broken dental appliances
- Self-Help, Non Dental Self-Care, Training, or Instructional Programs
- Services and Supplies provided by a Family Member: Services and supplies provided to a member by an immediate family member
- Surgical procedures for isolation of a tooth with rubber dam
- Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)
- Treatment for an illness or injury caused by a member's unlawful instigation and/or active participation in a riot, rebellion, war or illegal act
- Treatment of simple or compound fractures of the mandible
- Treatment of Temporomandibular Joint Dysfunction
- Unspecified implant procedures
- Work-related injuries

If you have any questions, please call toll-free 1-800-756-4105.

Keep this brochure for your records.

INDIVIDUAL DOLLAR-BASED DENTAL INSURANCE
OUTLINE OF COVERAGE

ELIGIBILITY
Eligible dependents include your Spouse and your unmarried dependent children under age 26.

WAITING PERIOD
This policy has a 6 month benefit waiting period. The benefit waiting period is the continuous length of time a member must be covered under the policy before becoming eligible for benefits.

COVERED SERVICES
Covered Services are those services or supplies that are required to prevent, diagnose, or treat diseases or conditions of the teeth and supporting tissues and are dentally appropriate. These services must be performed by a dentist or other provider practicing within the scope of his or her license.

COINSURANCE BENEFIT	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
100% OF THE FIRST	$150	$150	$150	$150
80% OF THE NEXT	$500	$500	$500	$500
50% OF THE NEXT	$400	$900	$1,400	$1,900

BENEFIT YEAR MAXIMUM	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
	$750	$1,000	$1,250	$1,500

Please note that the benefit levels will increase on the anniversary date of the policy only if the member receives at least one dental cleaning and one periodic or comprehensive oral evaluation during the prior benefit year. In no event will the benefit level increase by more than one level each benefit year.

OPTIONAL VISION BENEFITS RIDER
You may elect to include Vision Benefits along with your dental coverage. The Optional Vision Benefit reimburses up to $150 per member for vision examinations and/or hardware every 24 months.

EXCLUSIONS
Your policy does not cover:

- Aesthetic dental procedures such as bleaching of teeth and labial veneers
- Orthodontic services, including craniomandibular orthopedic treatment; procedures for tooth movement, regardless of purpose; correction of malocclusion; preventive orthodontic procedures; and other orthodontic treatment
- Expenses payable by motor vehicle insurance or other liability insurance coverage
- Treatment of an illness or injury caused by a Member's unlawful instigation and/or active participation in a Riot, Rebellion, War or Illegal Act
- Work-related injuries

If you have any questions, please call toll-free 1-800-756-4105.
Keep this brochure for your records

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LifeMap®
Insurance for every step of life.

LifeMap Assurance Company
00 SW Market Street
P.O. Box 1271, MS E-8L
Portland, OR 97207-1271
(800) 756-4105

Individual Dental Application Checklist

Please review the following checklist before submitting your application

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- Please confirm that the application and rate page (found separately) you are using has a 5/16 in the lower right corner. If not, contact our Customer Service Department at 1(800) 756-4105.

- On the Application have you:
  - ☐ Indicated your requested effective date?
  - ☐ Completed all personal information, including mailing address and e-mail?
  - ☐ Selected which Policy you are applying for?
  - ☐ Selected to add or decline the option of a Vision Rider?
  - ☐ Selected a Premium Payment Schedule?
  - ☐ Entered the total premium due based on family status of members enrolling?
  - ☐ Signed and dated the application?

- With your completed, signed and dated Application, please return to LifeMap:
  - ☐ Your check or money order for full premium due plus the $25.00 application fee

- Please keep for your records:
  - ☐ The Outline of Coverage
  - ☐ The Fraud Notice
  - ☐ The Notice of Privacy Practices

Please note: missing information or inadequate premium may cause a delay or denial of your application for coverage.

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You may enroll for Dental Only Coverage or Dental with Vision Coverage.
All members must be enrolled for the same coverage and premium payment schedule.

I am making application for:

☐ **DOLLAR-BASED DENTAL INSURANCE**
NOTE: This coverage has a **6 MONTH BENEFIT WAITING PERIOD (BWP)*** for **ALL SERVICES**.

☐ **INCENTIVE 10 DENTAL INSURANCE**
NOTE: This coverage has a **6 MONTH BWP*** for **RESTORATIVE SERVICES and a 12 MONTH BWP* for MAJOR SERVICES**

☐ **EXCLUSIVE PROVIDER ORGANIZATION DENTAL INSURANCE** (Services **must** be performed by a Participating Provider, please see the Outline of Coverage and Policy for more information.)
NOTE: This coverage has a **6 MONTH BWP*** for **All ORTHODONTIC and SOME MAJOR SERVICES**

*The **BENEFIT WAITING PERIOD** is the continuous length of time the member must be covered under the Policy before becoming eligible for benefits.

Add Vision Rider?	**Premium Payment Schedule:**
☐ **Yes** ☐ **No**	☐ **Monthly** ☐ **Quarterly**

Premium Calculation for Dollar Based and Incentive 10 Dental

	Number enrolling for coverage		Enter Monthly or Quarterly Premium Rate per Member		
Under Age 18	____________	x	$____________________	=	= $__________________
Age 18 through age 64	____________	x	$____________________	=	= $__________________
Age 65 and over	____________	x	$____________________	=	= $__________________

Total Monthly or Quarterly Premium Rate $ __________________

Premium Calculation for Exclusive Provider Organization Dental

Family Status of Member(s) enrolling:

☐ Individual ☐ Individual & Spouse ☐ Individual & Child(ren) ☐ Family

Total Monthly or Quarterly Dental Only or Dental with Vision Premium Rate$ ________________

Your 1st premium payment must be enclosed with this Application.

Total Monthly or Quarterly Premium Rate $ _________

+ Policy Fee $_25.00_

= **Total Due $**_____________ **(Enclosed)**

Other coverage information - This is not a waiver of coverage. This information is required for payment of claims.

<table>
<tr><td colspan="2">Name of Family Member with other coverage</td><td>Relationship</td></tr>
<tr><td>Name of Insurance Carrier</td><td>Policy No.</td><td>ID No.</td></tr>
<tr><td colspan="2">Address of Other Carrier City State Zip</td><td>Carrier Phone No.
(   )</td></tr>
<tr><td colspan="2">This plan covers (check all that apply): ☐ Self ☐ Spouse ☐ Child(ren)
☐ Family as listed above ☐ Other ______________________________</td><td>Termination Date
(if applicable)</td></tr>
<tr><td colspan="3">Is the coverage of any dependent affected by a divorce decree/court order? ☐ Yes ☐ No
If yes, please include portion of decree that shows responsibility for health expenses.</td></tr>
</table>

I hereby apply for enrollment with LifeMap Assurance Company under the Individual Dental Insurance plan. I acknowledge and understand LifeMap Assurance Company and the Participating Provider may request or disclose health information about me or my dependents (persons who are listed for benefit coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.

Health information requested or disclosed may be related to treatment or services performed by:

- a physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- a clinic, hospital, long-term care or other medical facility;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or
- an insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

DISCLOSURE: If you have an insurance producer, they may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from LifeMap Assurance Company. Incentives may be based on any of several factors including the products you buy, your insurance producer's volume of business with LifeMap Assurance Company and the other services your insurance producer provides to you. These incentives may have a direct or indirect impact on your rates. For more information, please contact your broker or agent.

INSURANCE FRAUD WARNING: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

I represent that each of the above statements and answers are complete and true to the best of my knowledge and belief. I understand that if I have made intentionally false or misleading statements or answers on behalf of myself or any family members that all entitlements to benefits are void and the contract may be canceled or modified retroactively to its effective date.

▶ ____ ____
Insured's Signature Parent's or Guardian's Signature

▶ __________________________ __________________________ __________________________________
Date Signed Insurance Producer Number Insurance Producer Name (Please Print)

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NOTICE OF PRIVACY PRACTICES

THE FOLLOWING NOTICE APPLIES TO ALL SHORT TERM MEDICAL, VISION, AND DENTAL POLICIES.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

We, at LifeMap Assurance Company (LifeMap), know you value your privacy. That is why we are committed to the confidentiality and security of your personal information. We maintain physical, administrative and technical safeguards to protect against unauthorized access, use, or disclosure of your personal information, including information we share internally either orally, electronically, or in writing.

We collect personal information, such as your name, contact information, and health information, from you, your health care providers, and other insurers that provide you coverage. We are required by law to maintain the privacy of this information and to explain our legal duties and privacy practices. We are also required by law to notify affected individuals following a breach of unsecured protected health information. We provide the protections and apply the practices described in this notice to all personal information that we maintain, including to personal information of former members who are no longer covered by us. We hope this notice will clarify our responsibilities to you and give you an understanding of your rights. We are required to abide by the notice that is currently in effect. This notice is in effect as of August 7, 2013.

Your Rights

You may exercise the following rights by calling our Customer Service department or writing our Privacy Official. See “Contacting Us” at the end of this notice.

Inspection and Copies. You have the right to request an inspection or copies of protected health information that we maintain about you in a “designated record set” except psychotherapy notes and information that we compiled in anticipation of, or for use in, a civil, criminal, or administrative proceeding. A “designated record set” is a group of records that is used to administer your health benefits, including enrollment information and claims. We may limit the information that you can inspect or copy if we have reason to believe that is necessary to protect you or another person from harm. If we limit your right to inspect or copy, you can ask for a review of that decision.

Amendment. If you believe that protected health information we maintain about you in a designated record set is inaccurate or incomplete, you have the right to request an amendment to correct or complete the information. You must submit your request in writing and explain the reason for the amendment. If the amendment is made, we will make reasonable efforts to inform others, including people you identify, that the information has been amended and we will use our best efforts to include the amendment with any future disclosure. We may decline to

amend information under certain circumstances. This is likely to occur if we did not create the original record. If we decline to amend the information, you have the right to submit a statement of disagreement. You should know that we are allowed to attach a rebuttal statement in response to your statement of disagreement.

Notice. You have the right to receive a paper copy of this notice upon request.

Accounting. You have the right to request a list of certain disclosures of protected health information. The list will not include disclosures made for treatment, payment, or health care operations. It also will not include disclosures made pursuant to an authorization, made more than six years before the date of the request, incidental disclosures, disclosures made for national security or intelligence, or disclosures made to a correctional facility. The list will include the date of any accountable disclosure, to whom that disclosure was made, a brief description of the information disclosed, and the purpose for that disclosure (provided this information is known to us). We will supply this list free of charge once a year at your request. If you request an accounting more than once in a 12-month period, we may charge a reasonable fee.

Special Handling. You have the right to request restrictions on our use or disclosure of protected health information in addition to the restrictions imposed by law. We are not required to agree to your request and we may be unable to do so. If we do agree, we will comply with your request except in the case of emergency. You also have the right to request that we communicate with you in confidence with respect to communications you believe may endanger you. We will make every effort to accommodate your request if it is reasonable and you provide an alternate means to communicate. You should know that redirecting communication may not prevent others on your policy from discovering that you sought medical care. Accumulated deductibles and co-payment information may reveal that you obtained services. In addition, historic claims reports may include services that were obtained during the time communications were redirected.

Complaints. You have the right to submit a complaint if you believe we have violated your privacy rights. To submit a complaint, write to: LifeMap, Privacy Office, P.O. Box 1271, Mailstop E12P, Portland, OR 97207 or call our Customer Service department at the phone number provided at the end of this notice. You also have the right to submit a complaint to the Secretary of the U.S. Department of Health & Human Services. Be assured that we will not retaliate against you for submitting a complaint.

Permitted Uses and Disclosures

To administer health benefits, we collect, use and disclose protected health information for a variety of purposes:

Treatment. We may disclose protected health information to a health care provider in order for the provider to treat you. We may also use or disclose protected health information to support a provider's activities to furnish preventive health, early detection, and case management programs.

Payment. We may use or disclose protected health information for payment purposes, including to adjudicate claims, issue Explanation of Benefits, or coordinate benefits with other entities responsible for paying your claims.

Health Care Operations. We may use or disclose protected health information to facilitate operations, including underwriting, customer service, and detection or prevention of fraud or abuse. We may not, however, use or disclose genetic information for underwriting purposes.

Business Associates. Occasionally, we contract with business associates to perform insurance-related functions on our behalf. We may disclose protected health information to these business associates in order to allow them to perform these functions. They also may collect, use or disclose protected health information on our behalf. We contractually obligate our business associates and they are required by law to provide the same privacy protections that we provide.

Employers and Other Plan Sponsors. If you are enrolled in an employer-sponsored group health plan (or a group health plan sponsored by another entity), we may disclose protected health information to the group health plan or plan sponsor to facilitate administration of the plan. For example, we supply enrollment lists to employers so that premiums can be paid appropriately. When we provide your personal information to your employer or other plan sponsors we comply with the required safeguards to protect your information.

As Permitted or Required by Law. We use or disclose protected health information as permitted or required by law. For example, some laws permit or require us to disclose protected health information for workers' compensation programs or to certain government agencies, such as the Food and Drug Administration.

Public Health Activities. We may disclose protected health information to: (a) public health agencies for the prevention and control of disease; (b) coroners or medical examiners as necessary for fulfillment of their duties; (c) agencies that engage in the procurement, banking, or transportation of organs or tissue to facilitate such donation and transplantation services; (d) researchers to conduct medical research or research intended to improve the health care system; and (e) third parties as necessary to avert a serious threat to the health or safety of a person.

Health Oversight. We may disclose protected health information to health oversight agencies. These agencies are authorized by law to conduct audits; perform inspections and investigations; license health care providers, insurers and facilities; to enforce regulatory requirements; and to investigate healthcare fraud. These agencies include: State Commissioner of Insurance, State Board of Medicine, the U.S. Department of Health and Human Services, and the FBI.

Legal Proceedings. We may disclose protected health information in the course of a judicial or administrative proceeding, and in response to a court order, subpoena, discovery request, or other lawful process.

Law Enforcement. We may disclose protected health information to law enforcement officials in response to an administrative subpoena, a warrant, or an administrative request intended to identify or locate a suspect, victim, or witness. We also may disclose protected health information for the purpose of reporting a crime on our premises.

Military and National Security. We may disclose protected health information to armed forces personnel for military activities and to authorized federal officials for national security and intelligence activities.

Correctional Institution. If you are an inmate, we may disclose protected health information to your correctional institution for treatment purposes or to ensure the safety of yourself and others.

You. We may disclose your protected health information to you at your request, to inform you about the status of your claims, or for other purposes. For example, we may use protected health information to provide information about treatment alternatives or other health related benefits or services that may be of interest to you. This may include enhancements to your health plan and health related products or services available only to health plan members that add value to, but are not a part of, your benefit plan.

Others Involved in Your Health Care. We may disclose protected health information to personal representatives such as appointed guardians, executors, conservators, and in many cases parents of minor children, as well as to attorneys in fact when a valid power of attorney exists. In addition, if you give us verbal permission or if your permission can be implied (for example, while you are unconscious during an emergency), we may disclose protected health information to family members or others who call on your behalf. This permission is valid only for a limited time. If you want to authorize on-going disclosures to family members or friends, you must submit written authorization.

Authorizations. You may give us written authorization to use protected health information or disclose protected health information about yourself to anyone for any purpose. An authorization remains valid for two years unless the authorization states otherwise or you revoke it. You may revoke an authorization at any time by submitting a written revocation (see “Contacting Us,” below), but a revocation will not affect any use or disclosure permitted by the authorization while it was in effect. An authorization is required for us to use or disclose your protected health information for purposes other than those described in this notice. In particular, we need your written authorization to use or disclose psychotherapy notes, except in limited circumstances such as when the disclosure is required by law. We also must obtain your written authorization to sell information about you to a third party or when we receive financial compensation to use or disclose your protected health information to send you communications about products and services.

Future Changes

We reserve the right to change our privacy practices and this notice at any time without advance notice. Before we make any material change in our privacy practices, we will change this notice and post the new notice on our website. We will provide a copy of the new notice (or information about the changes to our privacy practices and how to obtain the new notice) in our next annual mailing to members who are then covered by one of our health plans. The new notice will apply to all protected health information in our possession, including any information created or received before the revised notice became effective.

Contacting Us

You may reach us during regular business hours by calling us at (800) 794-5390. For more information about this notice or to file a written privacy-related complaint, you may write to: LifeMap Privacy Official, P.O. Box 1271, MS E12P, Portland, OR 97207; Email: privacy@lifemapco.com; Fax: 1-888-875-6893.