# Group Plan

# BENEFIT SUMMARY

## Group Dental Plan for Idaho School District Council Self-Funded Benefit Trust

*This coverage is not an insurance policy and the Idaho School District Council Self-Funded Benefit Trust does not participate in the State Guaranty Association*

## Lapwai School District #341

Dental

***Effective Date: September 1, 2016***

***Quick View***

***Benefit Period: January 1 through December 31***

09-16 SWS Dental (09012016)

Blue Cross of Idaho

*An Independent Licensee of the Blue Cross and Blue Shield Association*

This Benefits Outline describes the benefits in general terms. It is important to read the Summary Plan Description document in full for specific and detailed information that includes additional exclusions and limitations on benefits. Your manager of employee benefits should be able to help if you have questions.

For Covered Services under the terms of this Plan, Maximum Allowance is the amount established as the highest level of compensation for a Covered Service. There is more detailed information on how Maximum Allowance is determined and how it affects out-of-state coverage in the Definitions Section of the Summary Plan Description.

To locate a Contracting Provider in your area, please visit Blue Cross of Idaho's Web site at www.bcidaho.com. You may also call Blue Cross of Idaho's Dental Customer Services Department at 208-363-8755 or 800-289-7929 for assistance in locating a Provider.

SPANISH (Español): Para obtener asistencia en Español, llame al (208) 331-7347 or (800) 627-1188.
TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (208) 331-7347 or (800) 627-1188.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 (208) 331-7347 or (800) 627-1188。
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (208) 331-7347 or (800) 627-1188.

## ELIGIBILITY AND ENROLLMENT

To qualify as an Eligible Employee under this Plan, a person must be and remain a full-time employee of a Participating School District who regularly works at least 20 hours per week and is paid on a regular, periodic basis through the school district's payroll system. Pre-65 retirees may also be eligible.
*(see the Summary Plan Description for additional Eligibility and Enrollment provisions)*

## PROBATIONARY PERIOD

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

Trad

## DENTAL BENEFITS SECTION - DEDUCTIBLE

| For Covered Providers and Services | In-Network | Out-of-Network |
|---|---|---|
| Benefit Limit | $1,000 per Participant, per Benefit Period | |
| **Deductible:** Individual | Participant pays $50 per Benefit Period | |
| Family | The Benefit Period Family Deductible is satisfied after three (3) Participants of the same family have met their Individual Deductible (No Participant may contribute more than the Individual Deductible amount toward the Family Deductible) | |
| **Preventive Dental Services** | Plan pays 100% of Maximum Allowance | |

| | |
|---|---|
| **Basic Dental Services** | Plan pays 80% of Maximum Allowance after Deductible |
| **Major Dental Services** | Plan pays 50% of Maximum Allowance after Deductible |

# DENTAL

# MASTER GROUP PLAN

# AND

# SUMMARY PLAN DESCRIPTION

GROUP DENTAL PLAN

FOR

Idaho School District Council Self-Funded Benefit Trust

Administered by Blue Cross of Idaho

*This coverage is not an insurance policy and the Idaho School District Council Self-Funded Benefit Trust does not participate in the State Guaranty Association.*

Group Name: Lapwai School District #341

Group # 10003633

Effective Date: September 1, 2016

# TABLE OF CONTENTS

# PLAN INFORMATION

The Idaho School District Cooperative Service Council sponsors the Idaho School District Council Health and Welfare Plan, which provides various medical, dental and vision benefit programs through the Idaho School District Council Self-Funded Benefit Trust to active employees and pre-65 retirees and their Eligible Dependents. These medical, dental and vision benefits are not paid through an insurance policy. Rather, the Trust funds the payment of claims through employer and employee contributions up to a certain limit and then has an agreement for stop-loss coverage that pays for claims that exceed that limit. The Idaho Department of Insurance requires the Trust to provide an annual audit and to have an independent accredited actuary provide annual certification of the funding amounts and the contributions.

Blue Cross of Idaho ("BCI") is the Plan's third-party administrator. BCI may act on behalf of the Plan Administrator as directed. This Plan document and Summary Plan Description will be used to administer and determine the benefits under this Plan.

## BLUE CROSS OF IDAHO CONTACT INFORMATION

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

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

*Mailing Address*
P.O. Box 7408
Boise, ID 83707
(208) 387-6683 (Boise Area)
1-800-365-2345

**Lewiston**
(208) 746-0531

*Mailing Address*
P.O. Box 7408
Boise, ID 83707

**Coeur d'Alene**
1450 Northwest Blvd., Suite 106
Coeur d'Alene, ID 83814
(208) 666-1495

**Pocatello**
275 South 5th Ave., Suite 150
Pocatello, ID 83201
(208) 232-6206

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

**Twin Falls**
1503 Blue Lakes Blvd. N.
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

# HOW TO SUBMIT CLAIMS

A Participant must submit a claim to BCI in order to receive benefits for Covered Services. There are two ways for a Participant to submit a claim:

1. The Provider can file the claims for the Participant. Most Providers will submit a claim on a Participant's behalf if the Participant shows them a BCI identification card and asks them to send BCI the claim.
2. The Participant can send BCI the claim.

## I. To File A Participant's Own Claim

If a Covered Provider prefers that a Participant file the claim, here is the procedure to follow:

A. Ask the Dentist or other Covered Provider for an itemized billing. The itemized billing should show each service received and its procedure code and its diagnosis code, the date each service was furnished, and the charge for each service. BCI cannot accept billings that only say "Balance Due," "Payment Received" or some similar statement.

B. Obtain a Member Claim Form from the Covered Provider or any of BCI's offices, and follow the instructions. Use a separate billing and Member Claim Form for each patient.

C. Attach the billing to the Member Claim Form and send it to:

Blue Cross of Idaho Claims Control
Blue Cross of Idaho
P.O. Box 7408
Boise, ID 83707

For assistance with claims or health benefit information, please call BCI Dental Customer Service at (208) 363-8755 or 1-800-289-7929.

## II. How Blue Cross Of Idaho Notifies The Participant

BCI will send the Participant an Explanation of Benefits (EOB) as soon as the claim is processed. The EOB will show all the payments BCI made and to whom the payments were sent. It will also explain any charges BCI did not pay in full. Participants should keep this EOB for their records.

## DENTAL BENEFITS SECTION - DEDUCTIBLE

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

### I. Benefit Period And Benefit Limit For Covered Services

The Benefit Period and the Benefit limits are shown in the Benefits Outline.

### II. Covered Providers

The following are Covered Providers under this section:

- Dentist
- Denturist

### III. Deductibles

The individual and family Deductible amounts are shown in the Benefits Outline.

### IV. Predetermination Of Benefits

A recommended Dental Treatment Plan must be submitted to Blue Cross of Idaho (BCI) for a Predetermination of Benefits before treatment begins if the Plan includes one (1) or more of the following procedures:

A. Bonding Procedures
B. Bridgework
C. Crowns
D. Full or Partial Dentures
E. Inlays/Onlays
F. Laminate Veneers
G. Periodontal Surgery
H. Surgical Removal of Impacted Teeth
I. Implants

The Dental Treatment Plan must be accompanied by supporting preoperative x-rays and any other appropriate diagnostic materials requested by BCI or the Dental Consultant(s).

BCI will notify the Participant and his or her Dentist of the benefits available based upon the Dental Treatment Plan. In determining the amount of benefits available, BCI or the Dental Consultant(s) considers whether alternate procedures would accomplish a professionally satisfactory result. If the charges or fees for the treatment chosen by the Participant and his or her Dentist exceed the charges or fees for the treatment BCI has determined will accomplish a professionally satisfactory result, then BCI will only provide benefits based on the charges or fees for the less costly treatment.

If a Participant submits a claim for completed treatment that includes services in the above listed categories, and benefits have not been predetermined by BCI, the claim is reviewed in the same manner as if it were being submitted for a Predetermination of Benefits. BCI or the Dental Consultant(s) will consider whether alternate procedures would have accomplished a professionally satisfactory result. If the Participant and his or her Dentist have chosen a more expensive method of treatment than is determined professionally satisfactory by BCI, the excess charge is solely the responsibility of the Participant, whether services are provided by a Contracting or Noncontracting Provider.

A Predetermination of Benefits is valid for six (6) months from the date it is issued. After six (6) months, a Dental Treatment Plan must be resubmitted for a new Predetermination of Benefits before treatment begins. All Predetermination of Benefits will be processed without taking into consideration dental benefits that may be paid under another certificate of insurance.

### V. Amount of Payment For Services Rendered By A Contracting Dentist

Unless stated otherwise, if Dental Covered Services are rendered by a Dentist outside the state of Idaho, BCI will provide the same benefits as described for an in-state Contracting Dentist.

A Contracting Dentist rendering Covered Services as described shall not make an additional charge to a Participant for amounts in excess of the Maximum Allowance except for Deductibles, Cost Sharing, and noncovered services.

Except as stated elsewhere in this Plan, BCI pays benefits for Preventive, Basic, and Major Dental Covered Services after a Participant has satisfied his or her Deductible, if applicable. The reimbursement schedule is shown in the Benefits Outline.

## VI. Amount of Payment For Services Rendered By A Noncontracting Dentist

A Noncontracting Dentist is not obligated to accept the Maximum Allowance as payment in full, and BCI is not responsible for the difference, if any, between BCI's payment and the actual charge, unless otherwise specified in this section. Participants are responsible for any such difference, including Deductibles, Cost Sharing, Copayments, charges for noncovered services and the amount charged by the Noncontracting Dentist that is in excess of the Maximum Allowance.

## VII. Closed List of Dental Covered Services

The following is a complete list of Dental Covered Services for which benefits are available. Only those services included on this list are eligible for payment.

There are no waiting periods for benefits except as stated in the following list of Dental Covered Services or in the exclusions and limitations provisions.

### A. Type I: Preventive Dental Services

1. Oral examination—limited to once in a six (6) month period.
2. Emergency oral examination—covered for trauma, acute infection, or acute pain.
3. Complete mouth series or panoramic x-ray—limited to one (1) time in any five (5) consecutive Benefit Periods, unless requested by BCI for verification of treatment claimed.
4. Individual periapical x-rays—limited to the same benefit as a complete mouth series or panoramic x-ray. Individual periapical x-rays are not covered when performed during root canal therapy as an intra-operative procedure.
5. Occlusal x-rays—limited to once per Benefit Period.
6. Extraoral x-rays – limited to once per Benefit Period.
7. Bitewing x-rays—limited to once per Benefit Period. Limited to the same benefit as a complete mouth series or panoramic x-ray.
8. Dental prophylaxis—limited to one prophylaxis every six (6) months regardless of type (dental prophylaxis or periodontal maintenance).
9. Fluoride treatments—limited to one (1) application per Benefit Period and limited to Participants who are under age twenty-six (26).
10. Palliative treatment—paid as a separate benefit only if no other treatment is rendered during the visit.
11. Topical application of sealants per tooth—limited to permanent posterior unrestored dentition of Participants under age sixteen (16). Also limited to one (1) time per tooth in any three (3) consecutive Benefit Periods.
12. Biopsy of soft or hard oral tissue (for removal of specimen only).

### B. Type II: Basic Dental Services

1. Amalgam restorations—posterior restorations involving multiple surfaces will be combined for benefit purposes and paid according to the number of surfaces treated. Same tooth surface restoration is covered once in a two (2) year period.

2. Pin retention.
3. Resin-Composite restorations—posterior restorations involving multiple surfaces will be combined for benefit purposes and paid according to the number of surfaces treated. Same tooth surface restoration is covered once in a two (2) year period.
4. Simple extractions.
5. Surgical removal of an erupted or partially erupted tooth or mucoperiosteal flap or incision of soft tissue.
6. Impaction that requires incision of overlying soft tissue, elevation of a flap and either removal of bone and tooth or sectioning and removal of the tooth (extraction of tooth, partial bony impaction).
7. Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone, and sectioning of the tooth for removal (extraction of tooth, complete bony extraction).
8. Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone, sectioning of the tooth for removal, and/or presents unusual difficulties and circumstances (including report).
9. Root recovery.
10. Excision of pericoronal tissues.
11. Tooth reimplantation.
12. Tooth transplantation—separate benefits are not payable for donor site charges.
13. Alveoloplasty and alveolectomy—not separately payable if performed on the same date as extraction.
14. Removal of exostosis.
15. Frenectomy (frenulectomy).
16. Excision of hyperplastic tissue.
17. Incision and drainage.
18. Radical excision (lesion diameter up to or greater than 1.25 cm)—not payable in addition to extraction performed in same site on same date.
19. Excision pericoronal gingiva (operculectomy).
20. Excision of benign tumor (lesion diameter up to or greater than 1.25 cm) —not payable in addition to extraction performed in same site on same date.
21. Removal of odontogenic cyst or tumor (diameter up to or greater than 1.25 cm)—not payable in addition to extraction performed in same site on same date.
22. Suture of small wounds.
23. General Anesthesia.
24. I.V. Sedation.
25. Pulp cap (direct or indirect).
26. Pulpotomy.
27. Root canal therapy—multiple endodontic treatments, on the same tooth within a period of one (1) year, are subject to review and approval by BCI.
28. Apicoectomy and retrograde filling.
29. Hemisection.
30. Scaling and root planing—limited to once per quadrant of the mouth, every three (3) Benefit Periods.
31. Periodontal maintenance—limited to once in a six (6) month period. Benefits are limited to one (1) prophylaxis every six (6) months regardless of type (dental prophylaxis or periodontal maintenance).
32. Gingivectomy—one (1) such surgical procedure per quadrant, once every three (3) years.
33. Osseous Surgery—one (1) such surgical procedure per quadrant, once every three (3) years.
34. Osseous grafts—only autogenous grafts are covered. Synthetic grafting techniques are not covered.

35. Pedicle grafts.
36. Free soft tissue grafts.
37. Occlusal guard—covered for erosion or abrasion limited to one (1) appliance every two (2) Benefit Periods.
38. Space maintainers—limited to Participants who are under age sixteen (16). Benefits limited to deciduous teeth. Includes all adjustments made within six (6) months of installation.
39. Full Mouth Debridement—limited to one time in a three (3) year period.
40. Sedative Fillings.

**C. Type III: Major Dental Services**

Benefits for the services listed below include an allowance for all temporary restorations and appliances and for one (1) year follow-up care:

1. Synthetic bone grafting procedures.
2. Periodontal splinting procedures.
3. Recement inlays; recement crowns; recement bridges.
4. Crown build-up—covered only for endodontically treated teeth that require crowns and only if Medically Necessary.
5. Tissue conditioning—limited to repairs or adjustments performed more than twelve (12) months after the initial insertion of prosthesis.
6. Repairs to full dentures, repairs to partial dentures, and/or repairs to bridges—limited to repairs performed more than twelve (12) months after the initial insertion of prosthesis.
7. Repairs to crowns.
8. Inlays and onlays—covered only when the teeth cannot be restored by a filling, and only if more than five (5) years have elapsed since the last placement. If a tooth can be restored with a filling, the benefit will be limited to the allowable benefit for an amalgam or composite restoration.
9. Crowns and laminate veneers—covered only when the tooth has visible destruction of tooth surface from decay and the tooth cannot be restored by a filling. Benefits will not be allowed when placement of the crown or veneer is for micro fractures, stress fractures, or craze lines. Coverage is available if more than one-third (1/3) of the tooth is missing due to accident or erosion. Coverage is allowed if more than five (5) years have elapsed since the last placement. For Participants under age sixteen (16), benefits are limited to plastic/resin based or stainless steel crowns.
10. Stainless steel crowns—covered only when the tooth has visible destruction of tooth surface from decay and the tooth cannot be restored by a filling. Benefits will not be allowed when placement of the crown or veneer is for micro fractures, stress fractures, or craze lines. Coverage is available if more than one-third (1/3) of the tooth is missing due to accident or erosion. Coverage is allowed if more than five (5) years have elapsed since the last placement.
11. Post and core.
12. Full dentures—includes all adjustments within six (6) months of installation. Replacement of a denture is covered only if the existing denture is more than five (5) years old and cannot be repaired. There are no additional benefits for overdentures or customized dentures.
13. Partial dentures—includes two (2) clasps and rests, all teeth, and all adjustments within six (6) months of installation. Replacement of a partial denture with another denture or fixed bridgework is eligible for benefits only if the existing denture is more than five (5) years old and cannot be repaired. There are no additional benefits for precision or semi-precision attachments.
14. Each additional clasp and rest (beyond two (2)).

15. Denture adjustments—one (1) adjustment per Benefit Period and only if performed more than six (6) months after the insertion of the denture.
16. Relining dentures—Relines performed twelve (12) months after initial placement and no more than once in a twenty-four (24) month period.
17. Fixed bridges—upgrading from a partial denture to fixed bridgework is covered only if the patient's arch cannot be adequately restored with a partial denture. Replacement of an existing fixed bridge or partial denture is eligible only if the existing appliance is more than five (5) years old and cannot be repaired.
18. Implants, including the implant body, implant abutment and implant crown – benefits may be available up to the Maximum Allowance of a standard complete or partial denture, or a bridge.
    a. Implant body—limited to once per tooth, per Lifetime. Coverage is allowed if more than five (5) years has elapsed since the last placement of a prosthetic of any type on the tooth.
    b. Implant abutment—limited to once per tooth, per Lifetime. Coverage is allowed if more than five (5) years has elapsed since the last placement of a prosthetic of any type on the tooth.
    c. Implant Crown – Coverage is allowed if more than five (5) years has elapsed since the last placement of a prosthetic of any type on the tooth.

## ELIGIBILITY AND ENROLLMENT FOR EMPLOYEES SECTION

### I. Eligibility And Enrollment

All Eligible Employees will have the opportunity to apply for coverage under this Plan. 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**

Qualifications for eligibility are shown in the Benefits Outline.

**B. Eligible Dependent**

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

1. The Participating Employee's spouse under a legally valid marriage.

2. The Participating Employee's natural child, stepchild, legally adopted child, child placed with the Participating Employee for adoption, or child for whom the Participating Employee or the Participating Employee'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 intellectual disability or physical handicap *and* financially dependent upon the Participating Employee for support, regardless of age.

3. A Participating Employee must notify the BCI or the Trust 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 status took place.

### II. Leave Of Absence for Participating Employees

**A.** Participating Employees who subsequently fail to fulfill the twenty (20) or thirty (30) hour-per-week employment requirement and who have been enrolled for nine (9) months or more, may retain coverage and receive benefits defined in this Plan 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 Participant and remits the entire contribution due with the payment for the other Participants. 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 the Plan.

**B.** Participating Employees who fail to fulfill the twenty (20) or thirty (30) hour-per-week employment requirement and who have been enrolled for at least one (1) month may retain coverage and receive benefits defined in this Plan while on an unpaid, approved leave of absence for a period not to exceed one (1) year. The monthly contribution is the sole responsibility of the Participant and must be submitted with the Group payment for the other Participants.

**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 Participant intends to return to employment with the Group at the end of the leave of absence.

### III. Group Contribution for Participating Employees

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 Participant from district funds. The balance of the contribution will be payroll-deducted from the Participant's wage.

**IV. Miscellaneous Eligibility And Enrollment Provisions**

A. The Group will collect Participating Employee contributions through payroll withholding and be responsible for making the required payments to the Trust through BCI on or before the first of each month. Unless required by state or federal law or unless agreed to in writing by the Trustees, the Group will not offer to its employees any other hospital, medical, dental or surgical coverage that is not provided by or through this Plan, 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 through the Plan during the 12 month period from September 1 through August 31of each year.

B. This Plan is offered to the Group upon the express condition that a pre-established required percentage of the Eligible Employees specified in the Application for Group Coverage who meet the underwriting criteria of BCI are and continue to be Participating Employees. This Plan is issued under the express condition that the Group continues to make the employer contribution specified in the Application for Group Coverage and this Plan. BCI may terminate this Plan if the percentage of Eligible Employees as Participating Employees or the percentage of the employer contribution drops below the required level. It is understood that no Plan will be in effect 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 Plan will be subject to surcharge or discontinued at the next renewal date. Existing districts that do not meet this criteria must submit to the Plan Administrator a written plan showing how and when compliance will be accomplished.

C.

1. For an Eligible Employee to enroll himself or herself and any Eligible Dependents for coverage (or for a Participating Employee to enroll Eligible Dependents for coverage) the Eligible Employee or Participating Employee must complete a BCI application and submit it and any required contributions to BCI in a manner approved by both BCI and the Plan Administrator.

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

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

D.

1. Except as stated otherwise in subparagraphs D.2. 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 Employees or Eligible Dependent first becomes eligible for coverage.

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

the date of birth for 60 days.

3. In order to continue coverage beyond the sixty (60) days outlined above, the Participating Employee must complete an enrollment application and submit the required contribution, for the first sixty (60) days, within thirty-one (31) days following receipt of a billing by the employee.

   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 Plan, '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 Plan, "placed for adoption" means physical placement in the care of the adoptive Participating Employee, 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 Participating Employee signs an agreement for adoption of the child and signs an agreement assuming financial responsibility for the child.

4. The initial enrollment period is thirty (30) 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.

E. **Late Participating Employee**

If an Eligible Employee or Eligible Dependent does not enroll during the initial enrollment period described in Paragraph D. of this section or during a special enrollment period described in Paragraph F. of this section, the Eligible Employee or Eligible Dependent is a Late Participating Employee. Following the receipt and acceptance of a completed enrollment application, the Effective Date of coverage for a Late Participating Employee will be the date of the Group's next Plan Date.

F. **Special Enrollment Periods**

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

1. Individuals Losing Other Coverage — An Eligible Participating Employee or Eligible Dependent losing other coverage may enroll for coverage under this Plan if each of the following conditions is met:
   a) The Eligible Participating Employee or Eligible Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the Eligible Person or Eligible Dependent.
   b) The Eligible Participating Employee's or Eligible Dependent's coverage described in subparagraph a):
      (1) was under a COBRA continuation provision and the coverage under such provision was exhausted; or
      (2) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination

of employment or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.

c) Under the terms of this Plan, the Eligible Participating Employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph b)(1) or termination of coverage or employer contribution described in subparagraph b)(2).

2. For Dependent Beneficiaries —

a) If a person becomes an Eligible Dependent of a Participating Employee (or of an Eligible Employee who failed to enroll during a previous enrollment period) through marriage, birth, adoption before age 18 or placement for adoption before age 18, the Eligible Dependent (or, if not otherwise enrolled, the Eligible Person) may enroll, and in the case of the birth or adoption of a child, the spouse of the Participating Employee or Eligible Employee may enroll as an Eligible Dependent if such spouse is otherwise eligible for coverage.

b) The dependent special enrollment period under this subparagraph 2 shall be a period of 60 days and shall begin on the date of the marriage, birth, adoption or placement for adoption (as the case may be).

c) If a Participating Employee enrolls an Eligible Dependent during the dependent special enrollment period described in this subparagraph 2, the Effective Date of coverage shall be:

(1) in the case of marriage, the first day of the month beginning after the date a completed application and any required contribution is received by Blue Cross of Idaho;

(2) in the case of an Eligible Dependent's birth, as of the date of such birth; or

(3) in the case of an Eligible Dependent's adoption or placement for adoption, the date of birth for an Eligible Dependent adopted or placed for adoption within 60 days of the Eligible Dependent's date of birth; and the date of such adoption or placement for adoption for an Eligible Dependent adopted or placed for adoption more than 60 days after the Eligible Dependent's date of birth.

3. 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 Plan is requested no later than 60 days after the date the Eligible Employee and/or Eligible Dependent is determined to be eligible for such assistance.

4. 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 Plan no later than 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, which is a Blue Cross of Idaho program that supplements Medicare.

## V. Eligible Employees Changing To Other Participating School Districts

Coverage 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.

## VI. Retirement

If a Participant separates from public school employment by retirement in accordance with Idaho Code Title 59, Chapter 13, the Participant and/or his or her spouse shall be eligible for coverage under the retiree Plan of the Statewide Schools Group Program only if the Participant 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 Participant's retirement. Any exceptions will require a health statement.

## VII. Qualified Medical Child Support Order

A. If this Plan provides for Family Coverage, BCI, on behalf of the Plan Administrator, will comply with a Qualified Medical Child Support Order (QMCSO) according to the provisions of applicable federal or state laws. A medical child support order is any judgement, 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 a Participating Employee 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 Plan, 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 Participating Employee 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 Plan 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 Participating Employee, the party who sent the order, and each affected child of such determination.

D. BCI, on behalf of the Plan Administrator, 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 FOR RETIREES SECTION

### I. Eligibility And Enrollment

All Eligible Retirees will have the opportunity to apply for coverage under this Plan. 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 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 coverage 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 Plan, a person must be and remain one (1) of the following:

1. The Participating Employee's spouse under a legally valid marriage.
2. The Participating Employee's natural child, stepchild, legally adopted child, child placed with the Participating Employee for adoption, or child for whom the Participating Employee or the Participating Employee'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 intellectual disability or physical handicap *and* financially dependent upon the Participating Employee for support, regardless of age.
3. A Participating Employee must notify the BCI or the Trust 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 status took place.

### II. Loss Of Eligibility If A Participating School District Cancels

If the Participating School District through which the retired Participant was last employed cancels its coverage under the Plan and leaves the Statewide School Group Program, the retired Participant ceases to be an Eligible Retiree on the Effective Date of the cancellation.

### III. Payment Of Contribution 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 contribution will be deducted from the Participant's sick leave fund to the extent such funds are available. When the sick leave funds are exhausted, the contribution shall be deducted from the Participant's pension fund to the extent such funds are available.

If there is a sufficient amount of funds in the Retiree's sick leave and/or pension fund, the Public Employees Retirement System of Idaho agrees to collect required Retiree 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 Plan. If the Retiree's monthly pension and/or sick leave fund is less than the required payment, the Retiree 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 Plan.

C. For a person who is an Eligible Retiree and who applies for Single, Two-Party or Family Coverage on or before the first day he or she first becomes eligible as provided herein, the Effective Date is either the Participating School District's Plan Date, or the first day of the month after the person first becomes eligible, whichever is earlier. A Retiree may not add a Dependent who was not enrolled when the Retiree 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 Retiree to enroll himself or herself and any Eligible Dependents for coverage under this Plan (or for A Participant to enroll Eligible Dependents for coverage under this Plan) the Eligible Person or Participant, as the case may be, must complete a Blue Cross of Idaho application and submit it and any required contributions to Blue Cross of Idaho.
2. Except as provided otherwise in this section, the Effective Date of coverage for an Eligible Retiree 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 Retiree and any Eligible Dependents listed on the Eligible Retiree's application is the Group's Plan Date if the application is submitted to Blue Cross of Idaho by the Group on or before the Plan 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 Plan.
2. A Participant's newborn Dependent, including adopted newborn children who are placed with the adoptive Participant within sixty (60) days of the adopted child's date of birth, are covered under this Plan from and after the date of birth for sixty (60) days.

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

   When a newborn child is added and the monthly contribution changes, a full month's contribution is required for the child if his or her date of birth falls on the 1st through the 15th day of the month. No contribution 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 Plan, '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 Plan, "placed for adoption" means physical placement in the care of the adoptive Participant, 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 Participant signs an agreement for adoption of the child and signs an agreement assuming financial responsibility for the child.

4. 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.

## IV. Qualified Medical Child Support Order

A. If this Plan provides for Family Coverage, BCI, on behalf of the Plan Administrator, will comply with a Qualified Medical Child Support Order (QMCSO) according to the provisions of applicable federal or state laws. A medical child support order is any judgement, 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 a Participating Employee 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 Plan**,** 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 Participating Employee 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 Plan 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 Participating Employee, the party who sent the order, and each affected child of such determination.

D. BCI, on behalf of the Plan Administrator, 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.

## DEFINITIONS SECTION

For reference, most terms defined in this section are capitalized throughout this Plan. Other terms may be defined where they appear in this Plan. All Providers and Facilities listed in this Plan 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 Plan shall control over any other definition or interpretation unless the context clearly indicates otherwise.

**Accidental Injury or 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 Participant'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, rescission of coverage, or termination of, or the failure to provide payment for, a benefit for services or ongoing treatment under this Plan.

**Amendment (Amend)—**a formal document signed by the representatives the Idaho School District Council Self-Funded Benefit Trust. The Amendment adds, deletes or changes the provisions of the Plan and applies to all covered persons, including those persons covered before the Amendment becomes effective, unless otherwise specified.

**Benefit Period—**the specified period of time during which a Participant accumulates annual benefit limits, Deductible amounts and Out-of-pocket Limits.

**Benefits—**the amount Blue Cross of Idaho will pay for Covered Services after Deductible requirements are met.

**Benefits After Termination**—the benefits, if any, remaining under this Plan after a person ceases to be a Participant.

**Blue Cross Of Idaho (BCI)—**a nonprofit mutual insurance company, hired by the Board of Trustees of the Idaho School District Council Self-Funded Benefit Trust to act as the third party Contract Administrator to perform claims processing and other specific administrative services as outlined in the Plan and/or Administrative Services Agreement.

**Closed List of Dental Covered Services—**the list of Covered Dental Services in the Dental Benefits Section for which benefits are available under this Plan.

**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 Plan, 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 conditions that are medically diagnosed to be Congenital Anomalies.

**Contracting Dentist—** a Dentist that has entered into a written agreement with BCI to accept the Participant's Deductible and/or Cost-Sharing plus BCI's Benefit payment as payment in full for Covered Services rendered to a Participant.

**Contract Administrator—**Blue Cross of Idaho has been hired as the third party Contract Administrator by the Plan Administrator to perform claims processing and other specified administrative services in relation to the Plan. The Contract Administrator is not an insurer of health benefits under this Plan, and does not exercise any of the discretionary authority and responsibility granted to the Plan Administrator. The Contract Administrator is not responsible for Plan financing and does not guarantee the availability of benefits under this Plan.

**Copayment—**a designated dollar and/or percentage amount, separate from Cost-sharing, that a Participant is financially responsible for and must pay to a Provider at the time certain Covered Services are rendered.

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

1. Provided in the most cost-appropriate setting consistent with the Participant'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 Participant's condition, Disease, Illness or injury.

**Cost-Sharing or Cost Sharing—**the percentage of the Maximum Allowance or the actual charge, whichever is less, a Participant is responsible to pay Out-of-Pocket for Covered Services after satisfaction of any applicable Deductibles or Copayments, or both.

**Covered Provider—**a Provider specified in this Plan from whom a Participant must receive Covered Services in order to be eligible to receive benefits.

**Covered Service—**when rendered by a Covered Provider, a service, supply, or procedure specified in this Plan for which benefits will be provided to a Participant.

**Custodial Care—**care designated principally to assist a Participant in engaging in the activities of daily living; or services which constitute personal care, such as help in walking and getting in and out of bed, assistance in eating, dressing, bathing, and using the toilet; preparation of special diets; and supervision of medication, which can usually be self-administered and does not require the continuing attention of trained medical or paramedical personnel. Custodial Care is normally, but not necessarily, provided in a nursing home, convalescent home, rest home, or similar institution.

**Deductible—**the amount a Participant is responsible to pay Out-of-pocket before BCI, on behalf of the Plan Administrator, begins to pay benefits for Covered Services. The amount credited to the Deductible is based on the Maximum Allowance or the actual charge, whichever is less.

**Dental Consultant—**a duly licensed dentist retained by BCI for the purpose of advising and performing any and all services requested in connection with review of dental claims, as well as consulting and advising in the area of dentistry.

**Dental Hygienist—**a person licensed to practice dental hygiene who is acting under the supervision and direction of a Dentist. For BCI to provide benefits, the Dental Hygienist must be licensed in the state where service is rendered and the hygienist must be performing within the scope of his/her license.

**Dental Treatment Plan—**the Dentist's report of recommended treatment on a form satisfactory to BCI that:

1. Itemizes dental procedures necessary for the care of a Participant.
2. Lists the charges for each procedure.
3. Is accompanied by supporting preoperative x-rays and any other appropriate diagnostic materials reasonably required by BCI.

**Dentist—**an individual licensed to practice Dentistry.

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

**Denturist—**a person licensed in the state where service is rendered to engage in the practice of denturism. 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 Participant's awareness of it, and can be of known or unknown cause(s).

**Effective Date—**the date when coverage for a Participant begins under this Plan.

**Eligible Dependent—**a person eligible for enrollment under a Participating Employee's coverage.

**Eligible Employee—**an employee of a Group who is entitled to apply as a Participating Employee.

**Family Coverage—**the enrollment of a Participating Employee and two (2) or more Eligible Dependents under this Plan.

**Group—** the Idaho District School Council Self-Funded Benefit Trust, also referred to as the Trust.

**Health Benefit Plan—**any dental Plan or certificate, any subscriber contract provided by a dental or professional service corporation, or managed care organization subscriber contract. Health Benefit Plan does not include policies or certificates of insurance for specific Disease, hospital confinement indemnity, accident-only, credit, vision, Medicare supplement, long-term care or disability income insurance, student health benefits-only coverage issued as a supplement to liability insurance, Workers' Compensation or similar insurance, automobile medical payment insurance, or nonrenewable short-term coverage issued for a period of twelve (12) months or less.

**Hypnosis—**an induced passive state in which there is an increased responsiveness to suggestions and commands, provided that these do not conflict seriously with the subject's conscious or unconscious wishes.

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

**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.

**In-Network Services—**Covered Services provided by a Covered Provider.

**Inpatient—**a Participant 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—**any technology (service, supply, procedure, treatment, drug, device, facility, equipment or biological product), which is in a developmental stage or has not been proven to improve health outcomes

such as length of life, quality of life, and functional ability. A technology is considered investigational if, as determined by BCI, it fails to meet any one of the following criteria:

1. The technology must have final approval from the appropriate government regulatory body. This applies to drugs, biological products, devices, and other products/procedures that must have approval from the U.S. Food and Drug Administration (FDA) or another federal authority before they can be marketed. Interim approval is not sufficient. The condition for which the technology is approved must be the same as that BCI is evaluating.
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of current published medical literature and investigations published in peer-reviewed journals. The quality of the studies and consistency of results will be considered. The evidence should demonstrate that the technology can measure or alter physiological changes related to a Disease, injury, Illness, or condition. In addition, there should be evidence that such measurement or alteration affects health outcomes.
3. The technology must improve the net health outcome. The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
4. The technology must be as beneficial as any established alternatives.
5. The technology must show improvement that is attainable outside the investigational setting. Improvements must be demonstrated when used under the usual conditions of medical practice.

6. If a technology is determined to be investigational, all services specifically associated with the technology, including but not limited to associated procedures, treatments, supplies, devices, equipment, facilities or drugs will also be considered investigational.

   In determining whether a technology is investigational, BCI considers the following source documents: Blue Cross Blue Shield Association Technology Evaluation Center (TEC) assessments, the Blue Cross and Blue Shield Association Medical Plan 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.

**Lifetime Benefit Limit—**the greatest aggregate amount payable by the Plan on behalf of an Individual for specified Covered Services during all periods in which the Participant has been continuously enrolled with the Group.

**Maximum Allowance—**for Covered Services under the terms of this Plan, Maximum Allowance is the lesser of the billed charge or the amount established by BCI as the highest level of compensation for a Covered Service. If the Covered Services are rendered outside the state of Idaho by a Noncontracting or Contracting Dentist with a Blue Cross and/or Blue Shield affiliate in the location of the Covered Services, the Maximum Allowance is the lesser of the billed charge or the amount established by the affiliate as compensation.

Maximum Allowance for Covered Services provided by Contracting or Noncontracting Dentists is determined using many factors, including pre-negotiated payment amounts, a calculation of charges submitted by Contracting Idaho Dentists, and/or a calculation of the average charges submitted by all Idaho Dentists. Moreover, Maximum Allowance may differ depending on whether the Provider is Contracting or Noncontracting.

**Medicaid**—Title XIX (Grants to States for Medical Assistance Programs) of the United States Social Security Act as amended.

**Medically Necessary (or Medical Necessity)—**the Covered Service or supply recommended by the treating Covered Provider to identify or treat a Participant'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 Participant.
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 Participant or Covered Provider.
4. Cost Effective for this condition.

The fact that a Covered 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 Policy.

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

In determining whether a service is Medically Necessary, BCI considers the medical records and, the following source documents: Blue Cross Blue Shield Association Technology Evaluation Center (TEC) 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.

**Medicare**—Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act as amended.

**Noncontracting Dentist—**a Professional Provider or Facility Provider that has not entered into a written agreement with BCI regarding payment for Covered Services rendered to a Participant.

**Out-Of-Network Services—**any Covered Services rendered by a Noncontracting provider.

**Out-Of-Pocket Limit—**the amount of Out-of-Pocket expenses incurred during one (1) Benefit Period that a Participant is responsible for paying. Eligible Out-of-Pocket expenses include only the Participant's Deductible and Cost-sharing for eligible Covered Services.

**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).

**Outpatient—**a Participant who receives services or supplies while not an Inpatient.

**Participant—**a Participating Employee or an enrolled Eligible Dependent covered under this Plan.

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

**Participating School District—**a school district that has a current participation agreement with the Trust.

**Plan—**the Administrative Services Agreement between Blue Cross of Idaho and the Group and Amendments and attachments to such agreement, and all benefit outlines and summary plan descriptions.

**Plan Administrator—**the Board of Trustees of the Idaho School District Council Self-Funded Benefit Trust, which is the sole fiduciary of the Plan, has all discretionary authority to interpret the provisions and control the operation and administration of the Plan within the limits of the law. All decisions made by the Plan Administrator, including final determination of Medical Necessity, shall be final and binding on all parties. The Board of Trustees of the Idaho School District Council Self-Funded Benefit Trust also reserves the right to modify eligibility clauses for new Plan participants. The Plan Administrator also has the right to amend, modify or terminate the Plan at any time or in any manner as outlined in the Administrative Services Agreement.

The administration of the Plan document is under the supervision of the Plan Administrator. The Idaho School District Cooperative Service Council, for limited clerical duties, acts on behalf of the Plan Administrator. The Board of Trustees of the Idaho School District Council Self-Funded Benefit Trust has agreed to indemnify each employee in the Idaho School District Cooperative Service Council for any liability he/she incurs as a result of acting on behalf of the Plan Administrator, except if such liability is due to his/her gross negligence or misconduct.

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

**Plan Sponsor —**the Idaho School District Cooperate Service Council.

**Post-Service Claim—**any claim for a benefit under this Plan that does not require Prior Authorization before services are rendered.

**Preferred Provider Organization (PPO)—**a Health Benefit Plan in which the highest level of Benefits is received when the Participant obtains Covered Services from an In-Network Provider.

**Pre-Service Claim—**any claim for a benefit under this Plan that requires Prior Authorization before services are rendered.

**Provider—** a Dentist, Dental Hygienist or Denturist who provides services under this Plan and is acting within the scope of his or her license.

**Sound Natural Tooth—**for avulsion or traumatic tooth loss, a Sound Natural Tooth is considered to be one in which the existing conditions of the tooth and its supporting structures did not influence the outcome of the Injury in question, is without impairment, including but not limited to periodontal or other conditions, and is not in need of the treatment provided for any reason other than the Accidental Injury.

For injuries related to fracture of the coronal surface, a Sound Natural Tooth is considered to be one which has not been restored by, including but not limited to, a crown, inlay, onlay or porcelain restoration, or treated by endodontics.

**Statewide School Group Program**—the self-funded program for the group of Participating School Districts who provide benefits for Eligible Employees and Eligible Retirees by selecting benefit options provided in the Plan.

**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.

**Trust—**the Idaho School District Council Self-Funded Benefit Trust.

## EXCLUSIONS AND LIMITATIONS SECTION

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

### I. General Exclusions And Limitations

There are no benefits for services, supplies, drugs or other charges that are:

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

B. Charges for services that were started prior to the Participant'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 are explored 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 Plan: on the date any bands or other appliances are first inserted.

C. Cast restorations (crowns, inlays or onlays) for teeth that are restorable by other means (i.e., by amalgamor composite fillings).

D. Replacement of an existing crown, inlay or onlay that was installed within the preceding five (5) years or replacement of an existing crown, inlay or onlay that can be repaired.

E. Appliances, restorations or other services provided or performed solely to change, maintain or restore vertical dimension or occlusion.

F. A service for cosmetic purposes, unless necessitated as a result of Accidental Injuries received while the Participant was covered by BCI.

G. In excess of the Maximum Allowance.

H. A partial or full removable denture for fixed bridgework, or the addition of teeth thereto, if involving a replacement or modification of a denture or bridgework that was installed during the preceding five (5) years.

I. Orthodontic services and supplies unless otherwise specifically listed in the Closed List of Dental Covered Services.

J. Replacement of lost or stolen appliances.

K. Ridge augmentation procedures.

L. Any procedure, service or supply other than alveoloplasty or alveolectomy required to prepare the alveolus, maxilla or mandible for a prosthetic appliance. Excluded services

include, but are not limited to, vestibuloplasty, stomatoplasty and bone grafts (either synthetic or autogenous) to the alveolars, maxilla or mandible.

M. 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.

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. Temporary dental services. Charges for temporary services are considered an integral part of the final dental services and are not separately payable.

P. Any service, procedure or supply for which the prognosis for success is not reasonably favorable as determined by BCI.

Q. Myofunctional therapy and biofeedback procedures.

R. For hospital Inpatient or Outpatient care for extraction of teeth or other dental procedures.

S. Diagnostic casts.

T. Occlusal adjustments.

U. Not prescribed by or upon the direction of a Provider.

V. Investigational in nature;

W. Provided for any condition, Disease, Illness or Accidental Injury to the extent that the Participant 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 Participant claims such benefits or compensation or recovers losses from a third party.

X. Provided or paid for by any federal governmental entity or unit except when payment under this Plan 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 Plan.

Y. Provided for any condition, Accidental Injury, Disease or Illness suffered as a result of any act of war or any war, declared or undeclared.

Z. Furnished by a Provider who is related to the Participant by blood or marriage and who ordinarily dwells in the Participant's household.

AA. Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.

BB. For personal hygiene, comfort, beautification or convenience items even if prescribed by a Dentist, including but not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment or programs.

CC. For telephone consultations; for failure to keep a scheduled visit or appointment; for completion of a claim form; or for personal mileage, transportation, food or lodging expenses or for mileage, transportation, food or lodging expenses billed by a Dentist or other Provider.

DD. For Congenital Anomalies, or for developmental malformations, unless the patient is an Eligible Dependent child.

EE. For the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation, unless such injuries are a result of a medical condition or domestic violence.

FF. For treatment or other health care of any Participant in connection with an Illness, Disease, Accidental Injury or other condition which would otherwise entitle the Participant to Covered Services under this Plan, if and to the extent those benefits are payable to or due the Participant under any medical payments provision, no fault provision, uninsured motorist provision, underinsured motorist provision, or other first party or no fault provision of any automobile, homeowner's or other similar Plan of insurance, contract or underwriting plan;

In the event Blue Cross of Idaho for any reason makes payment for or otherwise provides benefits excluded by this provision, it shall succeed to the rights of payment or reimbursement of the compensated Provider, the Participant, and the Participant 's heirs and personal representative against all insurers, underwriters, self-insurers or other such obligors contractually liable or obliged to the Participant or his or her estate for such services, supplies, drugs or other charges so provided by Blue Cross of Idaho in connection with such Illness, Disease, Accidental Injury or other condition.

GG. Any services or supplies for which A Participant would have no legal obligation to pay in the absence of coverage under this Plan or any similar coverage; or for which no charge or a different charge is usually made in the absence of insurance coverage.

HH. Provided to persons who were enrolled as Eligible Dependents after they cease to qualify as Eligible Dependents due to a change in Eligibility status which occurs during the Plan term.

II. Provided outside the United States, which if had been provided in the United States, would not be Covered Services under this Plan.

JJ. Not directly related to the care and treatment of an actual condition, Illness, Disease or Accidental Injury.

KK. For acupuncture or hypnosis.

LL. Repair, removal, cleansing or reinsertion of Implants.

MM. Precision or semi-precision attachments (including implants placed to support a fixed or removable denture).

NN. Denture duplication.

OO. Oral hygiene instruction.

PP. Treatment of jaw fractures.

QQ. Charges for acid etching.

RR. Charges for oral cancer screening which are included in a regular oral examination.

SS. No benefits are available for replacement and/or repair of orthodontic appliances. This includes removable and/or fixed retainers.

## II. Conditions

### A. Right to Review Dental Work

Before providing benefits for Covered Services, Blue Cross of Idaho has the right to refer the Participant to a Dentist of its choice and at its expense to verify the need, quantity and quality of dental work claimed as a benefit under this section.

### B. Care Rendered by More Than One Dentist

If a Participant transfers from the care of one Dentist to another Dentist during a Dental Treatment Plan, or if more than one Dentist 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 Dentist rendered the service.

### C. Alternate Treatment Plan

If a Dentist and a Participant select a Dental Treatment Plan other than that which is customarily provided by the dental profession, payments of benefits available under this section shall be limited to the Dental Treatment Plan that is the standard and most economical, according to generally accepted dental practices.

## GENERAL PROVISIONS SECTION

### I. Termination Or Modification Of A Participant's Coverage Under This Plan

**A.** If a Participating Employee ceases to be an Eligible Employee or the Group does not remit the required contribution, the Participating Employee'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. If the Group does not remit the required payments as required by the Administrative Services Agreement and Blue Cross of Idaho elects to terminate this Agreement, the Participating Employee's coverage and the coverage of any and all enrolled Eligible Dependents will terminate on the last day for which the Group reimbursed Blue Cross of Idaho for the payment of claims and administrative fees.

**B.** Except as provided in this paragraph, coverage for a Participant who is no longer eligible under this Plan will terminate on the date a Participant no longer qualifies as a Participant, as defined in the Eligibility and Enrollment Section. Coverage will not terminate because of age for a Participant who is a dependent child incapable of self-sustaining employment who is medically certified as disabled , who became so incapable prior to reaching the age limit, and who is chiefly dependent on the Participating Employee for support and maintenance, provided the Participating Employee, within thirty-one (31) days of when the dependent child reaches the age limit, has submitted to BCI (at the Participating Employee's expense) a Physician's certification of such dependent child's incapacity. BCI, on behalf of the Plan Administrator, 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, on behalf of the Plan Administrator, may require such subsequent proof once each year. Coverage for the dependent child will continue so long as this Plan remains in effect, the child's disability and financial dependency exists, and the child has not exhausted benefits.

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

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

**E.** The Plan Administrator may terminate or retroactively rescind a Participant's coverage under this Plan for any intentional misrepresentation, omission, or concealment of fact by, concerning, or on behalf of any Participant that was or would have been material to the Plan Administrator's acceptance of a risk, extension of coverage, provision of benefits, or payment of any claim.

**F.** Prior to legal finalization of an adoption, the coverage provided in this Plan for a child placed for adoption with a Participating Employee continues as it would for a naturally born child of the Participating Employee 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 Participating Employee 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 Plan 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.

## II. Benefits After Termination Of Coverage

### A. Continuation of Coverage Under Federal Law

As mandated by federal law, the Plan offers optional continuation of coverage to the Participating Employee and their covered dependents if coverage ends due to one of the following qualifying events:

1. Termination of the Participating Employee's employment for any reason, except gross misconduct as defined in the Participating School District's personnel policies. Coverage may continue for the Participating Employee and/or their Eligible Dependents.

2. A reduction in hours worked by the Participating Employee that results in loss of Plan eligibility. Coverage may continue for the Participating Employee and/or their Eligible Dependents.

3. The Participating Employee's death. Coverage may continue for their Eligible Dependents.

4. Divorce or legal separation from the Participating Employee's spouse. Coverage may continue for that spouse and the Eligible Dependents.

5. The Participating Employee becomes entitled to Medicare. Coverage may continue for Eligible Dependents that are not entitled to Medicare.

6. Loss of eligibility of covered dependent children due to Plan eligibility requirements. Coverage may continue for that dependent.

To choose this continuation of coverage, an individual must be a Participating Employee or an enrolled Eligible Dependent under the Plan on the day before the qualifying event. Choosing this continuation of coverage may interfere with the Participant's ability to receive coverage, which may be subsidized, under a state or federal exchange.

### B. Notification Requirement

The Participating Employee or the Eligible Dependent has the responsibility to inform the Plan Administrator of a divorce, legal separation or a child losing dependent status under the Plan within 60 days of the qualifying event. Failure to provide this notification within 60 days will result in the loss of continuation coverage rights.

The Group has the responsibility of notifying BCI of your death, termination of employment, reduction in hours, or entitlement to Medicare within 30 days of the qualifying event.

BCI, on behalf of the Plan Administrator, will notify a qualifying individual of continuation coverage rights within 14 days of notification. The qualifying individual then has 60 days to elect continuation coverage. Failure to elect continuation coverage within 60 days after being notified by BCI, on behalf of the Plan Administrator, will result in loss of continuation of coverage rights.

**C. Cost of Continuation Coverage**

The cost of continuation coverage is determined by the Plan Administrator and paid by the qualifying individual. If the qualifying individual is not disabled, the applicable contribution cannot exceed 102% of the Plan Administrator's cost of providing coverage. The cost of coverage during a period of extended continuation coverage due to a disability cannot exceed 150% of the Plan Administrator's cost of coverage.

The qualified individual must make the first payment within 45 days of notifying the Contract Administrator (BCI) of selection of continuation coverage. Future payments can be made in monthly installments within 30 days of the due date. Rates and payment schedules are established by the Trust and may change when necessary due to Plan modifications.

The cost of continuation coverage is computed from the date coverage would normally end due to the qualifying event.

Failure to make the first payment within 45 days or any subsequent payment within 30 days of the established due date will result in the permanent cancellation of continuation coverage.

**D. Maximum Period of Continuation Coverage**

The maximum period of continuation coverage for individuals who qualify due to termination of employment or reduction in hours worked is 18 months from the date of the qualifying event.

If a qualifying individual is disabled (as determined by the Social Security Administration) at the Participating Employee's time of termination or reduction in hours or is declared disabled within the first sixty (60) days of continuation coverage, continuation coverage for the qualifying individual may be extended to twenty-nine (29) months provided the qualifying individual notifies the Contract Administrator (Blue Cross of Idaho) within the eighteen (18) month continuation coverage period and within sixty (60) days after they receive notification of disability from the Social Security Administration (SSA).

The maximum period of continuation coverage for individuals who qualify due to any other described qualifying event, except bankruptcy, is 36 months from the date of the qualifying event.

**E. Multiple Qualifying Events**

Should the Eligible Dependent(s) experience more than one qualifying event, they may be eligible for an additional period of continued coverage not to exceed a total of thirty-six (36) months from the date of the first qualifying event. For example, if the Participating Employee terminates employment, the Participating Employee and any enrolled Eligible Dependents may be eligible for eighteen (18) months of continued coverage. If during this eighteen (18) month period a second qualifying event (divorce, legal separation, death, Medicare entitlement, or a dependent child ceasing to be a dependent) takes place, then the original eighteen (18) months of continuation coverage can be extended to thirty-six (36) months from the date of the original qualifying event date for the enrolled Eligible Dependent qualified beneficiaries. If a second event occurs, it is the qualified beneficiary's responsibility to notify BCI.

**F. When Continuation Coverage Ends**

Continuation Coverage ends on the earliest of:

1. The date the maximum continuation period expires.

2. The date the qualifying individual becomes entitled to coverage under Medicare.
3. The last period for which payment was made when coverage is cancelled due to nonpayment of the required cost.
4. The date the Trust no longer offers a group health plan to any of its employees.
5. The date the qualifying individual becomes covered under another group health plan.

**III. Contract Between BCI And The Group**

This Plan is part of the contract between BCI and the Group. This Plan shall not be construed as a contract between BCI and any Participant.

**IV. Applicable Law**

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

**V. Benefits To Which Participants Are Entitled**

**A**. Subject to all of the terms of this Plan, a Participant is entitled to benefits for Covered Services in the amounts specified in the benefit sections and/or in the Benefits Outline.

**B.** In the event of an Inpatient Admission that occurs prior to the Group's transfer to BCI and the Effective Date of coverage under this Plan, benefits will be provided only when the Participant receives services that are Covered Services under this Plan. The outgoing carrier has primary responsible for providing benefits for the Inpatient treatment from the date of admission until the first of the following events occur:

- The Participant is discharged,
- The Benefit Period under the previous coverage ends, or
- Until benefits under the outgoing carrier's policy are exhausted.

**C.** BCI will provide benefits for Covered Services incurred following the Effective Date of coverage reduced by the benefits paid by the outgoing carrier.

**D.** Benefits will be provided only if Covered Services are prescribed by, or performed by, or under the direction of a Physician or other Professional Provider and are regularly and customarily included in such Providers' charges.

**E**. Covered Services are subject to the availability of Licensed General Hospitals and other Facility Providers and the ability of the employees of such Providers and of available Physicians to provide such services. The Plan Administrator and/or BCI shall not assume nor have any liability for conditions beyond its control which affect the Participant's ability to obtain Covered Services.

**F.** The Board of Trustees of the Idaho School District Council Self-Funded Benefit Trust intends the Plan to be permanent, but because future conditions affecting the Idaho School District Council Self-Funded Benefit Trust cannot be anticipated or foreseen, the Board of Trustees of the Idaho School District Council Self-Funded Benefit Trust reserves the right to amend, modify, or terminate the Plan at any time (pursuant to Idaho Code and Rules), which may result in the termination or modification of the Participants' Coverage. Expenses incurred prior to the Plan modification or termination will be paid as provided under the terms of the Plan prior to its modification or termination. Any material change made to this Plan will be provided in writing within sixty (60) days of the Effective Date of change.

**VI. Notice Of Claim**

BCI will process claims for benefits on behalf of the Group according to the Administrative Services Agreement between the parties. A claim for Covered Services must be submitted within one year

from the date of service and must include all the information necessary for BCI, on behalf of the Plan Administrator, to determine benefits.

## VII. Release And Disclosure Of Medical Records And Other Information

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

**B.** As a condition of coverage under this Plan, each Participant authorizes Providers to testify at BCI's request as to any information regarding the Participant's medical 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 Participant.

## VIII. Exclusion Of General Damages

Liability under this Plan for benefits conferred hereunder, including recovery under any claim or breach of this Plan, shall be limited to the actual benefits for Covered 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.

## IX. Payment Of Benefits

Blue Cross of Idaho provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

**A.** BCI, on behalf of the Plan Administrator, is authorized by the Participant to make payments directly to Providers rendering Covered Services to the Participant for benefits provided under this Plan. Notwithstanding this authorization, BCI, on behalf of the Plan Administrator, reserves and shall have the right to make such payments directly to the Participant. Except as provided by law, BCI's right, on behalf of the Plan Administrator, to pay a Participant directly is not assignable by a Participant nor can it be waived without BCI, on behalf of the Plan Administrator, nor may the right to receive benefits for Covered Services under this Plan be transferred or assigned, either before or after Covered Services are rendered. Payments will also be made in accordance with any assignment of rights required by state Medicaid plan.

**B.** Once Covered Services are rendered by a Provider, BCI, on behalf of the Plan Administrator, shall not be obliged to honor Participant requests not to pay claims submitted by such Provider, and BCI, on behalf of the Plan Administrator, shall have no liability to any person because of its rejection of such request; however, in its sole discretion, for good cause, BCI, on behalf of the Plan Administrator, may nonetheless deny all or any part of any Provider claim.

**C.** Under normal conditions, all benefits are payable to the Provider of services or supplies. All other benefits are payable to the Provider of services or supplies and can only be paid directly to another party upon signed authorization from the Participant. If conditions exist under which a valid release or assignment cannot be obtained, this Plan may make payment to any individual or organization that has assumed the care or principal support for the Participant and is equitably entitled to payment. This Plan must make payments to the

Participant's separated/divorced spouse, state child support agency or Medicaid agency if required by a qualified medical child support order (QMCSO), or state Medicaid law.

This Plan may also honor benefit assignments made prior to the Participant's death in relation to remaining benefits payable by this Plan.

Any payment made by BCI, on behalf of the Plan Administrator, in accordance with this provision will fully release the Plan Administrator of its liability to the Participant.

## X. Participant/Provider Relationship

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

**B.** BCI does not render Covered Services but only makes payment for Covered Services received by Participants. BCI and the Plan Administrator are not liable for any act or omission or for the level of competence of any Provider, and BCI and the Plan Administrator have no responsibility for a Provider's failure or refusal to render Covered Services to a Participant.

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

## XI. 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 Services to Participants, but it shall have no obligation to do so.

## XII. Coordination Of This Plan's Benefits With Other Benefits

This Coordination of Benefits (COB) provision applies when a Participant 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 policy 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: 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 Participant 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, Cost-sharing and Copayments, that is covered at least in part by any Contract covering the Participant. 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 Participant 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 Participant 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 Participant 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 Participant 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 Plan, 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 Participant 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 Participant 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 Participant as a dependent is the Secondary Contract. However, if the Participant is a Medicare beneficiary and, as a result of

federal law, Medicare is secondary to the Contract covering the Participant as a dependent; and primary to the Contract covering the Participant 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 Participant 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:

a) 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;

b) 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;

c) 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;

d) 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 Participant as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Contract. The Contract covering that same Participant as a retired or laid-off employee is the Secondary

Contract. The same would hold true if a Participant is a dependent of an active employee and that same Participant 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 Participant 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 Participant as an employee, member, subscriber or retiree or covering the Participant 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 Participant as an employee, member, policyholder, subscriber, or retiree longer is the Primary Contract and the Contract that covered the Participant 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**

1. When This Contract is secondary, it may reduce its benefits so that the total benefits paid or provided by all Contracts during a Contract year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Contract 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 Secondary 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 claim do not exceed the total Allowable Expenses for that claim. In addition, the Secondary Contract shall credit to its Contract deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

2. 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. Facility Of Payment**

A payment made under another Contract may include an amount that should have been paid under This Contract. If it does, BCI 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. BCI 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.

**E. Right Of Recovery**

If the amount of the payments made by BCI is more than it should have paid under this COB provision, it may recover the excess from one or more of the Participants it has paid or for whom it has paid; or any other Participant or organization that may be responsible for the benefits or services provided for the covered Participant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

## XIII. Benefits For Medicare Eligibles Who Are Covered Under This Plan

**A.** If the Group has twenty (20) or more employees, any Eligible Employee or spouse of an Eligible Employee who becomes or remains a Participant of the Group covered by this Plan after becoming eligible for Medicare (due to reaching age sixty-five (65)) is entitled to receive the benefits of this Plan as primary.

**B.** If the Group has one hundred (100) or more employees or the Group is an organization which includes an employer with one hundred (100) or more employees, any Eligible Employee, spouse of an Eligible Employee or dependent child of an Eligible Employee who becomes or remains a Participant of the Group covered by this Plan after becoming eligible for Medicare due to disability is entitled to receive the benefits of this Plan as primary.

**C.** A Participant eligible for Medicare based solely on end stage renal Disease is entitled to receive the benefits of this Plan as primary for eighteen (18) months only, beginning with the month of Medicare entitlement, if Medicare entitlement is effective before March 1, 1996. If Medicare entitlement is effective on or after March 1, 1996, the Participant is entitled to receive the benefits of this Plan as primary for thirty (30) months only, beginning with the month of Medicare entitlement.

D. The Group's retirees, if covered under this Plan, and Eligible Employees or spouses of Eligible Employees (if a Participant) who are not subject to paragraphs A., B. or C. of this provision and who are Medicare eligible, will receive the benefits of this Plan reduced by any benefits available under Medicare. This applies even if the Participant fails to enroll in Medicare or does not claim the benefits available under Medicare.

## XIV. Incorporated By Reference

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

## XV. Inquiry And Appeals Procedures

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

**A. Informal Inquiry**

For any initial questions concerning a claim, a Participant should call or write BCI's Customer Service Department. BCI's phone numbers and addresses are listed on the Explanation of Benefits (EOB) form and in the Contact Information section of this Plan.

**B. Formal Appeal**

A Participant who wishes to formally appeal a Pre-Service Claim decision by BCI, on behalf of the Plan Administrator, may do so through the following process:

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

2. 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 by a BCI Medical Director or physician designee. For non-urgent claim appeals, BCI will mail a written reply to the Participant within fifteen (15) days after receipt of the written appeal. Urgent claim appeals will be notified orally within seventy-two (72) hours. 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 taking into account the medical exigencies of each claim.

3. Furthermore, the Participant 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.

4. If the original, non-urgent claim decision is upheld upon reconsideration, the Participant may send an additional written appeal to the Appeals and Grievance Coordinator requesting further review. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within thirty (30) days of BCI's mailing of the initial reconsideration decision. A BCI Medical Director who is not subordinate to the Medical Director or physician designee who decided the initial appeal, will issue a final decision after consideration of all relevant information. A final decision on the appeal will be made within fifteen (15) days of its receipt.

**C. A Participant who wishes to formally appeal a Post-Service Claims decision by BCI, on behalf of the Plan Administrator, may do so through the following process:**

1. A written appeal must be sent to the Appeals and Grievance Coordinator within one hundred eighty (180) days after receipt of the notice of Adverse Benefit Determination. This written appeal should set forth the reasons why the Participant contends BCI's decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.

2. After receipt of the written 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 by a BCI Medical Director, or physician designee if the appeal requires medical judgment. BCI shall mail a written reply to the Participant within thirty (30) days after receipt of the written appeal. If the original decision is upheld, the reply will list the specific reasons for denial and the specific provisions on which the decision is based. Each appeal will be processed as quickly as possible.

3. Furthermore, the Participant 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.

4. If the original decision is upheld upon reconsideration, the Participant may send an additional written appeal to the Appeals and Grievance Coordinator 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. A BCI Medical Director who is not subordinate to the Medical Director or physician designee who decided the initial appeal, will issue a final decision after consideration of all relevant information, if the appeal requires medical judgment. A final decision on the appeal will be made within thirty (30) days of its receipt. If the appeal does not require medical judgment, a BCI Vice President who did not decide the initial appeal will issue the decision.

**D. External Review**

At BCI's discretion, on behalf of the Plan Administrator, an additional review is available for Adverse Benefit Determinations based upon medical issues including medical necessity and investigational treatment. A Participant must first exhaust both levels of the formal appeals process before submitting a request for External Review to the Appeals and Grievance Coordinator. A request for External Review must be sent within sixty (60) days of the date of Blue Cross of Idaho's second formal written appeal decision. External Review will be made by an impartial provider, associated with an independent review organization, who practices in the same or a similar specialty as the one involved in the review. The Independent Review Organization will issue a determination within sixty (60) days of receipt of the request for External Review.

Submission of an appeal for External Review is voluntary and does not affect a Participant's right to file a civil action under section 502(a) of the Employee Retirement Income Security Act (ERISA) following the exhaustion of the formal appeals process, except that the time to file such action shall be tolled while the External Review is pending.

## XVI. Reimbursement of Benefits Paid By Mistake

If BCI mistakenly makes payment for benefits on behalf of a Participating Employee or his or her Eligible Dependent(s) that the Participating Employee or his or her Eligible Dependent(s) is not entitled to under this Plan, the Participating Employee must reimburse the erroneous payment to BCI, on behalf of the Plan Administrator.

The reimbursement is due and payable as soon as BCI notifies the Participating Employee and requests reimbursement. BCI, on behalf of the Plan Administrator, may also recover such erroneous payment from any other person or Provider to whom the payments were made. If reimbursement is not made in a timely manner, BCI, on behalf of the Plan Administrator, may reduce benefits or reduce an allowance for benefits as a set-off toward reimbursement.

Even though BCI, on behalf of the Plan Administrator, may elect to continue to provide benefits after mistakenly paying benefits, BCI, on behalf of the Plan Administrator, may still enforce this provision. This provision is in addition to, not instead of, any other remedy BCI, on behalf of the Plan Administrator, may have at law or in equity.

## XVII. Subrogation and Reimbursement Rights Of Blue Cross Of Idaho

The benefits of this Plan will be available to a Participant 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 Services are provided or paid for by Blue Cross of Idaho, on behalf of the Plan Administrator under this Plan or any other Blue Cross of Idaho plan, agreement, certificate, contract or plan, Blue Cross of Idaho, on behalf of the Plan Administrator shall be subrogated and

succeed to the rights of the Participant or, in the event of the Participant's death, to the rights of his or her heirs, estate, and/or personal representative.

As a condition of receiving benefits for Covered Services in such an event, the Participant or his or her personal representative shall furnish Blue Cross of Idaho in writing with the names and addresses 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 Participant or his or her personal representative concerning the injury, harm or loss.

The Plan Administrator may at its option elect to enforce either or both of its rights of subrogation and reimbursement.

Subrogation is taking over the Participant's right to receive payments from other parties. The Participant or his or her legal representative will transfer to Blue Cross of Idaho, on behalf of the Plan Administrator 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 Participant. Thus, Blue Cross of Idaho, on behalf of the Plan Administrator may initiate litigation at its sole discretion, in the name of the Participant, against any third party or parties. Furthermore, the Participant shall fully cooperate with Blue Cross of Idaho in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm or loss and shall do nothing whatsoever to prejudice Blue Cross of Idaho's subrogation rights and efforts. Blue Cross of Idaho, on behalf of the Plan Administrator will be reimbursed in full for all benefits paid even if the Participant is not made whole or fully compensated by the recovery. Moreover, Blue Cross of Idaho and the Plan Administrator are not responsible for any attorney's fees or other expenses or costs incurred by the Participant without the prior written consent of Blue Cross of Idaho and, therefore, the "common fund" doctrine does not apply to any amounts recovered by any attorney the Participant hires regardless of whether amounts recovered are used to repay benefits paid by Blue Cross of Idaho, on behalf of the Plan Administrator, or otherwise.

Additionally, Blue Cross of Idaho, on behalf of the Plan Administrator may at its option elect to enforce its right of reimbursement from the Participant, or his or her legal representative, of any benefits paid from monies recovered as a result of the injury, harm or loss. The Participant shall fully cooperate with Blue Cross of Idaho, on behalf of the Plan Administrator in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm or loss and shall do nothing whatsoever to prejudice the Plans reimbursement rights and efforts.

The Participant shall pay Blue Cross of Idaho, on behalf of the Plan Administrator as the first priority, and Blue Cross of Idaho 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 Blue Cross of Idaho, on behalf of the Plan Administrator under this Plan, regardless of how the recovery is allocated (*i.e.*, pain and suffering) and whether the recovery makes the Participant whole. Thus, Blue Cross of Idaho will be reimbursed by the Participant, 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 Participant is not made whole or fully compensated by the recovery. Moreover, Blue Cross of Idaho and the Plan Administrator are not responsible for any attorney's fees or other expenses or costs incurred by the Participant without the prior written consent of Blue Cross of Idaho and, therefore, the "common fund" doctrine does not apply to any amounts recovered by any attorney the Participant hires regardless of whether amounts recovered are used to repay benefits paid by Blue Cross of Idaho, on behalf of the Plan Administrator, or otherwise.

To the extent that Blue Cross of Idaho, on behalf of the Plan Administrator provides or pays benefits for Covered Services, Blue Cross of Idaho's rights of subrogation and reimbursement extend to any

right the Participant has to recover from the Participant's insurer, or under the Participant's "Medical Payments" coverage or any "Uninsured Motorist," "Underinsured Motorist," or other similar coverage provisions, and workers' compensation benefits.

Blue Cross of Idaho, on behalf of the Plan Administrator shall have the right, at its option, to seek reimbursement from, or enforce its right of subrogation against, the Participant, the Participant'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 Participant including the Participant's attorney.

Blue Cross of Idaho's subrogation and reimbursement rights shall take priority over the Participant's rights both for expenses already incurred and paid by Blue Cross of Idaho, on behalf of the Plan Administrator for Covered Services, and for benefits to be provided or payments to be made by Blue Cross of Idaho, on behalf of the Plan Administrator in the future on account of the injury, harm or loss giving rise to Blue Cross of Idaho's subrogation and reimbursement rights. Further, the Plans subrogation and reimbursement rights for incurred expenses and/or future expenses yet to be incurred are primary and take precedence over the rights of the Participant, 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 Participant and the Plan Administrator.

Collections or recoveries made in excess of such incurred Plan expenses shall first be allocated to such future Plan expenses, and shall constitute a special Deductible applicable to such future benefits and services under this or any subsequent Plan. Thereafter, Blue Cross of Idaho, on behalf of the Plan Administrator shall have no obligation to make any further payment or provide any further benefits until the benefits equal to the special Deductible have been incurred, delivered, and paid by the Participant.

## XVIII. Individual Benefits Management

Individual Benefits Management allows BCI to provide alternative benefits in place of specified Covered Services when alternative benefits allow the Participant to achieve optimum health care in the most cost-effective way.

The decision to allow alternative benefits will be made by BCI on a case-by-case basis. BCI may allow alternative benefits in place of specified Covered Services when a Participant, or the Participant's legal guardian and his or her Physician concur in the request for and the advisability of alternative benefits. The Plan Administrator reserves the right to modify, limit, or cease providing alternative benefits at any time.

A determination to cover alternative benefits for a Participant shall not be deemed to waive, alter, or affect BCI's right to reject any other requests or recommendations for alternative benefits.

## XIX. Coverage And Benefits Determination

BCI is vested with authority and discretion to determine eligibility for coverage and whether a claim for benefits is covered under the terms of this Plan, based on all the terms and provisions set forth in this Plan, and also to determine the amount of benefits owed on claims which are covered.

## XX. Health Care Providers Outside the United States

The benefits available under this Plan are also available to Participants traveling or living outside the United States. Reimbursement for Covered Services will be made directly to the Participant. BCI will require the original claim along with an English translation. It is the Participant's responsibility to provide this information.

BCI will reimburse covered Prescription Drugs purchased outside the United States by Participants who live outside the United States where no suitable alternative exists. Reimbursement will also be

made in instances where Participants are traveling and new drug therapy is initiated for acute conditions or where emergency replacement of drugs originally prescribed and purchased in the United States is necessary. The reimbursable supply of drugs in travel situations will be limited to an amount necessary to assure continuation of therapy during the travel period and for a reasonable period thereafter.

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 Service under this Plan.