DENTAL BLUE CONNECT FOR IDAHO SCHOOL BENEFIT TRUST MASTER GROUP CONTRACT

AND

ENROLLEE CERTIFICATE

GROUP CONTRACT

FOR

Hagerman School District #233

Group Number: 10003662

Effective Date: September 1, 2021

BLUE CROSS OF IDAHO HEALTH SERVICES, INC.

Form No. 3-735 (09/21)

NONDISCRIMINATION STATEMENT: DISCRIMINATION IS AGAINST THE LAW

Blue Cross of Idaho complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Cross of Idaho does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

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

If you need these services, contact Blue Cross of Idaho Customer Service Department. Call 1-800-331-7347 (TTY: 711), or call the customer service phone number on the back of your card.

If you believe that Blue Cross of Idaho has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with Blue Cross of Idaho's Grievances and Appeals Department at:

Manager, Grievances and Appeals
3000 East Pine Avenue, Meridian, Idaho 83642
Telephone: (800) 274-4018, Fax: (208) 331-7493
Email: grievances&appeals@bcidaho.com
TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Grievances and Appeals team is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TTY).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Language Assistance

ATTENTION: If you speak Arabic, Bantu, Chinese, Farsi, French, German, Japanese, Korean, Nepali, Romanian, Russian, Serbo-Croatian, Spanish, Tagalog, or Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-627-1188 (TTY: 711).

،ةغللا ركذا ةيبرعلا ثدحتت تنك اذإ :ةظوحلم Arabic: لصتا
.ناجملاب كل رفاوتت ةيوغللا ةدعاسملا تامدخ نإف :مكبلاو مصلا فتاه
مقر) 1-800-627-1188 مقرب
(711).

Bantu ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-627-1188 (TTY: 711).

Chinese 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-627-1188（TTY：711)。

هجوت: رگا هب نابز یسراف وگتفگ یم دینک **Farsi:** مهارف یم
امش یارب ناگیار ترومصب ینابز تالیهست (711
1-800-627-1188 (TTY: اب دشاب
.دیریگب سامت

French ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS : 711).

German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (TTY: 711).

Japanese 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-627-1188（TTY: 711）まで、お電話にてご連絡ください。

Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-627-1188 (TTY: 711)번으로 전화해 주십시오.

Nepali ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-627-1188 (टिटिवाइ: 711) ।

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Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 711).

Serbo-Croatian OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-627-1188 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 711).

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Vietnamese CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-627-1188 (TTY: 711)

TABLE OF CONTENTS

GROUP APPLICATION AND ACCEPTANCE....1
BLUE CROSS OF IDAHO CONTACT INFORMATION....2
IDAHO DEPARTMENT OF INSURANCE LOCATION....2
DENTAL BENEFITS SECTION....3
List of Covered Dental Services and Copayments....3
Procedure for Obtaining Dental Covered Dental Services....3
Benefits for Dental Covered Dental Services....3
ELIGIBILITY AND ENROLLMENT SECTION – Active Employees....5
Probationary Period....5
Eligibility and Enrollment....5
Leave of Absence....5
Group Employee Premium Contribution....5
Miscellaneous Eligibility and Enrollment Provisions....5
Late Enrollee....7
Special Enrollment Periods....7
Eligible Employees Changing to Other Participating School Districts....7
Retirement....7
Qualified Medical Child Support Order....7
ELIGIBILITY AND ENROLLMENT SECTION - RETIREES....9
Eligibility and Enrollment....9
Loss of Eligibility if a Participating School District Cancels....9
Payment of Premium and Effective Date....9
Qualified Medical Child Support Order....11
DEFINITIONS SECTION....13
EXCLUSIONS AND LIMITATIONS SECTION....17
General Exclusions....17
Limitations....18
Extension of Benefits....19
GENERAL PROVISIONS SECTION....20
Entire Contract- Changes....20
Records of Member Eligibility and Changes in Member Eligibility....20
Premium Charges and Billings....20
Eligibility Requirements for School Districts Applying for Participation....20
Termination or Modification of this Contract....20
Termination or Modification of a Member's Coverage Under this Contract....21
Benefits After Termination of Coverage....22
Transfer Privilege....22
Contract Between BCI and the Group—Description of Coverage....22
Applicable Law....22
Notice....22
Benefit to Which Members are Entitled....23
Release and Disclosure of Health Records and Other Information....23
Exclusion of General Damages....23
Member/Provider Relationship....23
Participating Plan....23
Coordination of this Contract's Benefits with Other Benefits....23
Subrogation and Reimbursement Rights and Obligations....27
Indemnity by the Group and BCI....28
Incorporated by Reference....29
Inquiry and Appeals Procedures....29
Plan Administrator—COBRA and ERISA....29

Independent Blue Cross and Blue Shield Plans 30
Statements 30
Membership, Voting, Annual Meeting and Participation 30
Replacement Coverage 30
Coverage and Benefits Determination 30
Covered Dental Services Obtained Outside the United States 30
ATTACHMENT A - List Of Covered Dental Services And Copayments 32
ATTACHMENT B–Orthodontia Treatment 38
ATTACHMENT C - Dental Implant Surgery 1

GROUP APPLICATION AND ACCEPTANCE

Hagerman School District #233, a Participating School District, called the Group, hereby confirms that it has previously applied for and been furnished coverage by Blue Cross of Idaho Health Service, Inc., called Blue Cross of Idaho.

The Group acknowledges it has received sixty (60) days advance written notice of modification of the Contract as required by General Provision V.A. and that the attached Contract, which has been approved by the Council reflects the modification. The Group agrees to accept this Contract and signifies its acceptance by payment of its September 1, 2021 premium. The Group further agrees that this Contract shall supercede all previous contracts, certificates or agreements issued by Blue Cross of Idaho, but that the group enrollment agreement or master group application, whichever document was previously submitted by the Group, shall continue in force.

Blue Cross of Idaho agrees, in consideration of the group enrollment agreement or master group application and premium payments when due, and subject to all the terms of this Contract, to provide each Member of the Group the benefits of this Contract, beginning on September 1, 2021 and continuing on a month-to-month basis thereafter, unless modified or terminated as provided by this Contract.

This Contract renews on an annual basis. Premium payments are due on a month-to-month basis. The Group's Contract date is September 1 and, unless modified or terminated as provided by this Contract, the Contract will continue to renew each year on the Group's renewal date of September 1.

Paul Zurlo
President, Health Markets

BLUE CROSS OF IDAHO CONTACT INFORMATION

For general information, please contact your local Blue Cross of Idaho office:

Meridian
Customer Service Department
3000 East Pine Avenue
Meridian, ID 83642

2929 W. Navigator Drive, Suite 140
Meridian, ID 83642

Mailing Address
P.O. Box 7408
Boise, ID 83707
(208) 363-8755 (Boise Area)
1-800-289-7929

Coeur d'Alene
1812 N. Lakewood Dr., Suite 200
Coeur d'Alene, ID 83814
(208) 666-1495

Pocatello
850 W. Quinn
Chubbuck, ID 83202
(208) 232-6206

Idaho Falls
1910 Channing Way
Idaho Falls, ID 83404
(208) 522-8813

Twin Falls
428 Cheney Dr. W., Suite 101
Twin Falls, ID 83301
(208) 733-7258

IDAHO DEPARTMENT OF INSURANCE CONTACT INFORMATION

Idaho Department of Insurance
Consumer Affairs
700 W State Street, 3rd Floor
PO Box 83720
Boise ID 83720-0043
1-800-721-3272 or www.DOI.Idaho.gov

DENTAL BENEFITS SECTION

Please Note: The Member will receive maximum benefits for Covered Dental Services from a Contracting Provider.

This section specifies the benefits a Member is entitled to receive for Covered Dental Services, subject to the other provisions of this Contract.

I. List of Covered Dental Services and Copayments

The List of Covered Dental Services and Copayments is specified in the attachments.

II. Procedure for Obtaining Covered Dental Services

A. Contracting Providers

To receive the maximum benefits of this Contract, Member should receive Covered Dental Services from a Contracting Provider. Members are encouraged to establish a long-term relationship with a primary Willamette Dental Group Provider. Member may select their Willamette Dental Group Provider and may change Willamette Dental Group Providers at any time. To schedule an appointment with a Contracting Provider, Members should contact Willamette Dental Group's Appointment Center at 1-855-433-6825. Member may locate a Dental Blue Connect Contracting Dentist by visiting the Blue Cross of Idaho website at *www.bcidaho.com.*

If a Member has a Dental Emergency, call Willamette Dental Group's Appointment Center at 1-855-433-6825. Willamette Dental Group provides care for Dental Emergencies during regular office hours. After regular office hours, a Contracting Provider is available for Dental Emergency consultation over the telephone, at no cost.

B. Noncontracting Providers with a Referral from a Contracting Provider

If a Contracting Provider cannot provide a prescribed Covered Dental Service, the Contracting Provider may refer the Member to a Noncontracting Provider. Benefits for services provided by a Noncontracting Provider will be covered if:

The Contracting Provider refers the Member;
The services are authorized by the Referral; and
The services are as covered under this Contract.

C. Noncontracting Providers for Emergency Treatment While Out of Area

Members may seek treatment from a Noncontracting Provider for a Dental Emergency that occurs while traveling outside of a 50-mile radius of any Contracting Provider's office. The Member may seek reimbursement for the cost of the Covered Dental Services rendered for Dental Emergency Treatment up to the Out of Area Emergency Care Reimbursement amount less any Copayments specified in the List of Covered Dental Services and Copayments.

D. Noncontracting Providers without a Referral from a Contracting Provider

If a Member elects to receive services from a Noncontracting Provider without a Referral, the entire benefit reimbursement will be $10 per visit.

III. Benefits for Covered Dental Services

A. Contracting Providers

The Contracting Provider's office will collect the applicable copayments at the time of the visit. Copayments are specified in the List of Covered Dental Services and Copayment.

If a Member has a Dental Emergency, the Member will be responsible for the Emergency Office Visit Copayment, in addition to any copayments for Covered Dental Services rendered, at the time of the visit. The Member will be financially responsible for any additional services or provider fees not covered by this Contract.

B. Noncontracting Providers with a Referral from a Contracting Provider

If a Member is referred to a Noncontracting Provider by a Contracting Provider, the Member will be responsible for the Copayments specified in List of Covered Dental Services and Copayments for the Covered Dental Services authorized by the Referral. The Member will be financially responsible for any services or provider fees not authorized by the Referral or not covered by this Contract.

C. Noncontracting Providers for Emergency Treatment While Out of Area

To request the Out of Area Emergency Care Reimbursement benefit, the Member must submit a written request within six (6) months of the date of service to Willamette Dental Group at:

Willamette Dental Group
Attn: Emergency Care Reimbursement Benefit
6950 NE Campus Way
Hillsboro, OR 97124

The written request should include the Member's signature, the attending Provider's signature, and an itemized statement from the attending Provider. Additional information, including X-rays and other data, may be requested by Willamette Dental Group to process the request. The Out of Area Emergency Care Reimbursement will not be provided if the requested information is not received.

D. Noncontracting Providers without a Referral from a Contracting Provider.
If a Member elects to receive services from a Noncontracting Provider without a Referral, the entire benefit reimbursement will be $10 per visit. The Member is responsible for all other charges and fees charged by the Noncontracting Provider to the extent such amount exceeds $10. A written request for reimbursement must be submitted within six (6) months of the date of service to Willamette Dental Group at:

Willamette Dental Group
Attn: Noncontracting Provider Reimbursement Benefit
6950 NE Campus Way
Hillsboro, OR 97124

The written request should include the Member's signature, the attending Provider's signature, and the attending Provider's itemized statement.

ELIGIBILITY AND ENROLLMENT SECTION
ACTIVE EMPLOYEES

I. Probationary Period

The Group will determine if there are certain probationary periods that must be satisfied before a new Eligible Employee can qualify for coverage under this Contract.

II. Eligibility and Enrollment

All Eligible Employees will have the opportunity to apply for coverage under this Contract. All applications submitted to Blue Cross of Idaho (BCI) by the Group now or in the future, will be for Eligible Employees or Eligible Dependents only.

A. Eligible Employee

To qualify as an Eligible Employee under this Contract, a person must be and remain a full-time employee, sole proprietor, or partner of the Group who regularly works at least 20 hours per week and is paid on a regular, periodic basis through the Group's payroll system.

B. Eligible Dependent

To qualify as an Eligible Dependent under this Contract, a person must be and remain one (1) of the following:

1. The Enrollee's spouse under a legally valid marriage.

2. The Enrollee's or the Enrollee's spouse's natural child, stepchild, legally adopted child, child placed with the Enrollee for adoption, or child for whom the Enrollee or the Enrollee's spouse has court-appointed guardianship or custody. The child must be:
   a) Under the age of twenty-six (26); or
   b) Medically certified as disabled due to mental handicap or physical handicap *and* financially dependent upon the Enrollee or the Enrollee's spouse for support, regardless of age.

3. An Enrollee must notify BCI and/or the Group within thirty (30) days when a person no longer qualifies as an Eligible Dependent. Coverage for the former Eligible Dependent will terminate the last day of the month in which the change in eligibility occurred.

III. Leave of Absence

A. Enrollees who subsequently fail to fulfill the twenty (20) hour-per-week employment requirement and who have been enrolled for nine (9) months or more, may retain membership and receive benefits defined in this Contract while on a paid, approved leave of absence for a period not to exceed one (1) year; provided the Group continues to pay not less than fifty dollars ($50.00) per month for each Enrollee and remits the entire premium due with the payment for the other Enrollees. Coverage for an employee on a paid leave of absence in excess of twelve (12) months will be permitted only on an exception basis approved by Blue Cross of Idaho.

B. Enrollees who fail to fulfill the twenty (20) hour-per-week employment requirement and who have been enrolled for at least one (1) month may retain membership and receive benefits defined in this Contract while on an unpaid, approved leave of absence for a period not to exceed one (1) year. The monthly premium is the sole responsibility of the Enrollee and must be submitted with the Group payment for the other Enrollees.

C. An unpaid leave of absence may be granted by the Participating School District, provided it does not exceed twelve (12) months, and that the Enrollee intends to return to employment with the Group at the end of the leave of absence.

IV. Group Employee Premium Contribution

The Group will pay a uniform amount for each classification of employee; i.e., certified/noncertified, but not less than a rate in proportion to full-time employment for each Enrollee from district funds. The balance of the premium will be payroll-deducted from the Enrollee's wage.

V. Miscellaneous Eligibility and Enrollment Provisions

A. The Group agrees to collect required Enrollee payments through payroll withholding and be responsible for making the required payments to BCI on or before the first of each month.

Unless required by state or federal law or unless agreed to in writing by BCI and the Council, the Group agrees not to offer to its employees any other hospital, medical, dental or surgical coverage that is not provided by or through BCI, including but not limited to, coverage under a fee for service/indemnity plan, managed care organization or other similar program or plan, if such coverage is available to the Group from BCI during the twelve (12) month period from September 1 through August 31 of each year.

B. It is understood that no Contract will be issued or renewed unless 85% of all Eligible Employees enroll. Employees who certify enrollment under another employer Health Benefit Plan and for whom no cash-in-lieu payment is made are not included in the 85% calculation. Should the total enrollment of Eligible Employees fall below the required 85% the Contract will be subject to surcharge or discontinued at the next renewal date.

Existing districts that do not meet this criteria must submit to Blue Cross of Idaho a written plan showing how and when compliance will be accomplished. This plan is subject to approval, rejection or modification by Blue Cross of Idaho.

C. 1. For an Eligible Employee to enroll himself or herself and any Eligible Dependents for coverage under this Contract (or for an Enrollee to enroll Eligible Dependents for coverage) the Eligible Employee or Enrollee, as the case may be, must complete a BCI application and submit it and any required premiums to BCI.

2. Except as provided otherwise in this section, the Effective Date of coverage for an Eligible Employee or an Eligible Dependent will be the first day of the month following the month of enrollment.

3. The Effective Date of coverage for an Eligible Employee and any Eligible Dependents listed on the Eligible Employee's application is the Group's Contract Date if the application is submitted to BCI by the Group on or before the Contract Date.

D. 1. Except as stated otherwise in subparagraphs D.2. and D.3. below, the initial enrollment period is thirty (30) days for Eligible Employees and Eligible Dependents. The initial enrollment period begins on the date the Eligible Employee or Eligible Dependent first becomes eligible for coverage under this Contract.

2. An Enrollee's newborn Dependent, including adopted newborn children who are placed with the adoptive Enrollee within sixty (60) days of the adopted child's date of birth, are covered under this Contract from and after the date of birth for sixty (60) days.

In order to continue coverage beyond the sixty (60) days outlined above, the Enrollee must complete an enrollment application and submit the required premium within thirty-one (31) days of the date monthly billing is received by the Group and a notice of premium is provided to the Enrollee by the Group.

When a newborn child is added and the monthly premium changes, a full month's premium is required for the child if his or her date of birth falls on the 1st through the 15th day of the month. No premium for the first month is required if the child's date of birth falls on the 16th through the last day of the month.

The Effective Date of coverage will be the date of birth for a newborn natural child or a newborn child adopted or placed for adoption within sixty (60) days of the child's date of birth.

If the date of adoption or the date of placement for adoption of a child is more than sixty (60) days after the child's date of birth, the Effective Date of coverage will be the date of adoption or the date of placement for adoption. In this Contract, 'child' means an individual who has not attained age eighteen (18) years as of the date of the adoption or placement for adoption. In this Contract, "placed for adoption" means physical placement in the care of the adoptive Enrollee, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it means when the adoptive Enrollee signs an agreement for adoption of the child and signs an agreement assuming financial responsibility for the child.

3. The initial enrollment period is sixty (60) days for an Eligible Dependent who becomes eligible because of marriage. The initial enrollment period begins on the date of such marriage. The Effective Date of coverage will be the first day of the month following the month of enrollment.

E. Late Enrollee

If an Eligible Employee or an Eligible Dependent does not enroll during the applicable initial enrollment period described in Paragraph D. of this section, the Eligible Employee or Eligible Dependent is a Late Enrollee. A Late Enrollee may enroll only during next scheduled Open Enrollment Period.

F. Special Enrollment Periods

An Eligible Employee or Eligible Dependent will not be considered a Late Enrollee if:

1. The Eligible Employee or Eligible Dependent meets each of the following:
   a) The individual was covered under Qualifying Previous Coverage at the time of the initial enrollment period.
   b) The individual lost coverage under Qualifying Previous Coverage as a result of termination of employment or eligibility, the involuntary termination of the Qualifying Previous Coverage.
   c) The individual requests enrollment within thirty (30) days after termination of the Qualifying Previous Coverage.

2. The individual is employed by an employer that offers multiple dental plans and the individual elects a different plan during an open enrollment period.

3. A court has issued a court order requiring that coverage be provided for an Eligible Dependent by an Enrollee under this Contract, and application for enrollment is made within thirty (30) days after issuance of the court order.

4. The individual first becomes eligible.

5. The Eligible Employee and/or Eligible Dependent become eligible for a premium assistance subsidy under Medicaid or the Children's Health Insurance Program (CHIP) and coverage under this Contract is requested no later than sixty (60) days after the date the Eligible Employee and/or Eligible Dependent is determined to be eligible for such assistance.

6. Coverage under Medicaid or CHIP for an Eligible Employee and/or Eligible Dependent is terminated as a result of loss of eligibility for such coverage, and coverage is requested under this Contract no later than sixty (60) days after the date of termination of such coverage.

G. Eligible Employees and their enrolled Eligible Dependents who become eligible for retirement benefits by permanently separating from public employment in accordance with Idaho Code Title 59, Chapter 13 shall be continued on their former group's benefit schedule until eligible for Medicare coverage. At the age of 65 or when otherwise eligible for Medicare, the Eligible retired Employee or Eligible Dependent shall be converted to the Statewide School Retiree Program, a Blue Cross of Idaho program that supplements Medicare.

VI. Eligible Employees Changing to Other Participating School Districts

Membership may be continuous for any Eligible Employee who changes employment to another Participating School District. There will be no waiting period for full benefit eligibility if there is no interruption in coverage.

VII. Retirement

If a Enrollee separates from public school employment by retirement in accordance with Idaho Code Title 59, Chapter 13, the Enrollee and/or his or her spouse shall be eligible for coverage under the retiree Contract of the Statewide Schools Group Program only if the Enrollee and/or his or her spouse have been continuously enrolled in the active employee Statewide Schools Group Program for the twelve (12) months immediately prior to the Enrollee's retirement. Any exceptions will require a health statement.

VIII. Qualified Medical Child Support Order

A. If this Contract provides for family coverage, BCI will comply with a Qualified Medical Child Support Order (QMCSO) according to the provisions of Section 609 of ERISA and any other applicable federal or state laws. A medical child support order is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a child of an Enrollee or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law) and relates to benefits under this Contract, or

2. Enforces a law relating to medical child support described in Section 1908 of the Social Security Act with respect to a group health plan.

B. A medical child support order meets the requirements of a QMCSO if such order clearly specifies:

1. The name and the last known mailing address (if any) of the Enrollee and the name and mailing address of each child covered by the order.

2. A reasonable description of the type of coverage to be provided by this Contract to each such child, or the manner in which such type of coverage is to be determined.

3. The period to which such order applies.

C. 1. Within fifteen (15) days of receipt of a medical child support order, BCI will notify the party who sent the order and each affected child of the receipt and of the criteria by which BCI determines if the medical child support order is a QMCSO. In addition, BCI will send an application to each affected child. The application must be completed by or on behalf of the affected child and promptly returned to BCI. With respect to a medical child support order, affected children may designate a representative for receipt of copies of notices sent to each of them.

2. Within thirty (30) days after receipt of a medical child support order and a completed application, BCI will determine if the medical child support order is a QMCSO and will notify the Enrollee, the party who sent the order, and each affected child of such determination.

D. BCI will make benefit payments to the respective party for reimbursement of eligible expenses paid by an enrolled affected child or by an enrolled affected child's custodial parent, legal guardian, or the Idaho Department of Health and Welfare.

ELIGIBILITY AND ENROLLMENT SECTIONRETIREES

I. Eligibility and Enrollment

All Eligible Persons will have the opportunity to apply for coverage under this Contract. All applications submitted to Blue Cross of Idaho by the Group now or in the future, shall be for Eligible Persons or Eligible Dependents only.

A. Eligible Retiree

1. Eligible Retiree is defined as: A retired employee who was employed by a Participating School District but who has permanently separated from public school employment in accordance with Idaho Code Title 59, Chapter 13.

2. The date the retiree becomes eligible for membership in the Statewide School Retiree Program is on the first day of retirement in accordance with Idaho Code Title 59, Chapter 13, or the day a school district becomes a Participating School District, whichever is later.

3. A Retiree may, upon written request, defer enrollment in the Statewide School Retiree Program until a future date, thus postponing any draw on the unused sick leave account with PERSI.

   During the period of deferment, the Retiree must maintain continuous group coverage. The eligibility for Statewide School Retiree Program coverage ends should the School District from which the person retires move coverage for active employees to another insurance carrier.

B. Eligible Dependent

To qualify as an Eligible Dependent under this Contract, a person must be and remain one (1) of the following:

1. The Enrollee's spouse under a legally valid marriage.

2. The Enrollee’s or the Enrollee’s spouse’s natural child, stepchild, legally adopted child, child placed with the Enrollee for adoption, or child for whom the Enrollee or the Enrollee’s spouse has court-appointed guardianship or custody. The child must be:
   a) Under the age of twenty-six (26); or
   b) Medically certified as disabled due to mental handicap or physical handicap *and* financially dependent upon the Enrollee or the Enrollee’s spouse for support, regardless of age.

3. An Enrollee must notify BCI and/or the Group within thirty (30) days when a dependent no longer qualifies as an Eligible Dependent. Coverage for the former Eligible Dependent will terminate the last day of the month in which the change in eligibility occurred.

II. Loss of Eligibility if a Participating School District Cancels

If the Participating School District through which the retired Member was last employed cancels its Blue Cross of Idaho coverage and leaves the Statewide School Group Program, the retired Member ceases to be an Eligible Retiree on the effective date of the cancellation.

III. Payment of Premium and Effective Date

A. All Eligible Retirees will have the opportunity to apply for coverage. In order to be eligible for retiree benefits, the Eligible Retiree must have continuous coverage from their former group's benefit schedule. All applications submitted to Blue Cross of Idaho now or in the future, must be for Eligible Retirees or Eligible Dependents only.

B. The premium will be deducted from the Enrollee's sick leave fund to the extent such funds are available. When the sick leave funds are exhausted, the premium shall be deducted from the Enrollee's pension fund to the extent such funds are available.

If there is a sufficient amount of funds in the Enrollee's sick leave and/or pension fund, the Public Employees Retirement System of Idaho agrees to collect required Enrollee payments through withholding from the fund, be responsible for and make the payment to Blue Cross of Idaho on or before the first of the month during the term of this Contract. If the Enrollee's monthly pension and/or sick leave fund is less than the required payment, the Enrollee shall be responsible for remitting the entire monthly subscription payment to Blue Cross of Idaho on or before the first of the month during the term of this Contract.

C. For a person who is an Eligible Employee and who applies for Single, Two-Party or Family Coverage on or before the first day he or she first becomes eligible as provided in item I., the Effective Date is either the Participating School District's Contract Date, or the first day of the month after the person first becomes eligible, whichever is earlier. An Enrollee may not add a Dependent who was not enrolled when the Enrollee was an active employee under the Statewide School Group Program, except as provided for Eligible Dependents under paragraph III.F.

D. 1. For an Eligible Person to enroll himself or herself and any Eligible Dependents for coverage under this Contract (or for an Enrollee to enroll Eligible Dependents for coverage under this Contract) the Eligible Person or Enrollee, as the case may be, must complete a Blue Cross of Idaho application and submit it and any required premiums to Blue Cross of Idaho.

2. Except as provided otherwise in this section, the Effective Date of coverage for an Eligible Person or an Eligible Dependent will be the first day of the month following the month of enrollment.

3. The Effective Date of coverage for an Eligible Person and any Eligible Dependents listed on the Eligible Person's application is the Group's Date if the application is submitted to Blue Cross of Idaho by the Group on or before the Contract Date.

E. Eligible Retirees and Eligible Dependents shall be continued on this benefits schedule until eligible for Medicare coverage. When first eligible, Retirees and Eligible Dependents must enroll in Medicare (both Part A and Part B) in order to participate in the Statewide School Retiree Program that supplements Medicare.

1. Except as stated otherwise in subparagraphs E2. and 3. below, the initial enrollment period is thirty (30) days for Eligible Employees and Eligible Dependents. The initial enrollment period begins on the date the Eligible Employee or Eligible Dependent first becomes eligible for coverage under this Contract.

2. An Enrollee’s newborn Dependent, including adopted newborn children who are placed with the adoptive Enrollee within sixty (60) days of the adopted child’s date of birth, are covered under this Contract from and after the date of birth for sixty (60) days.

   In order to continue coverage beyond the sixty (60) days outlined above, the Enrollee must complete an enrollment application and submit the required premium within thirty-one (31) days of the date monthly billing is received by the Group and a notice of premium is provided to the Enrollee by the Group.

   When a newborn child is added and the monthly premium changes, a full month's premium is required for the child if his or her date of birth falls on the 1st through the 15th day of the month. No premium for the first month is required if the child's date of birth falls on the 16th through the last day of the month.

   The Effective Date of coverage will be the date of birth for a newborn natural child or a newborn child adopted or placed for adoption within sixty (60) days of the child’s date of birth.

   If the date of adoption or the date of placement for adoption of a child is more than sixty (60) days after the child’s date of birth, the Effective Date of coverage will be the date of adoption or the date of placement for adoption. In this Contract, ‘child’ means an individual who has not attained age eighteen (18) years as of the date of the adoption or placement for adoption. In this Contract, “placed for adoption” means physical placement in the care of the adoptive Enrollee, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it means when the adoptive Enrollee signs an agreement for adoption of the child and signs an agreement assuming financial responsibility for the child.

3. The initial enrollment period is sixty (60) days for an Eligible Dependent who becomes eligible because of marriage. The initial enrollment period begins on the date of such marriage. The Effective Date of coverage is the first day of the month following the month of enrollment.

F. Late Enrollee

If an Eligible Dependent does not enroll during the applicable initial enrollment period described in Paragraph E. of this section, the Eligible Dependent is a Late Enrollee. A Late Enrollee may enroll only during the next scheduled Open Enrollment Period.

G. Special Enrollment Periods

An Eligible Dependent will not be considered a Late Enrollee if:

1. The Eligible Dependent meets each of the following:
   a) The individual was covered under Qualifying Previous Coverage at the time of the initial enrollment period;
   b) The individual lost coverage under Qualifying Previous Coverage as a result of termination of employment or eligibility, the involuntary termination of the Qualifying Previous Coverage; and
   c) The individual requests enrollment within thirty (30) days after termination of the Qualifying Previous Coverage.

2. The individual is employed by an employer that offers multiple dental plans and the individual elects a different plan during an open enrollment period.

3. A court has issued a court order requiring that coverage be provided for an Eligible Dependent by an Enrollee under this Contract, and application for enrollment is made within thirty (30) days after issuance of the court order.

4. The individual first becomes eligible.

5. The Eligible Dependent become eligible for a premium assistance subsidy under Medicaid or the Children's Health Insurance Program (CHIP) and coverage under this Contract is requested no later than sixty (60) days after the date the Eligible Dependent is determined to be eligible for such assistance.

6. Coverage under Medicaid or CHIP for an Eligible Dependent is terminated as a result of loss of eligibility for such coverage, and coverage is requested under this Contract no later than sixty (60) days after the date of termination of such coverage.

IV. Qualified Medical Child Support Order

A. If this Contract provides for family coverage, Blue Cross of Idaho shall comply with a Qualified Medical Child Support Order (QMCSO) according to the provisions of Section 609 of ERISA and any other applicable federal or state laws. A medical child support order is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a child of an Enrollee under this Contract or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law) and relates to benefits under this Contract, or

2. Enforces a law relating to medical child support described in Section 1908 of the Social Security Act with respect to a group health plan.

B. A medical child support order meets the requirements of a QMCSO if such order clearly specifies:

1. The name and the last known mailing address (if any) of the Enrollee and the name and mailing address of each child covered by the order;

2. A reasonable description of the type of coverage to be provided by this Contract to each such child, or the manner in which such type of coverage is to be determined;

3. The period to which such order applies; and

4. Each group health plan to which such order applies.

C. 1. Within fifteen (15) days of receipt of a medical child support order, Blue Cross of Idaho shall notify the party who sent the order and each affected child of such receipt and of the criteria by which Blue Cross of Idaho determines if the medical child support order is a QMCSO. In addition, Blue Cross of Idaho will send an application to each affected child. The application must be completed by or on behalf of the affected child and promptly returned to Blue Cross of Idaho. Each affected child may designate a representative for receipt of copies of notices sent to each affected child with respect to a medical child support order.

2. Within thirty (30) days after receipt of a medical child support order and a completed application, Blue Cross of Idaho shall determine if the medical child support order is a QMCSO and shall notify the Enrollee, the party who sent the order and each affected child of such determination.

D. Blue Cross of Idaho shall make benefit payments to the respective party for reimbursement of eligible expenses paid by an enrolled affected child or by an enrolled affected child's custodial parent, legal guardian or the Idaho Department of Health and Welfare.

DEFINITIONS SECTION

For reference, most terms defined in this section are capitalized throughout this Contract. Other terms may be defined where they appear in this Contract. All Providers and Facilities listed in this Contract and in the following section must be licensed and/or registered by the state where the services are rendered, unless exempt by federal law, and must be performing within the scope of license in order for BCI to provide benefits. Definitions in this Contract shall control over any other definition or interpretation unless the context clearly indicates otherwise.

Accidental Injury—an objectively demonstrable impairment of bodily function or damage to part of the body caused by trauma from a sudden, unforeseen external force or object, occurring at a reasonably identifiable time and place, and without a Member's foresight or expectation, which requires medical attention at the time of the accident. The force may be the result of the injured party's actions, but must not be intentionally self-inflicted unless caused by a medical condition or domestic violence. Contact with an external object must be unexpected and unintentional, or the results of force must be unexpected and sudden.

Adverse Benefit Determination—any denial, reduction or termination of, or the failure to provide payment for, a benefit for services or ongoing treatment under this Contract.

Benefits After Termination—the benefits, if any, remaining under this Contract after a person ceases to be a Member.

Blue Cross of Idaho Health Service, Inc. (Blue Cross of Idaho or BCI)—a nonprofit mutual insurance company.

Congenital Anomaly—a condition existing at or from birth, which is a significant deviation from the common form or function of the body, whether caused by a hereditary or a developmental defect or Disease. In this Contract, the term significant deviation is defined to be a deviation which impairs the function of the body and includes but is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other condition that are medically diagnosed to be Congenital Anomalies.

Contract or Dental Blue Connect—this Dental Blue Connect Contract, which includes the Group application, individual enrollment applications, Member identification cards, any written endorsements, riders, amendments, or any other written agreements between BCI and the Group executed by an authorized officer.

Contract Date—the date specified in this Contract on which coverage commences for the Group.

Contracting Provider—a Dentist or Denturist who is employed by Willamette Dental Group to provide Covered Dental Services to Dental Blue Connect Members.

Copayment—a designated dollar amount that a Member is financially responsible for and must pay to a Provider at the time certain Covered Dental Services are rendered.

Council—the Idaho School District Cooperative Service Council, an organization to whom the Master Group Matrix Contract is issued and through which benefits are selected by Participating School Districts.

Cost Effective—a requested or provided dental service or supply that is Medically Necessary in order to identify or treat a Member's health condition, illness or injury and that is:

1. Provided in the most cost-appropriate setting consistent with the Member's clinical condition and the Covered Provider's expertise. For example, when applied to services that can be provided in either an Inpatient hospital setting or Outpatient hospital setting, the Cost Effective setting will generally be the outpatient setting. When applied to services that can be provided in a hospital setting or in a physician office setting, the Cost Effective setting will generally be the physician office setting.
2. Not more costly than an alternative service or supply, including no treatment, and at least as likely to produce an equivalent result for the Member's condition, Disease, Illness or injury.

Covered Dental Services—services listed in the List of Covered Dental Services and Copayments.

Dental Emergency—acute infection, traumatic damage to the oral cavity or discomfort that cannot be controlled by non-prescription pain medication.

Dental Implant—a device specifically designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental replacement.

Dentist—an individual licensed in the state where service is rendered to practice Dentistry.

Dentistry or Dental Treatment—the treatment of teeth and supporting structures, including but not limited to, the replacement of teeth.

Denturist—an individual licensed in the state where service is rendered to engage in the practice of denturitry. For BCI to provide benefits, the Denturist must be performing within the scope of his/her license.

Disease—any alteration in the body or any of its organs or parts that interrupts or disturbs the performance of vital functions, thereby causing or threatening pain, weakness, or dysfunction. A Disease can exist with or without a Member's awareness of it, and can be of known or unknown cause(s).

Effective Date—the date when coverage for a Member begins under this Contract.

Eligible Dependent—a person eligible for enrollment under an Enrollee's coverage.

Eligible Employee—an employee, sole proprietor or partner of a Group who is entitled to apply as an Enrollee.

Emergency Office Visit Copayment—the designated dollar amount that a Member is financially responsible for and must pay for each visit for emergency treatment.

Enrollee—an Eligible Employee who has enrolled for coverage and has satisfied the requirements of the Eligibility and Enrollment Section.

Enrollment Date—the date of enrollment of an Eligible Employee or Eligible Dependent under this Contract, or if earlier, the first day of the probationary period for such enrollment.

Group—a Participating School District.

General Office Visit Copayment—the designated dollar amount that a Member is financially responsible for and must pay for each visit with a Dentist, Denturist, or Dentist professionally qualified as an orthodontist or pediatric dentist.

Illness—a deviation from the healthy and normal condition of any bodily function or tissue. An Illness can exist with or without a Member's awareness of it, and can be of known or unknown cause(s).

Inpatient—a Member who is admitted as a bed patient in a Licensed General Hospital or other Facility Provider and for whom a room and board charge is made.

Investigational**—the use of any treatment, procedure, facility, equipment, drug, device or supply that:**

1. Is not yet generally recognized by Dentists practicing within the state of Idaho as accepted dental practice, or
2. Requires federal or other governmental approval, for other than Investigational purposes, and such approval has not been granted at the time the treatment, procedure, facility, equipment, drug, device or supply is used.

Large Employer—any person, firm, corporation, partnership, or association that is actively engaged in business that, on at least 50% of its working days during the preceding calendar year, employed no less than fifty-one (51) Eligible Employees, the majority of whom were employed within this state. In determining the number of Eligible Employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one (1) employer.

Medically Necessary (or Medical Necessity)—the Covered Dental Service or supply recommended by the treating Provider to identify or treat a Member's condition, Disease, Illness or Accidental Injury and which is determined by BCI to be:

1. The most appropriate supply or level of service, considering potential benefit and harm to the Member.
2. Proven to be effective in improving health outcomes;

a. For new treatment, effectiveness is determined by peer reviewed scientific evidence;
b. For existing treatment, effectiveness is determined first by peer reviewed scientific evidence, then by professional standards, then by expert opinion.

3. Not primarily for the convenience of the Member or Provider.
4. Cost Effective for this condition.

The fact that a Provider may prescribe, order, recommend, or approve a service or supply does not, in and of itself, necessarily establish that such service or supply is Medically Necessary under this Contract.

The term Medically Necessary as defined and used in this Contract is strictly limited to the application and interpretation of this Contract, and any determination of whether a service is Medically Necessary hereunder is made solely for the purpose of determining whether services rendered are Covered Dental Services.

In determining whether a service is Medically Necessary, BCI considers the health records and, the following source documents: Blue Cross Blue Shield Association Center for Clinical Effectiveness (CCE) assessments, the Blue Cross and Blue Shield Association Medical Policy Reference Manual as adopted by BCI, and Blue Cross of Idaho Medical Policies. BCI also considers, current published medical literature and peer review publications based upon scientific evidence, and evidence-based guidelines developed by national organizations and recognized authorities

Member—an Enrollee or an enrolled Eligible Dependent covered under this Contract.

Noncontracting Provider—a Dentist or Denturist who is not employed by Willamette Dental Group to provide Covered Dental Services to Members.

Noncontracting Provider Reimbursement—the reimbursement benefit available to Members who receive Covered Dental Services by a Noncontracting Provider without a Referral from a Contracting Provider. The amount of this benefit is stated in the List of Covered Dental Services and Copayments.

Orthodontia or Orthodontic Treatment—the movement of teeth through bone by means of active orthodontic appliances in order to correct a patient's malocclusion (misalignment of the teeth).

Out of Area Emergency Care Reimbursement—the reimbursement benefit available to Members who receive Covered Dental Services for treatment of Dental Emergency by a Noncontracting Provider while traveling outside of a 50 mile radius of any Willamette Dental Group office. The amount of this Benefit is stated in the List of Covered Dental Services and Copayments.

Participating School District—an Idaho school district that has made application for coverage herein and has agreed to comply with all the terms and requirements of this Contract.

Provider—a Dentist or Denturist who is acting within the scope of his or her license.

Qualifying Previous Coverage or Qualifying Existing Coverage—"Creditable coverage" means, with respect to an individual, health benefits or coverage provided under any of the following;

1. Group health benefit plan;
2. Health insurance coverage without regard to whether the coverage is offered in the group market, the individual market or otherwise;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid);
5. Chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents). For purposes of 55 Title 10, United States Code, "uniformed services" means the armed forces, the Commissioned Corps of the National Oceanic and Atmospheric Administration and the Public Health Service;
6. A medical care program of the Indian Health Services or of a tribal organization;
7. A state health benefits risk pool;
8. A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Program (FEHBP));
9. A public health plan, which for purposes of this act, means a plan established or maintained by a state, a foreign country, the U.S. government, or other political subdivision of a state, the U.S. government or foreign country that provides health insurance coverage to individuals enrolled in the plan; or
10. A health benefit plan under section 5 (e) of the Peace Corps Act (22 U.S.C. 2504 (e)).

A State Children's Health Insurance Program (CHIP), under Title XXI of the Social Security Act, is creditable coverage, whether it is a stand-alone separate program, a CHIP Medicaid expansion program, or a combination program, and whether it is provided through a group health plan, health insurance, or any other mechanism.

CMS Insurance Standards Bulletin, Transmittal No. 05-01 clarified that: "Any public health plan, including a plan established or maintained by the U. S. government, or a foreign country, is creditable coverage for purposes of identifying eligible individuals under Part B of Title XXVII of the Public Health Service Act (PHS Act)".

Reasonable Cash Value—the Provider's usual, customary, and reasonable fee-for-service price of dental services.

Referral—the written recommendation of the attending Contracting Provider for specified Covered Dental Services to be performed by a Noncontracting Provider if, in the professional judgment of the attending Contracting Provider, the Covered Dental Services are Medically Necessary for the care of the Member's dental condition and are not available from a Contracting Provider. The Copayments for the Covered Dental Services specified in the Referral are the same as those required for Covered Dental Services provided by a Contracting Provider. Any Covered Dental Services not specified in the Referral are not covered and are the financial responsibility of the Member.

Retired Person (also referred to as "Retiree")—a former employee of a Participating School District who has separated from public school employment by retirement in accordance with Idaho Code Title 59, Chapter 13.

Specialist Office Visit Copayment—the designated dollar amount that a Member is financially responsible for and must pay to a Provider at an appointment with a Dentist professionally qualified as an endodontist, oral surgeon, periodontist, or prosthodontist.

Statewide School Group Program—the insurance program for the group of Participating School Districts who provide benefits for Eligible Employees and Eligible Retirees by selecting benefit options provided in the Master Group Matrix Contract. It includes a Benefit Summary for active employees and Retirees under the age of 65.

Surgery—within the scope of a Provider's license, the performance of:

1. Generally accepted operative and cutting procedures.
2. Endoscopic examinations and other invasive procedures using specialized instruments.
3. The correction of fractures and dislocations.
4. Customary preoperative and postoperative care.

Willamette Dental Group, P.C. or Willamette Dental Group—the group dental practice with offices in Idaho, Oregon and Washington, which is under contract with Blue Cross of Idaho to provide Covered Dental Services to Members.

EXCLUSIONS AND LIMITATIONS SECTION

In addition to the exclusions and limitations listed elsewhere in this Contract, the following exclusions and limitations apply to the entire Contract, unless otherwise specified.

I. General Exclusions

There are no benefits for any of the following conditions, treatments, services, supplies, or for any direct complications or consequences thereof. There are no benefits for an excluded service or supply even if approved, prescribed, or recommended by a Provider.

A. Procedures that are not included in the List of Covered Dental Services and Copayments; or that are not Medically Necessary for the care of a Member's dental condition; or that do not have uniform professional endorsement.

B. Bridges, crowns, dentures or any prosthetic devices requiring multiple treatment dates or fittings if the prosthetic item is installed or delivered more than sixty (60) days after termination of coverage.

C. Charges for services that were started prior to the Member's Effective Date. The following guidelines will be used to determine the date when a service is deemed to have been started:

1. For full dentures or partial dentures: on the date the final impression is taken.
2. For fixed bridges, crowns, inlays or onlays: on the date the teeth are first prepared.
3. For root canal therapy: on the later of the date the pulp chamber is opened or the date canals areexplored to the apex.
4. For periodontal Surgery: on the date the Surgery is actually performed.
5. For all other services: on the date the service is performed.
6. For orthodontic services, if benefits are available under this Contract: on the date any bands or otherappliances are first inserted.

D. Dental Implants and implant related services, unless otherwise specified as a Covered Dental Service in Attachment C.

E. Endodontic services, prosthetic services, and Dental Implants that were provided prior to Member's Effective Date. Such services or supplies are the responsibility of the Member.

F. Endodontic therapy completed more than sixty (60) days after termination of coverage.

G. Services that are Investigational in nature.

H. Exams or consultations needed solely in connection with a service or supply not listed as covered in the attachments as part of this Contract.

I. Full mouth reconstruction, including the extensive restoration of the mouth with crowns, bridges, or Dental Implants; and occlusal rehabilitation, including crowns, bridges, or Dental Implants used for the purpose of splinting, altering vertical dimension, restoring occlusion or correction attrition, abrasion, or erosion.

J. General anesthesia, moderation sedation and deep sedation.

K. Inpatient or Outpatient care or facility fees for dental procedures.

L. Maxillofacial prosthetic services.

M. Occlusal guards (nightguards).

N. Orthognathic Surgery, including, but not limited to, osteotomy, ostectomy and other services or supplies to augment or reduce the upper or lower jaw.

O. Personalized restorations.

P. Plastic, reconstructive, or cosmetic surgery and other services or supplies, which are primarily intended to improve, alter, or enhance appearance.

Q. Prescription and over-the-counter drugs and pre-medications.

R. Provider charges for a missed appointment or appointments cancelled without twenty-four (24) hours prior notice.

S. Replacement of lost, missing, or stolen dental appliances; replacement of dental appliances that are damaged due to abuse, misuse, or neglect.

T. Replacement of sound restorations.

U. 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 Contracting Provider.

V. Services or supplies provided by any person other than a Provider.

W. Any procedure, service or supply required directly or indirectly to treat a muscular, neural, orthopedic or skeletal disorder, dysfunction or Disease of the temporomandibular joint (jaw hinge) and its associated structures including, but not limited to, myofascial pain dysfunction syndrome.

X. Provided for any condition, Disease, Illness or Accidental Injury to the extent that the Member is entitled to Benefits under occupational coverage, obtained or provided by or through the employer under state or federal Workers' Compensation Acts or under Employer Liability Acts or other laws providing compensation for work-related injuries or conditions. This exclusion applies whether or not the Member claims such benefits or compensation or recovers losses from a third party.

Y. Services or supplies for treatment of injuries sustained while practicing for or competing in a professional paid athletic contest of any kind.

Z. Provided or paid for by any federal governmental entity or unit except when payment under this Contract is expressly required by federal law, or provided or paid for by any state or local governmental entity or unit where its charges therefor would vary, or are or would be affected by the existence of coverage under this Contract.

II. Limitations

A. Care Rendered by More Than One Provider

If a Member transfers from the care of one Provider to another Provider during treatment, or if more than one Provider renders services for one dental procedure, Blue Cross of Idaho will pay no more than the amount that it would have paid had but one Provider rendered the service.

B. Alternate Treatment Plan

If alternative services can be used to treat a condition, the service recommended by the Contracting Provider is covered. In the event the Member elects a service that is more costly than the service the Contracting Provider has approved, the Member is responsible for the Copayment(s) for the recommended Covered Dental Service(s) plus the cost differential of the more costly requested service.

C. Congenital Anomaly

Services or supplies listed in the attachments, which are provided to correct congenital or developmental malformations which impair functions of the teeth and supporting structures will be covered for enrolled Eligible Dependent children if Medical Necessity is established.

D. Indirect Fabricated Restorations

Crowns, casts, or other indirect fabricated restorations are covered only if Medically Necessary and if recommended by the Contracting Provider. Crowns, casts, or other indirect fabricated restorations are Medically Necessary if provided for treatment for decay, traumatic injury or substantial loss of tooth structure undermining one or more cusps and the tooth cannot be restored with a direct restorative material or the tooth is an abutment to a covered partial denture or fixed bridge.

E. Endodontic Treatment

1. When initial root canal therapy was performed by a Contracting Provider, the retreatment of such root canal therapy will be covered as part of the initial treatment for the first 24 months. After that time, the applicable Copayments will apply.

2. When the initial root canal therapy was performed by a Noncontracting Provider, the retreatment of such root canal therapy by a Contracting Provider will be subject to the applicable Copayments.

G. Hospital Setting

The services provided by a Contracting Provider in a hospital setting are covered if the following criteria are met:

1. A hospital or similar setting is Medically Necessary.
2. The services are pre-authorized in writing by a Contracting Provider.
3. The services provided are the same services that would be provided in a dental office.
4. The Hospital Call Copayment and applicable Copayments are paid.

F. Replacements

The replacement of an existing denture, crown, inlay, onlay, or other prosthetic appliance or restoration denture is covered if the appliance is more than 5 years old and replacement is Medically Necessary due to one of the following conditions:

1. A tooth within an existing denture or bridge is extracted;
2. The existing denture, crown, inlay, onlay or other prosthetic appliance or restoration cannot be made serviceable; or
3. The existing denture was an immediate denture to replace one or more natural teeth extracted while covered under this Contract, and replacement by a permanent denture is necessary.

III. Extension of Benefits

Benefits for the following services that require multiple appointments may extend after coverage ends. Enrollees terminated for failure to pay premiums are not eligible for extension of benefits.

A. Crowns or Bridges.

Adjustments for crowns or bridges will be covered for up to six (6) months after placement if the final impressions are taken prior to termination and the crown or bridge is placed within sixty (60) days of termination.

B. Removable Prosthetic Devices

Adjustments for removable prosthetic devices will be covered for up to six (6) months after placement if final impressions are taken prior to termination and the prosthesis is delivered within sixty (60) days after termination. Laboratory relines are not covered after termination.

C. Immediate Dentures

Benefits for dentures may be extended if final impressions are taken prior to termination and the dentures are delivered within sixty (60) days after termination. If coverage terminates prior to the extraction of teeth, the extractions will not be covered.

D. Root Canal Therapy

Benefits for root canal therapy will be extended if the root canal is started prior to termination and treatment is completed within sixty (60) days after termination. Pulpal debridement is not a root canal therapy start. If after sixty (60) days from termination of coverage the root canal requires re-treatment, re-treatment will not be covered. Restorative work following root canal therapy is a separate procedure and not covered after termination.

E. Extractions

Post-operative checks are covered for sixty (60) days from the date of the extraction for extractions performed prior to termination. If teeth are extracted in preparation for a prosthetic device and coverage terminates prior to the final impressions, coverage for the prosthetic device will not be extended. Extractions are a separate procedure from prosthetic procedures.

GENERAL PROVISIONS SECTION

I. Entire Contract—Changes

This Contract, which includes the Group application, individual enrollment applications, data and information, Member identification cards, and any written endorsements, riders, amendments, or other written agreements and any policies, terms, conditions, or requirements incorporated by reference at bcidaho.com approved in writing by an authorized Blue Cross of Idaho (BCI) officer, is the entire Contract between the Group and BCI. No agent or representative of Blue Cross of Idaho, other than a Blue Cross of Idaho officer, may change this Contract or waive any of its provisions. This Contract supplants and replaces any and all previous oral or written agreements, certificates, contracts, policies or representations, which shall have no further force and effect.

II. Records of Member Eligibility and Changes in Member Eligibility

A. The Group shall furnish all data required by BCI for it to provide coverage of the Group's Members under this Contract. In addition, the Group will provide written notification to BCI within thirty (30) days of the effective date of any changes in a Member's enrollment and benefit coverage status under this Contract.

B. A notification by the Group to BCI must be furnished on BCI approved forms, and according to rules and regulations of BCI. The notification must include all information reasonably required by BCI to effect changes, and must be accompanied by payment of applicable premiums.

III. Premium Charges and Billings

A. Blue Cross of Idaho shall submit an itemized monthly billing to the Group in advance of the premium due date and the Group shall make appropriate adjustments in the billing to reflect the termination of any Eligible Person or the addition of any new Eligible Person, in accordance with the provisions of this Contract.

B. The payment of the premium for each month is due on the first day of each month.

IV. Eligibility Requirements for School Districts Applying for Participation

A. Blue Cross of Idaho shall conduct a thorough review of the applying school district's historical claims experience to determine if the district will be accepted into the Statewide Schools Group Program. Blue Cross of Idaho shall make the final decision on acceptability.

B. If a district is accepted, it will be subject to a surcharge on premium if the district's historical claims experience is greater than the claim experience of the Statewide Schools Group Program pool. Surcharges shall be limited to two (2) years. Blue Cross of Idaho shall determine the surcharge, based on the district's claims experience.

C. If the district wants to terminate participation sometime in the future, the district must provide at least sixty (60) days advance written notice of termination of participation immediately prior to the Statewide School Group Program annual renewal date of September 1. If the district fails to provide sixty (60) days notice or fails to pay premiums when due, the district shall pay Blue Cross of Idaho $5,000 plus associated administrative expenses as a penalty for such failure(s). The penalty shall be due within thirty (30) days after the district's termination or premium due date as the case may be.

D. If a district terminates its participation in the Statewide Schools Group Program, the district cannot reapply for two (2) years. After two (2) years, the district may apply for participation, and unless precluded by law, the district must participate in the Statewide Schools Group Program for at least two (2) years and must accept all rate adjustments and new endorsements during that period.

V. Termination or Modification of this Contract

A. Pursuant to the provisions of this Subsection V., the Group or BCI may unilaterally terminate this Contract. BCI may unilaterally modify the terms of this Contract, including but not limited to, benefits, Copayments, premiums, and other provisions. Unless specified otherwise in this Contract, such termination or modification may be accomplished by giving written notice to the other party at least sixty (60) days in advance of the effective date of the termination or modification. Except for modifications resulting from statutory and/or regulatory changes affecting benefits, BCI may modify benefits only at the time of the Group's annual renewal of coverage.

However, this provision does not obligate BCI to provide benefits beyond the term of this Contract. The Group agrees that it will notify Members of any changes in benefits, Copayments, or premiums, at least thirty

(30) days prior to the effective date of such modifications. The Group's subsequent payment of premiums constitutes conclusive documentation that the Group and its Members have accepted and agreed to any such modification(s).

B. This Contract may be unilaterally terminated by BCI for any of the following:

1. For the Group's nonpayment of the appropriate premiums when due. A payer financial institution's return of or refusal to honor a check or draft constitutes nonpayment of premiums.
2. For the Group's fraud or intentional misrepresentation of a material fact.
3. For the Group's failure to maintain the enrollment percentage specified in the Application for Group Coverage. BCI may randomly audit enrollment to insure compliance. Failure to provide information requested in the audit may also result in termination.
4. For the Group's failure to make the employer premium contribution specified in the Application for Group Coverage.
5. In the case where this Contract is available to the Group only through an association as defined in Idaho Code §41-2202, the membership of the Group in the association (on the basis of which the coverage of this Contract is provided) ceases but only if the coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any Member.
6. If BCI elects not to renew all of its Benefit Plans delivered or issued for delivery to Large Employers in the state of Idaho. In which case, BCI will provide notice to the Group and its Members of such nonrenewal at least one hundred eighty (180) days in advance of the date of nonrenewal.

C. If the Group fails to pay premiums as agreed in the Eligibility and Enrollment Section, this Contract will terminate without notice at the end of the period for which the last premiums were paid. This Contract does not have a grace period; however, if the Group makes premium payments within thirty (30) days after the due date, BCI will reinstate this Contract as of the due date. No benefits are available during this thirty (30)-day period unless all premiums are properly paid before expiration of the thirty (30)-day period. BCI reserves the right to apply a twelve percent (12%) annualized interest fee on any portion of the balance owed by the Group to BCI that remains unpaid thirty (30) days or more beyond the original due date.

VI. Termination or Modification of a Member's Coverage Under this Contract

A. If an Enrollee ceases to be an Eligible Employee or the Group does not remit the required premium, the Enrollee's coverage and the coverage of any and all enrolled Eligible Dependents will terminate on the last day of the last month for which payment was made.

B. Except as provided in this paragraph, coverage under this Contract will terminate on the date a Member no longer qualifies as a Member, as defined in the Eligibility and Enrollment Section. Coverage will not terminate because of age for a Member who is an unmarried dependent child incapable of self-sustaining employment by reason of mental handicap or physical handicap, who became so incapable prior to reaching the age limit, and who is chiefly dependent on the Enrollee for support and maintenance, provided the Enrollee, within thirty-one (31) days of when the dependent child reaches the age limit, has submitted to BCI (at the Enrollee's expense) a Physician's certification of such dependent child's incapacity. BCI may require, at reasonable intervals during the two (2) years following when the child reaches the age limit, subsequent proof of the child's continuing disability and dependency. After two (2) years, BCI may require such subsequent proof once each year. Coverage for the dependent child will continue so long as this Contract remains in effect, the child's disability and financial dependency exists, and the child has not exhausted benefits.

C. Termination or modification of this Contract automatically terminates or modifies all of the Member's coverage and rights hereunder. It is the responsibility of the Group to notify all of its Members of the termination or any modification of this Contract, and BCI's notice to the Group, upon mailing or any other delivery, constitutes complete and conclusive notice to the Members.

D. Except as otherwise provided in this Contract, no benefits are available to a Member for Covered Dental Services rendered after the date of termination of a Member's coverage.

E. If BCI discovers that a Member has made any misrepresentation, omission, or concealment of fact in obtaining coverage under this Contract which was or would have been material to BCI's acceptance of a risk, extension of coverage, provision of benefits or Covered Dental Services, or payment of any reimbursement

benefit, BCI may take action against the Group, including but not limited to increasing the Group's premiums.

F. Prior to legal finalization of an adoption, the coverage provided in this Contract for a child placed for adoption with an Enrollee continues as it would for a naturally born child of the Enrollee until the first of the following events occurs:
1. The date the child is removed permanently from placement and the legal obligation terminates, or
2. The date the Enrollee rescinds, in writing, the agreement of adoption or the agreement assuming financial responsibility.

If one (1) of the foregoing events occurs, coverage terminates on the last day of the month in which such event occurs.

G. Coverage under this Contract will terminate for an Eligible Dependent on the last day of the month he or she no longer qualifies as an Eligible Dependent due to a change in eligibility status.

VII. Benefits After Termination of Coverage

A. When this Contract remains in effect but a Member's coverage terminates for reasons other than those specified in General Provisions IV.E. benefits will be continued:
1. If the Member is eligible for and properly elects continuation coverage in accordance with the applicable provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any amendments thereto.
   Most employers who employ twenty (20) or more people on a typical business day are subject to COBRA. If the Group is subject to COBRA, a Member may be entitled to continuation coverage. Members should check with the Group for details.

VIII. Transfer Privilege

A Member is eligible to transfer his or her dental care coverage to a BCI individual contract if the Member ceases to be eligible for coverage under this Contract. If a Member's enrollment status changes as indicated below, the following Members may apply for transfer:

A. The Enrollee, if the Enrollee ceases to be an Eligible Employee as specified in the Eligibility and Enrollment Section. The Enrollee may include enrolled Eligible Dependents in the Enrollee's application for transfer.

B. An enrolled dependent child who ceases to be an Eligible Dependent as specified in the Eligibility and Enrollment Section.

C. The Enrollee's spouse (if a Member) upon entry of a final decree of divorce or annulment.

D. The Enrollee's enrolled Eligible Dependents upon the Enrollee's death.

To apply for a transfer, the Member must submit a completed application and the appropriate premium to BCI within thirty (30) days after the loss of eligibility of coverage. If approved, benefits under the new Contract are subject to the rates, regulations, terms, and provisions of the new Contract.

If the Group or BCI terminates this Contract, and the Group provides another dental care plan to its employees effective immediately after the termination of this Contract, no Member will be entitled to this transfer privilege.

IX. Contract Between BCI and the Group—Description of Coverage

This Contract is a contract between BCI and the Group. BCI will provide the Group with copies of the Contract to give to each Enrollee as a description of coverage, but this Contract shall not be construed as a contract between BCI and any Enrollee. BCI's mailing or other delivery of copies of this Contract to the Group constitutes complete and conclusive issuance and delivery thereof to each Enrollee.

X. Applicable Law

This Contract shall be governed by and interpreted according to the laws of the state of Idaho.

XI. Notice

Any notice required under this Contract must be in writing. BCI's notices to the Group will be sent to the Group's address as it appears on BCI's records, and mailing or delivery to the Group constitutes complete and conclusive

notice to the Members. Notice given to BCI must be sent to BCI's address contained in the Group Application. The Group must give BCI immediate written notice of any change of address for the Group or any of its Members. BCI shall give the Group immediate written notice of any change in BCI's address. When BCI is required to give advice or notice, the depositing of such advice or notice with the U.S. Postal Service, regular mail, or the other delivery conclusively constitutes the giving of such advice or notice on the date of such mailing or delivery.

XII. Benefits to Which Members are Entitled

A. Subject to all of the terms of this Contract, a Member is entitled to benefits for Covered Dental Services specified in the benefit sections and/or in the attachments.

B. Covered Dental Services are subject to the availability of Providers and the ability of the employees of such Providers to provide such services. BCI shall not assume nor have any liability for conditions beyond its control that affect the Member's ability to obtain Covered Dental Services.

XIII. Release and Disclosure of Health Records and Other Information

A. In order to effectively apply the provisions of this Contract, BCI may obtain information from Providers and other entities pertaining to any health related services that the Member may receive or may have received in the past. BCI may also disclose to Providers and other entities, information obtained from the Member's transactions such as Contract coverage, premiums, payment history and encounter data necessary to allow the processing of an encounter and for other health care operations. To protect the Member's privacy, BCI treats all information in a confidential manner. For further information regarding BCI's privacy policies and procedures, the Member may request a copy of BCI's Notice of Privacy Practices by contacting customer service at the number provided in this Contract.

B. As a condition of coverage under this Contract, each Member authorizes Providers to testify at BCI's request as to any information regarding the Member's health history, services rendered, and treatment received. Any and all provisions of law or professional ethics forbidding such disclosures or testimony are waived by and in behalf of each Member.

XIV. Exclusion of General Damages

Liability under this Contract for benefits conferred hereunder, including recovery under any claim or breach of this Contract, shall be limited to the actual benefits for Covered Dental Services as provided herein and shall specifically exclude any claim for general damages, including but not limited to, alleged pain, suffering or mental anguish, or for economic loss, or consequential loss or damages.

XV. Member/Provider Relationship

A. The choice of a Provider is solely the Member's.

B. BCI is not liable for any act or omission or for the level of competence of any Provider, and BCI has no responsibility for a Provider's failure or refusal to render Covered Dental Services to a Member.

C. The use or nonuse of an adjective such as Contracting or Noncontracting is not a statement as to the ability of the Provider.

XVI. Participating Plan

BCI may, in its sole discretion, make an agreement with any appropriate entity (referred to as a Participating Plan) to provide, in whole or in part, benefits for Covered Dental Services to Members, but it shall have no obligation to do so.

XVII. Coordination of this Contract's Benefits with Other Benefits

This Coordination of Benefits (COB) provision applies when a Member has health care coverage under more than one (1) Contract. Contract is defined below.

The Order of Benefit Determination Rules govern the order in which each Contract will pay a claim for benefits. The Contract that pays first is called the Primary Contract. The Primary Contract must pay benefits in accordance with its Contract terms without regard to the possibility that another Contract may cover some expenses. The Contract that pays after the Primary Contract is the Secondary Contract. The Secondary Contract may reduce the benefits it pays so that payments from all Contracts does not exceed one hundred percent (100%) of the total Allowable Expenses.

A. Definitions

1. A Contract is any of the following that provides benefits or services for medical or dental care or treatment. If separate Contracts are used to provide coordinated coverage for members of a group, the separate Contracts are considered parts of the same Contract and there is no COB among those separate contracts.
   a) Contract includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   b) Contract does not include: individual benefits, hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefit for non-medical components of long-term care policies; Medicare supplement policies; Medicare or any other federal governmental plans, unless permitted by law.

   Each Contract for coverage under a) or b) is a separate Contract. If a Contract has two (2) parts and COB rules apply only to one (1) of the two (2), each of the parts is treated as a separate Contract.

2. This Contract means, in a COB provision, the part of the Contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Contracts. Any other part of the Contract providing health care benefits is separate from this plan. A Contract may apply one (1) COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, any may apply under COB provision to coordinate other benefits.

3. The Order of Benefit Determination Rules determine whether This Contract is a Primary Contract or Secondary Contract when the Member has health care coverage under more than one (1) Contract. When This Contract is primary, it determines payment for its benefits first before those of any other Contract without considering any other Contract's benefits. When This Contract is secondary, it determines its benefits after those of another Contract and may reduce the benefits it pays so that all Contract benefits do not exceed one hundred percent (100%) of the total Allowable Expense.

4. Allowable Expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Contract covering the Member. When a Contract provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Contract covering the Member is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

   The following are examples of expenses that are not Allowable Expenses:
   a) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Contracts provides coverage for private hospital room expenses.

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

   c) If a Member is covered by two (2) or more Contracts that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees it not an Allowable Expense.

   d) If a Member is covered by one (1) Contract that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Contract that provides its benefits

or services on the basis of negotiated fees, the Primary Contract's payment arrangement shall be the Allowable Expense for all Contracts. However, if the provider has contracted with the Secondary Contract to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Contract's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Contract to determine its benefits.

e) The amount of any benefit reduction by the Primary Contract because a covered person has failed to comply with the Contract provisions is not an Allowable Expense. Examples of these types of Contract provisions include second surgical opinions, pre-certificate of admissions, and preferred provider arrangements.

5. Closed Panel Plan is a Contract that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Group, and that excludes coverage for services provided by other providers, except in cases of emergency or Referral by a panel member.

6. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

B. Order of Benefit Determination Rules

When a Member is covered by two (2) or more Contracts, the rules for determining the order of benefit payments are as follows:

1. The Primary Contract pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Contract.

2. a) Except as provided in Paragraph 2.b) below, a Contract that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Contracts state that the complying Contract is primary.

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

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

4. Each Contract determines its order of benefits using the first of the following rules that apply:

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

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

      (1) For a dependent child whose parents are married or are living together, whether or not they have ever been married: The Contract of the parent whose birthday falls earlier in the calendar year is the Primary Contract; or if both parents have the

same birthday, the Contract that has covered the parent the longest is the Primary Contract.

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

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

ii. If a court decree states that both parents are responsible for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (1) shall determine the order of benefits;

iii. If a court decree states both parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;

iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

1. The Contract covering the Custodial Parent;
2. The Contract covering the spouse of the Custodial Parent;
3. The Contract covering the non-Custodial Parent; and then
4. The Contract covering the spouse of the non-Custodial Parent.

For a dependent child covered under more than one Contract of individuals who are not the parents of the child, the provisions of Subparagraph (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.

c) Active Employee or Retired or Laid-off Employee. The Contract that covers a Member as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Contract. The Contract covering that same Member as a retired or laid-off employee is the Secondary Contract. The same would hold true if a Member is a dependent of an active employee and that same Member is a dependent of a retired or laid-off employee. If the other Contract does not have this rule, and as a result, the Contracts do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a) can determine the order of benefits.

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

e) Longer or Shorter Length of Coverage. The Contract that covered the Member as an employee, member, policyholder, subscriber, or retiree longer is the Primary Contract and the Contract that covered the Member the shorter period of time is the Secondary Contract.

f) If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Contracts meeting the definition of Contract. In addition, This Contract will not pay more than it would have paid had it been the Primary Contract.

C. Effect on the Benefits of this Contract

A. When This Contract is secondary, it may reduce its benefits so that the total benefits paid or provided by all contracts during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any Covered Dental Service, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that

calculated amount to any Allowable Expense under its Contract that is unpaid by the Primary Contract. The Contract may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Contract, the total benefits paid or provided by all contracts for the Covered Dental Service do not exceed the total Allowable Expenses for that Covered Dental Service. In addition, the Secondary Contract shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Contract and other Closed Panel Plans.

D. Right to Receive and Release Needed Information

Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits payable under This Contract and other contracts. Willamette Dental Group may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Contract and other contracts covering the person requesting benefits. Willamette Dental Group need not tell, or get the consent of, any person to do this. Each person requesting benefits under This Contract must give Willamette Dental Group any facts it needs to apply those rules and determine benefits payable.

E. Facility of Payment

A payment made under another Contract may include an amount that should have been paid under This Contract. If it does, Willamette Dental Group may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Contract. Willamette Dental Group will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the Reasonable Cash Value of the benefits provided in the form of services.

F. Right of Recovery

If the amount of the payments made by Willamette Dental Group is more than it should have paid under this COB provision, it may recover the excess from one or more of the Members it has paid or for whom it has paid; or any other Member or organization that may be responsible for the benefits or services provided for the covered Member. The “amount of the payments made” includes the Reasonable Cash Value of any benefits provided in the form of services.

G. Coordination of Benefits Administration

Willamette Dental Group will administer coordination of benefits in accordance with this section. If the Member has dental coverage under more than one plan and receives Covered Dental Services from a Contracting Provider, the Contracting Provider will submit a bill to the Member’s other Plan on the Member’s behalf. In the event the Member elects to receive Covered Dental Services from a Non-Contracting Provider without a Referral from a Contracting Provider, the Member is responsible for submitting a bill to the Contracting Provider to request for reimbursement under the Noncontracting Provider Reimbursement or the Out of Area Emergency Care Reimbursement.

XVIII. Subrogation and Reimbursement Rights and Obligations

The benefits of this Contract will be available to a Member when he or she is injured, suffers harm or incurs loss due to any act, omission, or defective or unreasonably hazardous product or service of another person, firm, corporation or entity (hereinafter referred to as “third party”). To the extent that such benefits for Covered Dental Services are provided by Willamette Dental Group under this Contract, Willamette Dental Group shall be subrogated and succeed to the rights of the Member or, in the event of the Member’s death, to the rights of his or her heirs, estate, and/or personal representative.

As a condition of receiving benefits for Covered Dental Services in such an event, the Member or his or her personal representative shall furnish Willamette Dental Group in writing with the names addresses and contract information of the third party or parties that caused or are responsible, or may have caused or may be responsible for such injury, harm or loss, and all facts and information known to the Member or his or her personal representative concerning the injury, harm or loss.In addition, the insured shall furnish the name and contract information of the liability insurer or its adjuster of the third party including the policy number of any liability insurance that covers, or may cover, such injury, harm, or loss. Willamette Dental Group may at its option elect to enforce either or both of its rights of subrogation and reimbursement.

Subrogation is taking over the Member's right to receive payments from other parties. The Member or his or her legal representative will transfer to Willamette Dental Group any rights he or she may have to take legal action arising from the injury, harm or loss to recover any sums paid on behalf of the Member. Thus, Willamette Dental Group may initiate litigation at its sole discretion, in the name of the Member, against any third party or parties. Furthermore, the Member shall fully cooperate with Willamette Dental Group in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm or loss and shall do nothing whatsoever to prejudice Willamette Dental Group's subrogation rights and efforts. Willamette Dental Group will be reimbursed in full for the Reasonable Cash Value of any benefits provided in the form of services even if the Member is not made whole or fully compensated by the recovery.

Additionally, Willamette Dental Group may at its option elect to enforce its right of reimbursement from the Member, or his or her legal representative, the Reasonable Cash Value of any benefits provided in the form of services from monies recovered as a result of the injury, harm or loss. The Member shall fully cooperate with Willamette Dental Group in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm or loss and shall do nothing whatsoever to prejudice Willamette Dental Group's reimbursement rights and efforts.

The Member shall pay Willamette Dental Group as the first priority, and Willamette Dental Group shall have a constructive trust and an equitable lien on, all amounts from any recovery by suit, settlement or otherwise from any third party or parties or from any third party's or parties' insurer(s), indemnitor(s) or underwriter(s), to the extent of benefits provided by Willamette Dental Group under this Contract, regardless of how the recovery is allocated (*i.e.*, pain and suffering) and whether the recovery makes the Member whole. Thus, Willamette Dental Group will be reimbursed by the Member, or his or her legal representative, from monies recovered as a result of the injury, harm or loss, for all benefits paid even if the Member is not made whole or fully compensated by the recovery. Moreover, Willamette Dental Group is not responsible for any attorney's fees or other expenses or costs incurred by the Member without prior written consent of Willamette Dental Group and, therefore, the "common fund" doctrine does not apply to any amounts recovered by any attorney the Member hires regardless of whether amounts recovered are used to repay benefits paid by Willamette Dental Group, or otherwise.

To the extent that Willamette Dental Group provides or pays benefits for Covered Dental Services, Willamette Dental Group's rights of subrogation and reimbursement extend to any right the Member has to recover from the Member's insurer, or under the Member's medical payments coverage or any uninsured motorist, underinsured motorist, or other similar coverage provisions, and workers' compensation benefits.

Willamette Dental Group shall have the right, at its option, to seek reimbursement from, or enforce its right of subrogation against, the Member, the Member's personal representative, a special needs trust, or any trust, person or vehicle that holds any payment or recovery from or on behalf of the Member including the Member's attorney.

Willamette Dental Group's subrogation and reimbursement rights shall take priority over the Member's rights both for benefits provided and payment made by Willamette Dental Group for Covered Dental Services, and for benefits to be provided or payments to be made by Willamette Dental Group in the future on account of the injury, harm or loss giving rise to Willamette Dental Group's subrogation and reimbursement rights. Further, Willamette Dental Group's subrogation and reimbursement rights for such benefits and payments provided or to be provided are primary and take precedence over the rights of the Member, even if there are deficiencies in any recovery or insufficient financial resources available to the third party or parties to totally satisfy all of the claims and judgments of the Member and Willamette Dental Group.

Collections or recoveries made by a Member for such injury, harm or loss in excess of such benefits provided and payments made shall first be allocated to such future Willamette Dental Group benefits and payments that would otherwise be owed by the Contract on account of the injury, harm or loss giving rise to Willamette Dental Group's subrogation and reimbursement rights, and shall constitute a Special Credit applicable to such future benefits and payments that would otherwise be owed by Willamette Dental Group under this or any subsequent Willamette Dental Group Contract or coverage. Thereafter, Willamette Dental Group shall have no obligation to provide any further benefits or make any further payments until the Member has incurred medical expenses in treatment of such injury, harm, or loss equal to such Special Credit.

XIX. Indemnity by the Group and Blue Cross of Idaho

The Group and BCI agree to defend, indemnify, and hold the other party harmless from and against any claim, demand, expense, loss, damage, cost, judgment, fee, or liability the other party may receive, incur, or sustain that is caused by or arises by reason of any misstatement, misrepresentation, oversight, error, omission, delay, or mistake in

providing the other party or any Member notice or advice of any relevant fact, event, or matter pertinent to claims, benefits, or coverage under this Contract.

XX. Incorporated by Reference

All of the terms, limitations and exclusions of coverage contained in this Contract are incorporated by reference into all sections, endorsements, riders, and amendments and are as effective as if fully expressed in each one unless specifically noted to the contrary.

XXI. Inquiry and Appeals Procedures

If the Member's claim for benefits is denied and BCI issues an Adverse Benefit Determination, the Member must first exhaust any applicable internal appeals process described below prior to pursuing legal action.

A. Informal Inquiry

For any initial questions concerning benefits under this Contract a Member should contact Willamette Dental Group's Member Services Department at 1-855-433-6825.

For any questions or concerns regarding dental care or treatment, Members are encouraged to discuss the matter with their primary Contracting Dentist. Members may also contact Willamette Dental Group's Member Services Department at 1-855-433-6825.

B. Formal Appeal of Adverse Benefit Determination

A Member who wishes to formally appeal an adverse benefits determination by BCI may do so through the following process:

A Member may have an authorized representative pursue a benefit claim or an appeal of an Adverse Benefit Determination on their behalf. BCI requires that a Member execute BCI's "Appointment of Authorized Representative" form before BCI determines that an individual has been authorized to act on behalf of the Member. The form can be found on BCI's website at www.bcidaho.com.

2. A written appeal must be sent to the BCI Grievance and Appeals Specialist within one hundred eighty (180) days after receipt of the notice of Adverse Benefit Determination. The documents in support of such appeals may be submitted by phone or facsimile. The appeal should set forth the reasons why the Member contends BCI's decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.

3. After receipt of the appeal, all facts, including those originally used in making the initial decision and any additional information that is sent or that is otherwise relevant, will be reviewed. BCI will mail a written reply to the Member within thirty (30) days after receipt of the written appeal. If the original decision is upheld, the reply will state the specific reasons for denial and the specific provisions on which the decision is based. Each appeal will be processed as quickly as possible.

4. Furthermore, the Member or their authorized representative has the right to reasonable access to, and copies of all documents, records, and other information that are relevant to the appeal.

5. If the original eligibility determination is upheld upon reconsideration, the Member may send an additional written appeal to the Appeals and Grievance Specialist requesting further review. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within sixty (60) days of BCI's mailing of the initial reconsideration decision. BCI will mail a written reply to the Member within thirty (30) days after receipt of the written appeal. A final decision on the appeal will be made within fifteen (15) days of its receipt.

XXII. Plan Administrator—COBRA and ERISA

The Group will notify Blue Cross of Idaho when an Enrollee and/or Eligible Dependent loses group health coverage. The notice must be provided within thirty (30) days unless the loss of coverage is due to divorce, legal separation, or a child's loss of dependent eligibility, in which case notice must be provided within sixty (60) days.

Blue Cross of Idaho will provide all necessary COBRA notices and forms to COBRA qualified beneficiaries in a timely manner. If a qualified beneficiary's completed notice and election form and application are received by Blue Cross of Idaho within the beneficiary's sixty (60) day COBRA election period, Blue Cross of Idaho will enroll the beneficiary as a COBRA participant.

Blue Cross of Idaho will bill a participant directly for the cost of COBRA continuation coverage until the participant ceases to be eligible, is terminated for non-payment of premiums when due, voluntarily terminates coverage, or this Contract is terminated, whichever occurs first.

XXIII. Independent Blue Cross and Blue Shield Plans

The Group (on behalf of itself and its participants), hereby expressly acknowledges its understanding this Contract constitutes a contract solely between the Group and BCI, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, as association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCI to use the Blue Cross and Blue Shield Service Marks in the state of Idaho, and that BCI is not contracting as the agent of the Association. The Group, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person, entity, or organization other than BCI and that no person, entity, or organization other than BCI shall be held accountable or liable to the Group for any of BCI's obligations to the Group created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of BCI other than those obligations created under other provisions of this Contract.

XXIV. Statements

In the absence of fraud, all statements made by an applicant, or the policyholder, or by an enrolled person shall be deemed representations and not warranties, and no statement made for the purpose of acquiring insurance shall void such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the enrolled person.

XXV. Membership, Voting, Annual Meeting and Participation

The Group, as the policyholder, is a member of BCI and is entitled to vote in person or by proxy at the meetings of policyholders. The Group shall designate to BCI in writing the person who has the right to vote in person or by proxy on behalf of the Group. The annual meeting of policyholders of BCI is held on the last Friday of April of each year at 2:00 p.m., at the corporation's registered office, 3000 East Pine Avenue, Meridian, Idaho. This notice shall be sufficient as to notification of such annual meetings. If any dividends are distributed, the policyholders shall share in them according to the articles of incorporation and bylaws of BCI and under the conditions set by the board of directors of BCI.

XXVI. Replacement Coverage

If this Contract replaces prior Group coverage within sixty (60) days of the date of termination of prior coverage, BCI will immediately cover all employees and dependents validly covered under the prior coverage at the date of termination who meet BCI's eligibility requirements and who would otherwise be eligible for coverage under this Contract, regardless of any exclusions or limitations relating to active employment or nonconfinement.

XXVII. Coverage and Benefits Determination

BCI is vested with authority and discretion to determine benefits provided and eligibility for coverage under the terms of this Contract, based on all the terms and provisions set forth in this Contract.

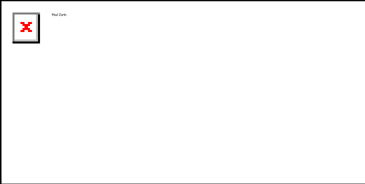
XXIII. Covered Dental Services Obtained Outside the United States

The Out of Area Emergency Care Reimbursement and the Noncontracting Provider Reimbursement benefits available under this Contract are also available to Members traveling or living outside the United States. Reimbursement for Covered Dental Services will be made directly to the Member. Willamette Dental Group will require the original itemized billing statement along with an English translation. It is the Member's responsibility to provide this information.

Finally, there are no benefits for services, supplies, drugs or other charges that are provided outside the United States, which if had been provided in the United States, would not be a Covered Dental Service under this Contract.

In witness whereof, BLUE CROSS OF IDAHO HEALTH SERVICE, INC., by its duly authorized officer, has executed this Contract.

Blue Cross of Idaho
Health Service, Inc.
PO Box 7408
Boise, ID 83707



Paul Zurlo
President, Health Markets

ATTACHMENT A - LIST OF COVERED DENTAL SERVICES AND COPAYMENTS

Attachment A - List Of Covered Dental Services And Copayments

Option 3

Attachment A - List Of Covered Dental Services and Copayments

Reimbursement for Covered Dental Services by a Non-Contracting Provider

	Reimbursement Amount
Out of Area Emergency Care Reimbursement (For Dental Emergency services provided by a Noncontracting Provider)	Up to $250
Noncontracting Provider Reimbursement (For services by a Noncontracting Provider without a referral from a Contracting Provider. The Enrollee is responsible for all other charges and fees charged by the Noncontracting Provider, to the extent such amount exceeds $10.)	$10 per visit

Code	Procedure	In Network Copayment
1.Office Visits		
	General Office Visit	$25
	Specialist Office Visit	$30
2. Diagnostic and Preventative Services		
D0120	Periodic oral evaluation - established patient	$0
D0140	Limited oral evaluation - problem focused	$0
D0145	Oral evaluation for patient under 3 and counseling with primary caregiver	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0160	Detailed and extensive oral evaluation - problem focused, by report	$0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$0
D0210	Intraoral - complete series of radiographic images	$0
D0220	Intraoral - periapical 1st- first radiographic image	$0
D0230	Intraoral - periapical film each additional radiographic image	$0
D0240	Intraoral - occlusal radiographic image	$0
D0250	Extraoral - 2D projection radiographic image	$0
D0270	Bitewings - 1 radiographic image	$0
D0272	Bitewings - 2 radiographic images	$0
D0273	Bitewings - 3 radiographic images	$0
D0274	Bitewings - 4 radiographic images	$0
D0277	Vertical bitewings - 7 to 8 radiographic images	$0
D0330	Panoramic radiographic image	$0
D0340	2D cephalometric radiographic images	$0
D0350	2D oral/facial photographic images	$0
D0425	Caries susceptibility tests	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D1110	Prophylaxis - adult	$0
D1120	Prophylaxis - child	$0
D1206	Topical application of fluoride varnish	$0
D1208	Topical application of fluoride - excluding varnish	$0
D1310	Nutritional counseling for control of dental disease	$0
D1320	Tobacco counseling for control of dental disease and prevention of oral disease	$0
D1330	Oral hygiene instruction	$0
D1351	Sealant - per tooth	$0

3. Space Maintainers

Code	Description	Amount
D1510	Space maintainer - fixed – unilateral – per quadrant	$0
D1516	Space maintainer - fixed – bilateral, maxillary	$0
D1517	Space maintainer - fixed – bilateral, mandibular	$0
D1520	Space maintainer - removable – unilateral – per quadrant	$0
D1526	Space maintainer - removable – bilateral, maxillary	$0
D1526	Space maintainer - removable – bilateral, mandibular	$0
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$0
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$0
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$0
D1556	Removal of fixed unilateral space maintainer - per quadrant	$0
D1557	Removal of fixed bilateral space maintainer – maxillary	$0
D1558	Removal of fixed bilateral space maintainer - mandibular	$0

4. Restorative Dentistry

Code	Description	Amount
D2140	Amalgam - 1 surface, primary or permanent	$25
D2150	Amalgam - 2 surfaces, primary or permanent	$25
D2160	Amalgam - 3 surfaces, primary or permanent	$25
D2161	Amalgam - 4 or more surfaces, primary or permanent	$25
D2330	Resin-based composite - 1 surface, anterior	$25
D2331	Resin-based composite - 2 surfaces, anterior	$25
D2332	Resin-based composite - 3 surfaces, anterior	$25
D2335	Resin-based composite - 4 surfaces or involving incisal angle (anterior)	$25
D2390	Resin-based composite crown, anterior	$25
D2391	Resin-based composite - 1 surface, posterior	$25
D2392	Resin-based composite - 2 surfaces, posterior	$25
D2393	Resin-based composite - 3 surfaces, posterior	$25
D2394	Resin-based composite - 4 or more surfaces, posterior	$25
D2510	Inlay - metallic - 1 surface	$300
D2520	Inlay - metallic - 2 surfaces	$300
D2530	Inlay - metallic - 3 or more surfaces	$300
D2542	Onlay - metallic - 2 surfaces	$300
D2543	Onlay - metallic - 3 surfaces	$300
D2544	Onlay - metallic - 4 or more surfaces	$300
D2610	Inlay - porcelain/ceramic - 1 surface	$300
D2620	Inlay - porcelain/ceramic - 2 surfaces	$300
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	$300
D2642	Onlay - porcelain/ceramic - 2 surfaces	$300
D2643	Onlay - porcelain/ceramic - 3 surfaces	$300
D2644	Onlay– porcelain/ceramic - 4 or more surfaces	$300

5. Crowns

Code	Description	Amount
D2710	Crown - resin-based composite (indirect)	$300
D2740	Crown - porcelain/ceramic	$300
D2750	Crown - porcelain fused to high noble metal	$300
D2780	Crown - ¾ high noble metal	$300
D2790	Crown - full cast high noble metal	$300
D2910	Recement or re-bond inlay, onlay, or partial coverage restoration	$0
D2920	Recement or re-bond crown	$0
D2930	Prefabricated stainless steel crown - primary tooth	$0
D2931	Prefabricated stainless steel crown - permanent tooth	$0
D2932	Prefabricated resin crown	$0
D2933	Prefabricated stainless steel crown with resin window	$0
D2940	Protective restoration	$0
D2950	Core buildup, including any pins when required	$0
D2951	Pin retention - per tooth, in addition to restoration	$0
D2954	Prefabricated post and core in addition to crown	$0

Code	Description	Copay
D2955	Post removal	$0
D2957	Each additional prefabricated post - same tooth	$0
D2975	Coping	$0
D2980	Crown repair necessitated by restorative material failure	$0

6. Endodontics

Code	Description	Copay
D3110	Pulp cap - direct (excluding final restoration)	$0
D3120	Pulp cap - indirect (excluding final restoration)	$0
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$0
D3221	Pulpal debridement, primary and permanent teeth	$0
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$0
D3240	Pulpal therapy (resorbable filling) - posterior, primary (excluding final restoration)	$0
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$125
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	$175
D3330	Endodontic therapy, molar (excluding final restoration)	$200
D3331	Treatment of root canal obstruction; non-surgical access	$0
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$0
D3333	Internal root repair of perforation defects	$0
D3346	Retreatment of previous root canal therapy - anterior	$125
D3347	Retreatment of previous root canal therapy - bicuspid	$175
D3348	Retreatment of previous root canal therapy - molar	$200
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$200
D3352	Apexification/recalcification - interim medication replacement	$0
D3353	Apexification recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$0
D3410	Apicoectomy - anterior	$125
D3421	Apicoectomy - premolar (first root)	$175
D3425	Apicoectomy - molar (first root)	$200
D3426	Apicoectomy - each additional root	$0
D3430	Retrograde filling - per root	$0
D3450	Root amputation - per root	$200
D3920	Hemisection (including any root removal), not including root canal therapy	$200
D3950	Canal preparation and fitting of preformed dowel or post	$0

7. Periodontics

Code	Description	Copay
D4210	Gingivectomy or gingivoplasty - 4 or more contiguous teeth or tooth bounded spaces per quadrant	$250
D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	$100
D4240	Gingival flap procedure, including root planing - 4 or more contiguous teeth or tooth bounded spaces per quadrant	$250
D4241	Gingival flap procedure, including root planing - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	$250
D4249	Clinical crown lengthening - hard tissue	$250
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - 4 or more contiguous teeth or tooth bounded spaces per quadrant	$250
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	$250
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$0
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$0
D4270	Pedicle soft tissue graft procedure	$250
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth or edentulous tooth position in graft	$250
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$250
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth or edentulous tooth position in graft	$250

Code	Description	Copay
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth or edentulous tooth position in same graft site	$250
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth or edentulous tooth position in the same graft site	$250
D4341	Periodontic scaling and root planing - 4 or more teeth per quadrant	$100
D4342	Periodontic scaling and root planing - 1 to 3 teeth per quadrant	$100
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluations	$0
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$0
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$0
D4910	Periodontic maintenance	$0

8. Prosthodontics - Removable

Code	Description	Copay
D5110	Complete denture- maxillary	$400
D5120	Complete denture - mandibular	$400
D5130	Immediate denture - maxillary	$400
D5140	Immediate denture - mandibular	$400
D5211	Maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$400
D5212	Mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	$400
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$400
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$400
D5282	Removable unilateral partial denture - 1 piece cast metal (including clasps and teeth), maxillary	$400
D5283	Removable unilateral partial denture - 1 piece cast metal (including clasps and teeth), mandibular	$400
D5410	Adjust complete denture - maxillary	$0
D5411	Adjust complete denture - mandibular	$0
D5421	Adjust partial denture - maxillary	$0
D5422	Adjust partial denture - mandibular	$0
D5511	Repair broken complete denture base, mandibular	$0
D5512	Repair broken complete denture base, maxillary	$0
D5520	Replace missing or broken teeth - complete denture (each tooth)	$0
D5611	Repair resin partial denture base, mandibular	$0
D5612	Repair resin partial denture base, maxillary	$0
D5621	Repair cast partial framework, mandibular	$0
D5622	Repair cast partial framework, maxillary	$0
D5630	Repair or replace broken retentive/clasping materials - per tooth	$0
D5640	Replace broken teeth - per tooth	$0
D5650	Add tooth to existing partial denture	$0
D5660	Add clasp to existing partial denture – per tooth	$0
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$0
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$0
D5710	Rebase complete maxillary denture	$0
D5711	Rebase complete mandibular denture	$0
D5720	Rebase maxillary partial denture	$0
D5721	Rebase mandibular partial denture	$0
D5730	Reline complete maxillary denture (chairside)	$0
D5731	Reline complete mandibular denture (chairside)	$0
D5740	Reline maxillary partial denture (chairside)	$0
D5741	Reline mandibular partial denture (chairside)	$0
D5750	Reline complete maxillary denture (laboratory)	$0
D5751	Reline complete mandibular denture (laboratory)	$0
D5760	Reline maxillary partial denture (laboratory)	$0
D5761	Reline mandibular partial denture (laboratory)	$0

D5810	Interim complete denture (maxillary)	$200
D5811	Interim complete denture (mandibular)	$200
D5820	Interim partial denture (maxillary)	$200
D5821	Interim partial denture (mandibular)	$200
D5850	Tissue conditioning, maxillary	$0
D5851	Tissue conditioning, mandibular	$0
D5863	Overdenture - complete, maxillary	$400
D5864	Overdenture - partial, maxillary	$400
D5865	Overdenture - complete, mandibular	$400
D5866	Overdenture - partial, mandibular	$400
D5986	Fluoride gel carrier	$0

9. Prosthodontics - Fixed

D6210	Pontic - cast high noble metal	$300
D6240	Pontic - porcelain fused to high noble metal	$300
D6241	Pontic - porcelain fused to predominately base metal	$300
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$300
D6720	Retainer crown - resin with high noble metal	$300
D6750	Retainer crown - porcelain fused to high noble metal	$300
D6780	Retainer crown - ¾ cast high noble metal	$300
D6790	Retainer crown - full cast high noble metal	$300
D6930	Re-cement or re-bond fixed partial denture	$0
D6980	Fixed partial denture repair necessitated by restorative material failure	$0

10. Oral Surgery

D7111	Extraction, coronal remnants - primary tooth	$25
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$25
D7210	Extraction of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$150
D7220	Removal of impacted tooth - soft tissue	$150
D7230	Removal of impacted tooth - partially bony	$150
D7240	Removal of impacted tooth - completely bony	$150
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$150
D7250	Removal residual roots (cutting procedure)	$150
D7260	Oroantral fistula closure	$150
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$150
D7280	Exposure of an unerupted tooth	$150
D7283	Placement of device to facilitate eruption of impacted tooth	$150
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$150
D7310	Alveoloplasty in conjunction with extractions - 4 or more tooth spaces, per quadrant	$0
D7311	Alveoloplasty in conjunction with extractions - 1 to 3 tooth spaces, per quadrant	$0
D7320	Alveoloplasty not in conjunction with extractions - 4 or more tooth spaces, per quadrant	$0
D7321	Alveoloplasty not in conjunction with extractions - 1 to 3 tooth spaces, per quadrant	$0
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	$150
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$150
D7471	Removal of lateral exostosis (maxilla or mandible)	$150
D7510	Incision and drainage of abscess - intraoral soft tissue	$0
D7520	Incision and drainage of abscess - extraoral soft tissue	$0
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$0
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$0
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$0
D7670	Alveolus - closed reduction, may include stabilization of teeth	$0
D7910	Suture of recent small wounds up to 5 cm	$0
D7911	Complicated suture - up to 5 cm	$0
D7953	Bone replacement graft for ridge preservation - per site	$150
D7960	Frenulectomy - also known as frenectomy or frenotomy – separate procedure not incidental to another	$150

Code	Description	Copayment
D7970	Excision of hyperplastic tissue - per arch	$150
D7971	Excision of pericoronal gingiva	$150

11. Anesthesia

Code	Description	Copayment
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$20

12. Miscellaneous

Code	Description	Copayment
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$0
D9120	Fixed partial denture sectioning	$0
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$0
D9420	Hospital call/Dental treatment provided in a hospital setting (Service Copayments still apply and facility fees not covered.)	$125
D9430	Observation visit (during regularly scheduled hours) - no other services performed	$0
D9440	Visit – after regularly scheduled hours	$20
D9910	Application of desensitizing medicaments	$0
D9911	Application of desensitizing resin for cervical and/or root surface (per tooth)	$0
D9951	Occlusal adjustment - limited	$0
D9970	Enamel microabrasion	$0

ATTACHMENT B–Orthodontia Treatment

I. General Provisions

A. Benefits for Orthodontia Treatment are provided only if a Contracting Dentist prepares the treatment plan prior to rendering services. The treatment plan is based on an examination that must take place while the Member is covered under this Contract. The examination must show a diagnosis of abnormal occlusion that can be corrected by Orthodontia Treatment.

B. The Member must remain covered under the Contract for the entire length of treatment. The Member must follow the post-treatment plan and keep all appointments after the Member is branded to avoid additional Copayments.

C. For Orthodontia Treatment started prior to the Effective Date of the Member, Copayments may be adjusted based upon the services necessary to complete the treatment.

D. If benefits for Orthodontia Treatment terminate prior to completion of Orthodontia Treatment, benefits will continue through the end of the month. If coverage terminates prior to completion of treatment, the Copayment may be pro-rated. The services necessary to complete treatment will be based on the Reasonable Cash Value of services rendered.

E. The Member is responsible for payment of the Copayments listed below for pre-Orthodontia and Orthodontia Treatment rendered. The Pre-Orthodontia Treatment Copayments will be deducted from the Comprehensive Orthodontia Treatment Copayment if the Member accepts the treatment plan. The Copayment for limited Orthodontia Treatment may be pro-rated based on the treatment plan.

F. The General Office Visit Copayment listed in Attachment A is charged at each visit for orthodontic treatment. Services connected with Orthodontia Treatment are subject to the Copayments listed in Attachment A.

II. Pre-Orthodontia Treatment Copayment

A.	Initial orthodontic exam	$25
B.	Study models and X-rays	$125
C.	Case presentation	$0

III. Orthodontia Treatment Copayment

A.	Comprehensive Orthodontia Treatment Copayment	$2,500

The following are procedures provided under the benefits for Orthodontia Treatment:

D8020	Limited orthodontic treatment of the transitional dentition
D8030	Limited orthodontic treatment of the adolescent dentition
D8040	Limited orthodontic treatment of the adult dentition
D8060	Interceptive orthodontic treatment of the transitional dentition
D8070	Comprehensive orthodontic treatment of the transitional dentition
D8080	Comprehensive orthodontic treatment of the adolescent dentition
D8090	Comprehensive orthodontic treatment of the adult dentition

ATTACHMENT C - Dental Implant Surgery

I. Benefits.

a. The Dental Implant services described in this Attachment C are covered for Members if all of the following requirements are met:
   1) A Contracting Provider determines that Dental Implants are dentally appropriate for the Member.
   2) A Contracting Provider prepares the treatment plan for Dental Implants prior to initiating any implant treatment.
   3) All Dental Implant services are provided by a Contracting Provider or under a referral from a Contracting Dentist.
   4) The Member follows the treatment plan prescribed by the Contracting Provider.
   5) The Member makes payment of amounts due.
   6) The Dental Implant service is listed as covered in this Dental Implant Section and is not otherwise limited or excluded.

b. **Services After Termination of Benefits.** If the Member's coverage ends before the completion of the Dental Implant services, the cost of any remaining treatment is the Member's responsibility.

c. **Dental Implant Surgery.** The Dental Implant services listed below are covered at 100% up to an annual Dental Implant benefit maximum of $1,500. The annual Dental Implant benefit maximum is the maximum dollar amount this Contract will pay for Dental Implant services in a calendar year.

CDT Code and Procedure Description
D6010 Surgical placement of implant body: endosteal implant
D6011 Second stage implant surgery

2. Limitations. The benefit for Dental Implants is subject to the following limitations:

a. Benefits for surgical placement of a Dental Implant are limited to one (1) implant per calendar year.
b. Dental Implants to replace an existing bridge or existing denture are not covered, unless five (5) years have elapsed since the placement of the bridge or delivery of the denture.

3. Exclusions. The following services are not covered under this benefit for Dental Implants:

a. Any Dental Implant services and related services that are not listed as covered on this Dental Implant Section.
b. Bone grafting.
c. Cone beam CT X-rays and tomographic surveys.
d. Dental Implant-supported prosthetics or abutment-supported prosthetics (crowns, bridges, and dentures).
e. A Dental Implant surgically placed prior to the Effective Date of the Member's Contract, that has not received final restoration.
f. Eposteal, transosteal, endodontic endosseous, or mini dental implants.
g. Maintenance, repair, replacement, or completion of an existing implant started or placed by a Non-Contracting Dentist without a referral from a Contracting Dentist.
h. Maintenance, repair, replacement, or completion of an existing implant started or placed prior to the Effective Date of the Member's Contract.
i. Treatment of a primary or transitional dentition.