Regence Life and Health Insurance Company

Dental coverage for the way you live

Discover two new dental plans:

Individual Dollar-Based Dental
Individual Incentive Dental

Regence
Life and Health Insurance Company

Independent Licensee of the Blue Cross and Blue Shield Association

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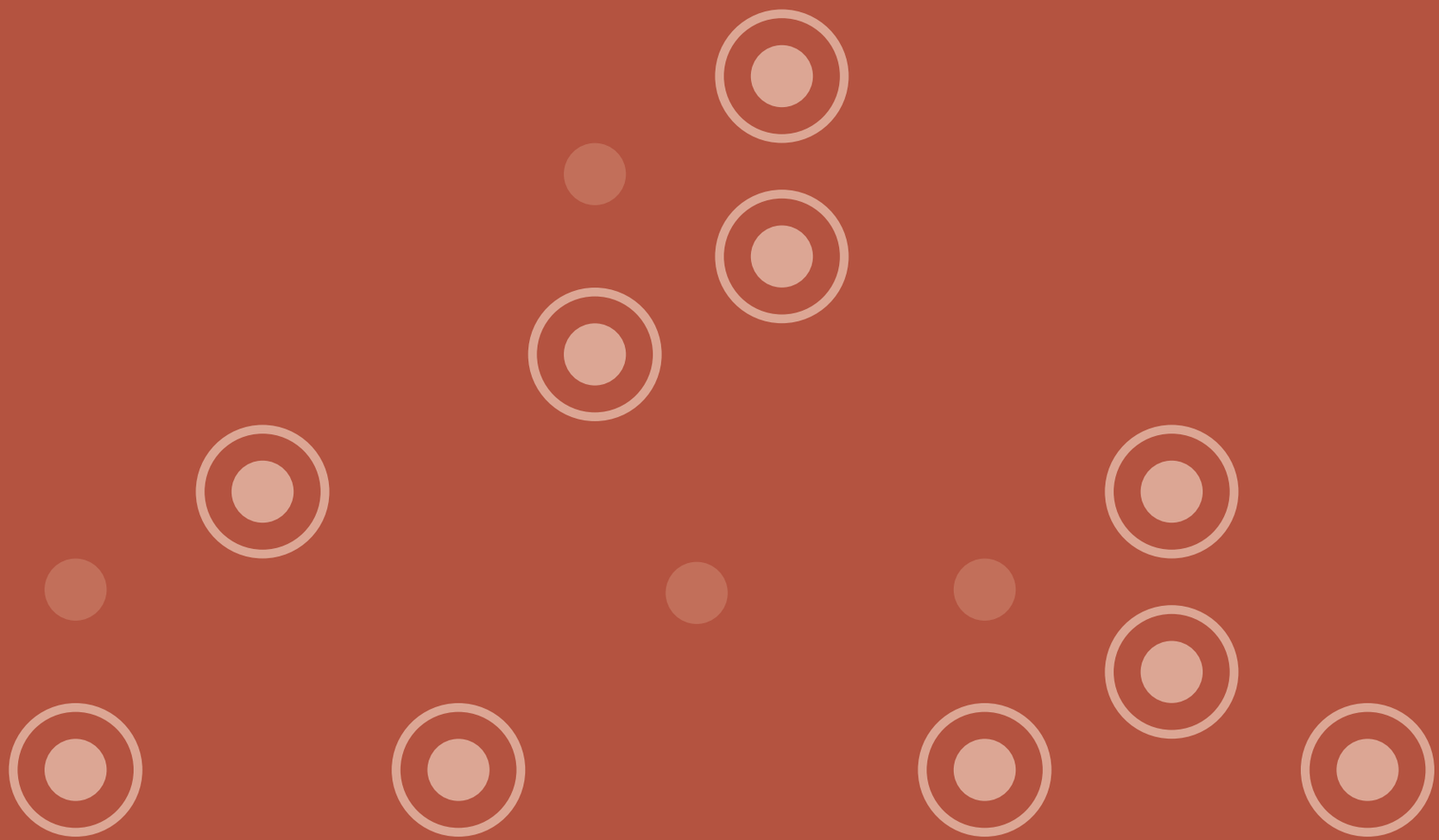
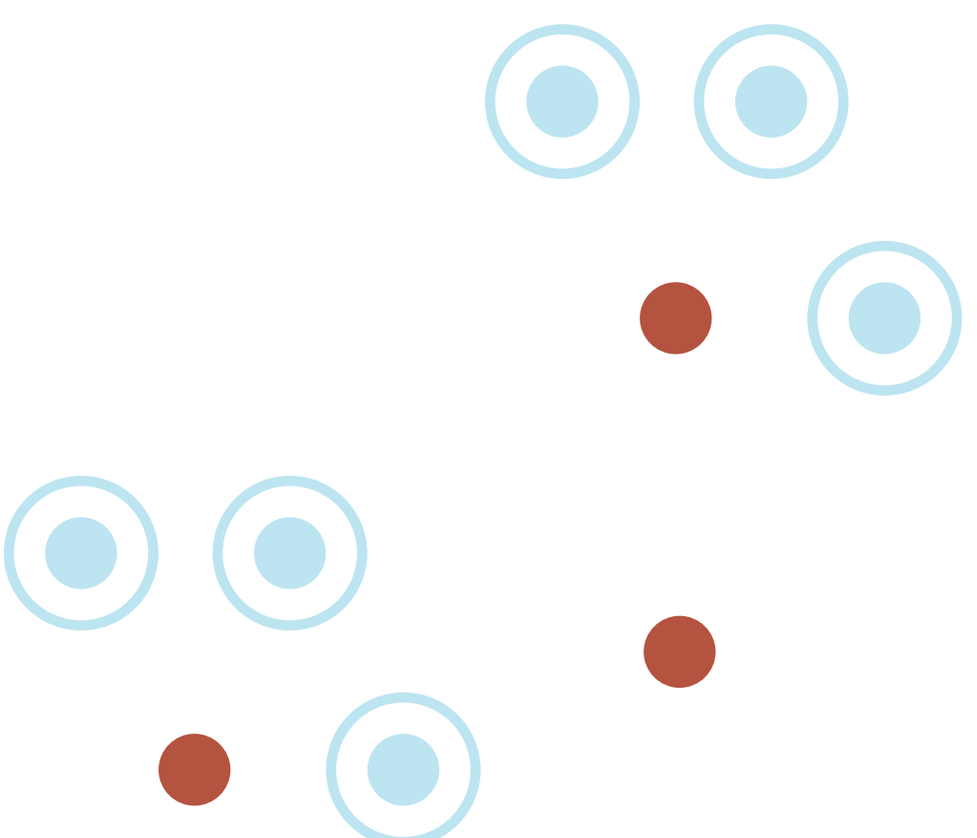
Dental health is essential to maintaining overall health.



You know it's important to receive an annual dental checkup and cleaning, but you also want the freedom to make choices about your care. That's the inspiration behind two new, innovative dental plans. As you are proactive with your health, you are rewarded with increased dental coverage.

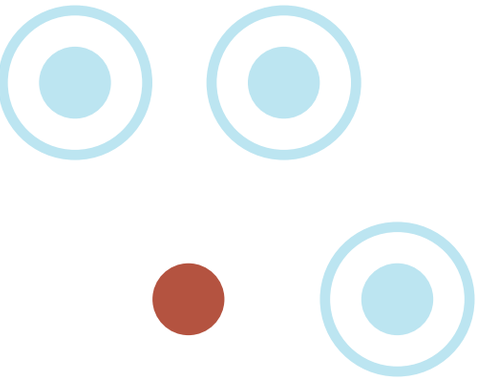


Dental done your way

Take care of yourself and watch your benefits grow

Individual Dollar-Based Dental* puts you in control of your dental health dollars. The plan is *dollar-based*. This means you can use your coverage almost any way you choose, with few exclusions and limitations. Each year you visit the dentist for an exam and cleaning, you are rewarded with a benefit increase the following year.

Individual Incentive Dental* is a more traditional plan, but unlike traditional dental plans you are rewarded for receiving routine preventive care. Each year that you visit the dentist for a checkup and cleaning, means greater benefits and less out-of-pocket expenses the next year.



**These plans are not available to persons currently enrolled in another dental plan or who are covered by other dental coverage.*

Choose the plan that's right for you and your family

Individual Dollar-Based Dental

Spend your benefit dollars on care that's important to you and your family. Include a routine exam and cleaning and watch your benefits grow in the next year.

Plan features:

- You decide how to spend your benefit dollars
- No deductibles
- No limitations or exclusions for covered services (orthodontia, teeth bleaching and veneers are not covered services)*
- Choose any dentist, but save even more by using one of our network providers
- Optional Vision rider available ($150 in services every two years)

Here's how it works:
Each year that you take advantage of an annual checkup and cleaning, the benefit dollars available to you increase. The goal is to reach $1,500 in available benefits by year four. Every year the plan pays: 100% of the first $150 of care, 80% of the next $500 of care, and 50% of remaining care until you reach your annual maximum benefit. The co-insurance stays constant each year, but you and your dentist choose which procedures to have done with no age restrictions or limitations for covered services. There is a six month waiting period on this plan.*

	Maximum Benefit The benefit dollars available to spend as you choose grow each year.	**Coinsurance Benefit** These are the percentages your plan will pay based on your accumulated treatment costs.
Year 1	$750	100/80/50
Year 2	$1,000	100/80/50
Year 3	$1,250	100/80/50
Year 4	$1,500	100/80/50

**Please see the Outline of Coverage.*

For quick, easy enrollment, visit our Web site: www.regencelife.com

Outline of Coverage

Individual Dollar-Based Dental

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.

Exclusions

Your policy does not cover:

- Bleaching of teeth
- 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
- Work-related injuries

Individual Incentive Dental

Imagine dental coverage that increases as you are proactive about visiting the dentist. That's the idea behind Individual Incentive Dental—offering financial rewards for an annual checkup and cleaning.

Plan features:

- No waiting period
- Deductible waived for exams and cleanings
- $50 deductible for other covered services*
- Choose any dentist, but save even more by using one of our network providers
- Optional Vision rider available ($150 in services every two years)

Here's how it works:
Have your teeth cleaned and examined every year and get rewarded with greater benefits the next year. Watch your annual benefits increase and your out-of-pocket expenses for co-insurance decrease. By year four, you can reach a maximum annual benefit of $1,500. And the percentage the plan pays in coinsurance increases to 100/80/50 by year three. This means we will pay 100% of preventive care, such as routine cleanings; 80% of restorative care, such as fillings; and 50% of major dental care like crowns or root canals.

	Maximum Benefit The benefit dollars available to spend as you choose grow each year.	**Coinsurance Benefit** These are the percentages your plan will pay for preventive, restorative or major procedures.
Year 1	$750	80/60/30
Year 2	$1,000	90/70/40
Year 3	$1,250	100/80/50
Year 4	$1,500	100/80/50

**Please see the Outline of Coverage.*

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Outline of Coverage

Individual Incentive Dental

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 and Diagnostic Services
- Cleanings allowed, two per benefit year (includes cleanings and/or periodontal maintenance)
- Oral exams allowed, two per benefit year
- Fluoride Treatment allowed two applications per benefit year for members age 17 and under
- X-ray 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 bicuspids and molars for members age 17 and under
- Space Maintainers allowed for members age 11 and under

Restorative 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 members age 6 and under or members who are physically or developmentally disabled.
- Direct pulp capping

Outline of Coverage cont.

Individual Incentive Dental

Major Services

- Crowns or onlays and related services
- Bridges (fixed partial dentures)
- Dentures (full or partial) and related services
- Endosteal Implants and related services; implants are limited to four per lifetime per member
- Endodontics including root canal treatment, pulpotomy, apicoectomy
- Periodontal Maintenance allowed two per calendar year (includes cleanings and/or periodontal maintenance)
- Scaling and root planing allowed once every two years per quadrant
- Debridement allowed once every three years
- Gingivectomy and gingivoplasty allowed once every three years per quadrant
- Osseous and mucogingival surgery allowed once every five years per quadrant

Replacement of prosthetics is limited to replacements made at least seven years from the most recent placement; limited to once in a seven year period.

Exclusions for Individual Incentive Dental

Your policy does not cover:

- Additional procedures to construct new crown under existing partial denture framework
- Application of desensitizing resin for cervical and/or root surface
- Bleaching of teeth
- 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
- Endodontic endosseous implants
- Exfoliate cytology sample collection or brush biopsy
- Expenses payable by motor vehicle insurance or other liability insurance coverage
- Fees, Taxes, Interest
- Gold foil restorations
- 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
- Labial veneers
- 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
- Occlusal analysis and adjustments
- Occlusal guards
- Oral hygiene instructions
- Oral/facial photographic images
- Orthodontic services, including craniomandibularorthopedic 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
- 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 of simple or compound fractures of the mandible
- Treatment of Temporomandibular Joint Dysfunction
- Unspecified implant procedures
- Work related injuries

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For quick, easy enrollment, visit our Web site:
www.regencelife.com

To learn more, call toll-free:
1-888-REGENCE (1-888-734-3623)

www.regencelife.com

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To choose the plan that's right for you, please see the following premium rates and applications for the *Incentive* and *Dollar-Based* dental plans.

INDIVIDUAL INCENTIVE DENTAL RATES AND APPLICATION

PREMIUM RATES FOR INCENTIVE DENTAL

	MONTHLY PREMIUM PER MEMBER		QUARTERLY PREMIUM PER MEMBER	
	Dental Only	**Dental & Vision**	**Dental Only**	**Dental & Vision**
Under Age 18	**$21.68**	**$24.29**	**$65.04**	**$72.87**
18 through 64	**$27.44**	**$32.06**	**$82.32**	**$96.18**
65 and over	**$29.88**	**$35.79**	**$89.64**	**$107.37**

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.

ELIGIBILITY

You are eligible for this policy if you and any family members who apply for coverage are not covered under any other plan that provides dental coverage, including any Medicare or Medicare supplement plan providing dental coverage.

Important Note: If we receive notice that a member has become covered under any other dental coverage, this policy's coverage for that member will be terminated as of the last day of the month (or the 14th day of the month if the effective date of the policy is the 15th of the month) in which such notice is received.

Eligible dependents include your Spouse and your unmarried dependent children under age 25 who are primarily dependent upon you for support.

HOW TO APPLY

- Complete the application in full. Missing information may cause your effective date to be delayed. If you have more than four children, please attach a separate list.
- Calculate the premium. Indicate if you are enrolling for the Optional Vision coverage. Be sure to select a monthly or quarterly payment schedule. Include the applicable payment for the first month or quarter of coverage, according to the payment schedule you have selected.
- You may enroll for Child Only coverage. If you are enrolling children only, a separate application must be completed and submitted for each child.
- If you have any questions, please call 503-721-7161 or toll-free 1-800-794-5390.
- Send the application and your check or money order made payable to Regence Life and Health Insurance Company to:

  Regence Life and Health Insurance Company
  PO Box 1271, MS E-3A
  Portland, OR 97207-1271

- Keep this brochure for your records.

REFUNDS

If you are not satisfied with this Policy, you may return the policy within 10 days of delivery for a full refund of premium.

Please note: The policy fee of $25 is non-refundable.

Please read your policy carefully and keep it available for future reference.

Regence
Life and Health Insurance Company
Independent Licensee of the Blue Cross and Blue Shield Association.

100 SW Market Street
P.O. Box 1271 E-3A
Portland, OR 97207-1271
1 (800) 794-5390 • (503) 721-7161

RENEWABLE INDIVIDUAL INCENTIVE DENTAL INSURANCE APPLICATION (WITH OPTIONAL VISION RIDER)

THE POLICY PROVIDES DENTAL BENEFITS ONLY. THE POLICY PROVIDES VISION BENEFITS ONLY IF ELECTED. PLEASE REVIEW YOUR POLICY CAREFULLY.

Please complete all information on this page and on Page 2.

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

We are always searching for ways to better serve your needs. You can help us by answering the following questions.

1. Are you : ☐ Hispanic/Latino ☐ Non-Hispanic/Latino
2. How would you describe yourself in terms of your racial heritage? ☐ African-American ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Caucasian ☐ Two or More Races You may choose to not answer this question.

Do you or any other family member for whom you are making application have other active dental coverage, including any Medicare or Medicare supplement plan providing dental coverage? ☐ Yes ☐ No If Yes, coverage cannot be issued for that family member. Please give name(s) of family member(s) with other dental coverage:

Requested Effective Date: (Your requested effective date must be within 60 days from the date the application is signed or a new application will be required.)

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

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

Amount of Payment Remitted With This Application $ _____

Dependents to be enrolled: Dependent children must be under 25 years of age and primarily dependent on you for support.

	Full Last Name*	Full First Name*	Middle Initial	Social Security Number	Date of Birth (mm/dd/yy)	Gender M/F	Relationship to Applicant
Applicant 1	**Same as above**	**Same as above**	**Same**	**Same as above**	**Same as above**	**Same**	**Self**
Spouse 2							
Child 3							
Child 4							
Child 5							
Child 6							

***List names as they should appear on your identification card. Please list additional children on a separate sheet.**

List any of the above children attending a boarding school, accredited college or university. Provide the name and location of the school for each child.

Please Continue To Page 2

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PREMIUM CALCULATION

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 the following:

	Number enrolling in Dental Only		Enter Monthly or Quarterly Dental Only Premium Rate		
Under Age 18	_____	**Times**	**$** _____	=	**$**_____
Age 18 through age 64	_____	**Times**	**$** _____	=	**$**_____
Age 65 and over	_____	**Times**	**$** _____	=	**$**_____

	Number enrolling in Dental & Vision		Enter Monthly or Quarterly Dental & Vision Premium Rate		
Under Age 18	_____	**Times**	**$** _____	=	**$**_____
Age 18 through age 64	_____	**Times**	**$** _____	=	**$**_____
Age 65 and over	_____	**Times**	**$** _____	=	**$**_____

Total Dental Only Premium $_____ **OR Total Dental &Vision Premium $**_____

PLUS Policy Fee of $ 25.00 = Total Due $ _____ **Enclosed With Application**

I hereby apply for enrollment with Regence Life and Health Insurance Company under the Individual Incentive Dental Insurance plan.

I acknowledge and understand Regence Life and Health Insurance Company 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 Regence Life and Health Insurance Company. Incentives may be based on any of several factors including the size of group business, the products you buy, your broker or agent's volume of business with Regence Life and Health Insurance Company 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

▶ _____ 765-0000 Ralston Insurance - Rich Ralston and Erin Hill
Date Signed — Agent Number — Licensed Agent's Name (Please Print)

INDIVIDUAL DOLLAR-BASED DENTAL RATES AND APPLICATION

PREMIUM RATES FOR DOLLAR-BASED DENTAL

	MONTHLY PREMIUM PER MEMBER		QUARTERLY PREMIUM PER MEMBER	
	Dental Only	**Dental & Vision**	**Dental Only**	**Dental & Vision**
Under Age 18	**$24.29**	**$26.90**	**$72.87**	**$80.70**
18 through 64	**$44.59**	**$49.21**	**$133.77**	**$147.63**
65 and over	**$56.47**	**$62.38**	**$169.41**	**$187.14**

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.

ELIGIBILITY

You are eligible for this policy if you and any family members who apply for coverage are not covered under any other plan that provides dental coverage, including any Medicare or Medicare supplement plan providing dental coverage.

Important Note: If we receive notice that a member has become covered under any other dental coverage, this policy's coverage for that member will be terminated as of the last day of the month (or the 14th day of the month if the effective date of the policy is the 15th of the month) in which such notice is received.

Eligible dependents include your Spouse and your unmarried dependent children under age 25 who are primarily dependent upon you for support.

HOW TO APPLY

- Complete the application in full. Missing information may cause your effective date to be delayed. If you have more than four children, please attach a separate list.
- Calculate the premium. Indicate if you are enrolling for the Optional Vision coverage. Be sure to select a monthly or quarterly payment schedule. Include the applicable payment for the first month or quarter of coverage, according to the payment schedule you have selected.
- You may enroll for Child Only coverage. If you are enrolling children only, a separate application must be completed and submitted for each child.
- If you have any questions, please call 503-721-7161 or toll-free 1-800-794-5390.
- Send the application and your check or money order made payable to Regence Life and Health Insurance Company to:

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  PO Box 1271, MS E-3A
  Portland, OR 97207-1271

- Keep this brochure for your records.

REFUNDS

If you are not satisfied with this Policy, you may return the policy within 10 days of delivery for a full refund of premium.

Please note: The policy fee of $25 is non-refundable.

Please read your policy carefully and keep it available for future reference.

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RENEWABLE INDIVIDUAL DOLLAR-BASED DENTAL INSURANCE APPLICATION (WITH OPTIONAL VISION RIDER)

THE POLICY PROVIDES DENTAL BENEFITS ONLY. THE POLICY PROVIDES VISION BENEFITS ONLY IF ELECTED. PLEASE REVIEW YOUR POLICY CAREFULLY.

Please complete all information on this page and on Page 2.

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

We are always searching for ways to better serve your needs. You can help us by answering the following questions.

1. Are you : ☐ Hispanic/Latino ☐ Non-Hispanic/Latino
2. How would you describe yourself in terms of your racial heritage? ☐ African-American ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Caucasian ☐ Two or More Races You may choose to not answer this question.

Do you or any other family member for whom you are making application have other active dental coverage, including any Medicare or Medicare supplement plan providing dental coverage? ☐ Yes ☐ No If Yes, coverage cannot be issued for that family member. Please give name(s) of family member(s) with other dental coverage:

Requested Effective Date: (Your requested effective date must be within 60 days from the date the application is signed or a new application will be required.)

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

NOTE: THIS COVERAGE HAS A SIX (6) MONTH BENEFIT WAITING PERIOD. The BENEFIT WAITING PERIOD is the continuous length of time the member must be covered under the Policy before becoming eligible for benefits.

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

Amount of Payment Remitted With This Application $ _____

Dependents to be enrolled: Dependent children must be under 25 years of age and primarily dependent on you for support.

	Full Last Name*	Full First Name*	Middle Initial	Social Security Number	Date of Birth (mm/dd/yy)	Gender M/F	Relationship to Applicant
Applicant 1	Same as above	Same as above	Same	Same as above	Same as above	Same	Self
Spouse 2							
Child 3							
Child 4							
Child 5							
Child 6							

***List names as they should appear on your identification card. Please list additional children on a separate sheet.**

List any of the above children attending a boarding school, accredited college or university. Provide the name and location of the school for each child.

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Under Age 18	_____	**Times**	**$** _____	**=**	**$**_____
Age 18 through age 64	_____	**Times**	**$** _____	**=**	**$**_____
Age 65 and over	_____	**Times**	**$** _____	**=**	**$**_____

	Number enrolling in Dental & Vision		Enter Monthly or Quarterly Dental & Vision Premium Rate		
Under Age 18	_____	**Times**	**$** _____	**=**	**$**_____
Age 18 through age 64	_____	**Times**	**$** _____	**=**	**$**_____
Age 65 and over	_____	**Times**	**$** _____	**=**	**$**_____

Total Dental Only Premium $_____ **OR Total Dental &Vision Premium $**_____

PLUS Policy Fee of $ 25.00 **= Total Due $** _____ **Enclosed With Application**

I hereby apply for enrollment with Regence Life and Health Insurance Company under the Individual Dollar-Based Dental Insurance plan.

I acknowledge and understand Regence Life and Health Insurance Company 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 Regence Life and Health Insurance Company. Incentives may be based on any of several factors including the size of group business, the products you buy, your broker or agent's volume of business with Regence Life and Health Insurance Company 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

▶ _____ 765-0000 Ralston Insurance - Rich Ralston and Erin Hill

Date Signed | Agent Number | Licensed Agent's Name (Please Print)

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Life and Health Insurance Company
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100 SW Market Street
P.O. Box 1271 E-3A
Portland, OR 97207-1271
(503) 721-7161 • (800) 794-5390

PRIVACY NOTICE

We, at Regence Life and Health, know you value your privacy. That is why we are committed to the confidentiality and security of your personal information. Because we endeavor to earn and keep your trust, we have long-standing privacy policies, robust training, and full-time staff dedicated to protecting privacy. We also maintain physical, administrative, and technical safeguards to protect your personal information from unauthorized access. Even if you are no longer a Regence member, we protect the confidentiality of your personal information as if you were.

Marketing

While other companies may sell or rent your contact information, Regence never sells or rents your personal information for marketing purposes. If you want Regence to share your personal information with a nonaffiliated third party so the third party can market to you, you must give us your express permission.

Your Personal Information

We collect personal information such as your name, contact information, health information, and financial information from you, your providers, and other insurers that provide coverage to you. We use this information to provide services to you and to conduct insurance transactions. You may receive a copy of your personal information by contacting us at the phone number or address below. We will not disclose your personal information unless we are permitted or required by law or you give your permission. As permitted or required by law, we may provide personal information to our affiliates and agents, reinsurers, insurance administrators, consultants, or regulatory and governmental authorities. We obligate entities receiving this information on our behalf to protect it in the same way that we protect it.

Changes to Our Practices

We may change our privacy practices in an effort to provide even better protection. If we change our privacy practices in a material way, we will notify current customers in writing.

Contact Us

If you have any questions about our privacy program, you may contact us at (800) 794-5390 or write to:

Regence Privacy Official
P.O. Box 1071, Mailstop E12B
Portland, OR 97207