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

Individual Incentive Dental 10
Insurance for Utah Individuals and Families

Benefits provided are supplemental and are not intended to cover all dental expenses

PLEASE READ THE 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. The Policy itself sets forth in detail your rights and obligations as well as those of LifeMap Assurance Company™ (LifeMap). It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

Dental care is a vital part of maintaining and improving overall health for both children and adults. It is about more than keeping teeth looking good.

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 Incentive Dental plan is available to you and your family.

HOW THE POLICY WORKS

Individual Incentive Dental 10 is unique. If you engage in your oral health by receiving both a Periodic or Comprehensive Exam and Dental Cleaning from your dentist during your benefit year, in the following year LifeMap will increase your benefits by lowering your share of the costs and increasing the annual benefit maximum. You are in control.

With the Incentive Dental 10 plan you and your family are free to visit any dentist. As an added bonus, when you visit one of the many LifeMap Participating Dentists you will not be charged for any balances for Covered Services beyond your benefit year Deductible and/or Coinsurance amount.

Nonparticipating dentists, however, may bill you for any balances over our payment level in addition to any Deductible and/or Coinsurance amount.

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.

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.

Preventive Dental Services	None
Restorative Dental Services	6 Months
Major Dental Services	12 Months

PERCENTAGE PAID UNDER THE POLICY (COINSURANCE)
After the annual Deductible is met, we pay a percentage of the Allowed Amount for Covered Services you receive, up to the Benefit Year Maximum, 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.

ALLOWED AMOUNT means the amount Participating Dentists have agreed to accept as full payment for Covered Services as determined by Us. Charges in excess of the Allowed Amount by Nonparticipating Dentists are not reimbursable by Us. Nonparticipating Dentists may charge the Insured the billed amount.

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 voluntary, unlawful instigation and/or voluntary 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

RENEWAL – This Policy will automatically be renewed annually unless We choose to change the rates, benefits or any other Policy provisions. If there is a change in rates, benefits or Policy provisions, you will be given written notice 30 days prior to the date of the change. You may reject such change by providing written notice to Us 15 days prior to the date such change is due to take place. If We do not receive any notice of rejection, the Policy will be renewed annually from that time forward.

If you have any questions, please call 503-721-7161 or toll-free 1-800-794-5390.

Keep this brochure for your records.

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

Individual Dollar-Based Dental Insurance for Utah Individuals and Families

Benefits provided are supplemental and are not intended to cover all dental expenses

PLEASE READ THE 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. The Policy itself sets forth in detail your rights and obligations as well as those of LifeMap Assurance Company™ (LifeMap). It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

Dental care is a vital part of maintaining and improving overall health for both children and adults. It is about more than keeping teeth looking good.

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 Dollar-Based Dental plan is available to you and your family.

HOW THE POLICY WORKS

Individual Dollar-Based Dental puts you and your dentist in control. With this dental plan there are no dental service limitations or treatment exclusions, except orthodontia, aesthetic dental procedures such as teeth bleaching and labial veneers, 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 and treatment for work-related injuries.

If you engage in your oral health by receiving both a Periodic or Comprehensive Evaluation and Dental Cleaning from your dentist during your benefit year, in the following year LifeMap will increase the annual benefit maximum. You are in control.

With the Individual Dollar-Based Dental plan you and your family are free to visit any dentist. As an added bonus, when you visit one of the many LifeMap Participating Dentists you will be accessing dental providers who have agreed to bill no more than our Allowed Amounts for Covered Services.

Nonparticipating dentists, however, may bill you for any balances over our payment level in addition to any Coinsurance amount.

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.

PERCENTAGE PAID UNDER THE POLICY (COINSURANCE)
We pay a percentage of the Allowed Amount for Covered Services you receive, up to the Benefit Year Maximum. When Our payment is less than 100%, you pay the remaining percentage (this is your Coinsurance). The percentage We pay varies, depending on the kind of service or supply you receive and who renders it.

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.

ALLOWED AMOUNT means the amount Participating Dentists have agreed to accept as full payment for Covered Services as determined by Us. Charges in excess of the Allowed Amount by Nonparticipating Dentists are not reimbursable by Us. Nonparticipating Dentists may charge the Insured the billed amount.

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 voluntary, unlawful instigation and/or voluntary participation in a Riot, Rebellion, War or Illegal Act
- Work-related injuries covered by worker's compensation

RENEWAL – This Policy will automatically be renewed annually unless We choose to change the rates, benefits or any other Policy provisions. If there is a change in rates, benefits or Policy provisions, you will be given written notice 45 days prior to the date of the change. You may reject such change by providing written notice to Us 15 days prior to the date such change is due to take place. If We do not receive any notice of rejection, the Policy will be renewed annually from that time forward.

If you have any questions, please call 503-721-7161 or toll-free 1-800-756-4105.

Keep this brochure for your records.

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Individual Dental Application Checklist

Please review the following checklist before submitting your application

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- 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 (total the daily rate of each member to calculate)?
  - ☐ 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
  - ☐ 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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Home Office Use Only	
ID #	
Eff. Date	
Vis. Rider ☐	EFT ☐

RENEWABLE INDIVIDUAL DENTAL INSURANCE APPLICATION (WITH OPTIONAL VISION RIDER)

Please Note: This Policy provides dental benefits only. The Policy provides vision benefits only if elected.

Please complete all information on this page and on Page 2. Incomplete information may result in a delayed Effective Date.

Applicant's Last Name	Applicant's First Name	M.I.	☐ M ☐ F	Date of Birth (mm/dd/yyyy
Social Security Number	☐ Married ☐ Divorced ☐ Single		E-mail Address	
Mailing Address: Street Address & Apt. No. City State Zip				Telephone Number ( )

Requested Effective Date

Your requested Effective Date must be following or coinciding with the date We receive your Application, after the date your Application is signed, and within 60 days from the date of your signature, or a new Application will be required.

A new Application may result in a delayed Effective Date. In no event may the Effective Date of this Policy be back-dated

☐ 1st OR ☐ 15th of _____ (month) _____ (year)

Dependents to be enrolled: Dependent children must be under 26 years of age.

Name (Last, First, M.I.)	Social Security Number	Birth Date	Sex	Relationship To You
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	

Please list names as they should appear on your identification card. If enrolling additional dependents, please attach a separate sheet including the information above.

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

Do you or any family members enrolling have other dental coverage? ☐ **Yes** ☐ **No**

If yes, provide the information regarding other coverage requested below.

Name of Family Member with other coverage		Relationship
Name of Insurance Carrier	Policy No.	ID No.
Address of Other Carrier City State Zip		Carrier Phone No. ( )
This plan covers ☐ Self ☐ Spouse ☐ Child(ren) ☐ Family as listed above ☐ Other _____ (check all that apply)		Termination Date (if applicable)

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.

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**

*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 ☐ Yes ☐ No **Premium Payment Schedule:** ☐ **Monthly** ☐ **Quarterly**

Premium Calculation

	Number enrolling for coverage		Enter Monthly or Quarterly Dental Only or Dental with Vision Premium Rate		
Under Age 18	_____	X	$ _____	=	$ _____
Age 18 through age 64	_____	X	$ _____	=	$ _____
Age 65 and over	_____	X	$ _____	=	$ _____

Total Monthly or Quarterly Dental or Dental with Vision Premium Rate **$** _____

Your 1st premium payment must be enclosed with this Application. **(Policy Fee is non-refundable)**

Total Monthly or Quarterly Dental or Dental with Vision $ _____

PLUS Policy Fee of $ 25.00

Equals Total Due **$** _____ **(Enclosed)**

I hereby apply for enrollment with LifeMap Assurance Company (LifeMap) under the Individual Dental Insurance plan.

I acknowledge and understand LifeMap 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 a broker or agent, they may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from LifeMap. Incentives may be based on any of several factors including the products you buy, your broker or agent's volume of business with LifeMap and the other services your agent or broker 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 / Agency (Please Print)

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.

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

Unless specific state language is provided below, the following fraud notice applies: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Arizona Residents: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California Residents: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Hawaii Residents: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Alabama, Arkansas, Louisiana, Maryland, New Mexico, Rhode Island, Texas and West Virginia Residents: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Maine, Tennessee, Virginia and Washington Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Alaska and Oregon Residents: 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.

Delaware, Idaho, Indiana and Oklahoma Residents: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.