DENTAL BLUE CONNECT MASTER GROUP CONTRACT

AND

ENROLLEE CERTIFICATE

Managed Care

GROUP CONTRACT

FOR

Boise Municipal Health Care Trust

Group Number: 10031331

Contract Date: January 1, 2019

BLUE CROSS OF IDAHO HEALTH SERVICES, INC.

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

Blue Cross of Idaho:

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

If you need these services, contact Blue Cross of Idaho's Customer Service Department. Call 1-800-627-1188 (TTY: 1-800-377-1363), or call the customer service phone number on the back of your card.

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

Manager, Grievances and Appeals
3000 East Pine Avenue, Meridian, Idaho 83642
Telephone: (800) 274-4018 ext.3838, Fax: (208) 331-7493
Email: grievances&appeals@bcidaho.com
TTY: 1-800-377-1363

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

Complaint forms are available at ***http://www.hhs.gov/ocr/office/file/index.html. Reference: https://federalregister.gov/a/2016-11458***

Language Assistance
ATTENTION: If you speak Arabic, Chinese, French, German, Korean, Japanese, Persian (Farsi), Romanian, Russian, Serbo-Croatian, Spanish, Sudanic Fulfulde, Tagalog, Ukrainian, or Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-627-1188 (TTY: 1-800-377-1363).

Arabic
ملحوظة: إذ كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-627-1188 (رقم هاتف الصم والبكم:1-800-377-1363).

Chinese 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-627-1188 (TTY：1-800-377-1363)。

French ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS : 1-800-377-1363).

German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (TTY: 1-800-377-1363).

Japanese 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-627-1188 (TTY: 1-800-377-1363）まで、お電話にてご連絡ください。

Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-627-1188 (TTY: 1-800-377-1363)번으로 전화해 주십시오.

Persian-Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت اریگان برای شما
فرا مهم می باشد. با (TTY: 1-800-377-1363) 1-800-627-1188 تماس بگیرید.

Romanian ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 1-800-377-1363).

Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 1-800-377-1363).

Serbo-Croation OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-627-1188 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-377-1363).

Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 1-800-377-1363).

Sudanic Fulfulde MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-627-1188 (TTY: 1-800-377-1363).

Tagalog PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-627-1188 (TTY: 1-800-377-1363).

Ukrainian УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-627-1188 (телетайп: 1-800-377-1363).

ACCEPTANCE

Boise Municipal Health Care Trust, called the Group, hereby confirms that it has previously applied for and been furnished coverage by Blue Cross of Idaho Health Service, Inc., called Blue Cross of Idaho.

The Group acknowledges it has received sixty (60) days advance written notice of modification of the Contract as required by General Provision III.A. and that the attached Contract reflects the modification. The Group agrees to accept this Contract and signifies its acceptance by payment of its January 1, 2019 premium. The Group further agrees that this Contract shall supercede all previous contracts, certificates or agreements issued by Blue Cross of Idaho, but that the group enrollment agreement or master group application, whichever document was previously submitted by the Group, shall continue in force.

Blue Cross of Idaho agrees, in consideration of the group enrollment agreement or master group application and premium payments when due, and subject to all the terms of this Contract, to provide each Member of the Group the benefits of this Contract, beginning on January 1, 2019 and continuing on a month-to-month basis thereafter, unless modified or terminated as provided by this Contract.

BLUE CROSS OF IDAHO HEALTH SERVICE, INC.

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

Paul Zurlo
Sr. Vice President Consumer
& Commercial Insurance Markets

BLUE CROSS OF IDAHO CONTACT INFORMATION

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

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

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

DENTAL BENEFITS SECTION

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

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

I. List of Covered Dental Services and Copayments

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

II. Procedure for Obtaining Covered Dental Services

A. Contracting Providers

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

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

B. Noncontracting Providers with a Referral from a Contracting Provider

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

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

C. Noncontracting Providers for Emergency Treatment While Out of Area

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

D. Noncontracting Providers without a Referral from a Contracting Provider

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

III. Benefits for Covered Dental Services

A. Contracting Providers

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

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

B. Noncontracting Providers with a Referral from a Contracting Provider

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

C. Noncontracting Providers for Emergency Treatment While Out of Area

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

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

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

D. Noncontracting Providers without a Referral from a Contracting Provider

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

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

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

ELIGIBILITY AND ENROLLMENT SECTION

I. Probationary Period

The Group will determine if there are certain probationary periods that must be satisfied before a new Eligible Employee can qualify for coverage under this Contract. Please contact your manager of employee benefits for the probationary period applicable to you.

II. Eligibility and Enrollment

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

A. Eligible Employee

To qualify as an Eligible Employee under this Contract, a person must be and remain (i) a full-time employee of the Group who regularly works at least 20 hours per week and is paid on a regular, periodic basis through the Group's payroll system; (ii) an employee on an approved leave of absence who has been designated by the Group as eligible for coverage; (iii) an elected official; or (iv) a retiree of the Group who has been designated by the Group as eligible for coverage.

(see the Plan for additional Eligibility and Enrollment provisions)

B. Eligible Dependent

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

1. The Enrollee's spouse under a legally valid marriage provided said spouse is not an Eligible Employee of the Group and enrolled in any other healthcare plan offered by the Group.

2. The Enrollee's natural child, stepchild, legally adopted child, child placed with the Enrollee for adoption, or child for whom the Enrollee or the Enrollee's spouse has court-appointed guardianship or custody. The child must be:
   a) Under the age of twenty-six (26);
   b) A child under a QMCSO is also eligible.
   c) **Disabled Adult Child:** A disabled adult child may continue coverage beyond the normal age limit if the Dependent child meets the eligibility requirements explained here. The Contract will require initial and periodic proof of disability. You will have 31 days from the date of the request for proof of disability to provide this proof before the child is determined to be ineligible. To be eligible as a disabled adult child, the individual must **meet all of the following** eligibility requirements:
      1. is a Dependent Child (as defined above) of a covered employee;
      2. is **age 26 or older**;
      3. Medically certified as disabled due to mental handicap or physical handicap *and* financially dependent upon the Enrollee or the Enrollee's spouse for support, regardless of age;,
      4. **dependent chiefly relies on** the employee or spouse for support and maintenance;
      5. the **Disability existed prior to attainment of the age that causes a non-disabled dependent child's coverage to end under this Contract** (e.g. the child's 26th birthday);
      6. **was covered under this Contract on the day before their 26th birthday**; and

   A child whose coverage has terminated coverage under this Contract due to reaching the age limit, and then becomes disabled, is not eligible to re-enroll as a disabled Dependent child under this Contract.

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

III. Leave Of Absence

If the Group maintains regular monthly payments with the regular Group billing, an employer approved temporary leave of absence may continue for a maximum of three (3) months and then cease or as allowed/approved by the Group.

On its regular billing, the Group will notify BCI of the Enrollee's date of departure for the leave of absence, and shall continue its regular employee premium contribution for the Enrollee's coverage during the leave of absence.

IV. Group Employee Premium Contribution

The Group agrees to pay a specified percentage of the premium for each Eligible Employee, and a specified percentage of the premium for each Eligible Dependent, if applicable. The Enrollee must pay the balance, if any, of the required premium.

V. Miscellaneous Eligibility and Enrollment Provisions

A. The Group agrees to collect required Enrollee premium payments through payroll withholding and make the required premium payments to BCI on or before the first of each month.

B. Before the effective date of the change, the Group shall submit all eligibility changes for Enrollees and Eligible Dependents on BCI's usual forms. It is the Group's responsibility to verify that all Members are eligible for coverage as specified in this Contract. BCI shall have the right to audit the Group's employment, payroll, and eligibility records to ensure that all Members are eligible and properly enrolled and to ensure that the Group meets enrollment requirements.

C. This Contract is issued 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 Enrollees. This Contract is issued upon the express condition that the Group continues to make the employer premium contribution specified in the Application for Group Coverage and this Contract. BCI may terminate this Contract if the percentage of Eligible Employees as Enrollees or the percentage of the employer premium contribution drops below the required level.

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

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

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

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

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

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

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

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

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

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

F. Late Enrollee

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

G. Special Enrollment Periods

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

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

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

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

4. The individual first becomes eligible.

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

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

VI. Qualified Medical Child Support Order

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

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

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

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

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

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

3. The period to which such order applies.

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

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

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

DEFINITIONS SECTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Eligible Dependent—a person eligible for enrollment under an Enrollee's coverage. For the purposes of this Policy, the child of a Surrogate Mother will not be considered an Eligible Dependent of the Surrogate Mother or her spouse.

Eligible Employee—an employee of a Group, an elected official or a retiree of the Group who has been designated by the Group as eligible for coverage who is entitled to apply as an Enrollee.

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

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

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

Group—a sole proprietorship, partnership, association, corporation, or other entity that has applied for Group coverage and has agreed to comply with all the terms and requirements of this Contract.

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

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

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

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

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

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

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

1. The most appropriate supply or level of service, considering potential benefit and harm to the Member.
2. Proven to be effective in improving health outcomes;
    a. For new treatment, effectiveness is determined by peer reviewed scientific evidence;
    b. For existing treatment, effectiveness is determined first by peer reviewed scientific evidence, then by professional standards, then by expert opinion.
3. Not primarily for the convenience of the Member or Provider.
4. Cost Effective for this condition.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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.

Surrogate Mother—a woman who agrees to become pregnant and give birth to a child for another individual or couple (the "Intended Parents") in order to give the child to the Intended Parents whether or not the Surrogate Mother is the genetic mother of the child and whether or not the Surrogate Mother does so for compensation.

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

EXCLUSIONS AND LIMITATIONS SECTION

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

I. General Exclusions

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

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

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

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

1. For full dentures or partial dentures: on the date the final impression is taken.
2. For fixed bridges, crowns, inlays or onlays: on the date the teeth are first prepared.
3. For root canal therapy: on the later of the date the pulp chamber is opened or the date canals 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 Contract: on the date any bands or other appliances are first inserted.

D. Dental Implants, including attachment devices and their maintenance.

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

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

G. Services that are Investigational in nature.

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

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

J. General anesthesia, moderation sedation and deep sedation.

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

L. Maxillofacial prosthetic services.

M. Occlusal guards (nightguards).

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

O. Personalized restorations.

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

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

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

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

T. Replacement of sound restorations.

U. Services or supplies and related exams or consultations that are not within the prescribed treatment plan and/or are not recommended and approved by a Contracting Provider.

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

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

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

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

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

II. Limitations

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

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

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

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

E. Endodontic Treatment

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

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

G. Hospital Setting

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

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

F. Replacements

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

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

III. Extension of Benefits

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

A. Crowns or Bridges.

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

B. Removable Prosthetic Devices

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

C. Immediate Dentures

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

D. Root Canal Therapy

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

E. Extractions

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

GENERAL PROVISIONS SECTION

I. Entire Contract—Changes

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

II. Records of Member Eligibility and Changes in Member Eligibility

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

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

III. Termination or Modification of This Contract

A. Pursuant to the provisions of this Subsection III., the Group or BCI may unilaterally terminate this Contract. BCI may unilaterally modify the terms of this Contract, including but not limited to, benefits, Copayments, premiums, and other provisions. Unless specified otherwise in this Contract, such termination or modification may be accomplished by giving written notice to the other party at least forty (40) days in advance of the effective date of the termination or modification. Except for modifications resulting from statutory and/or regulatory changes affecting benefits, BCI may modify benefits only at the time of the Group's annual renewal of coverage.

However, this provision does not obligate BCI to provide benefits beyond the term of this Contract. The Group agrees that it will notify Members of any changes in benefits, Copayments, or premiums, at least forty (40) days prior to the effective date of such modifications. The Group's subsequent payment of premiums constitutes conclusive documentation that the Group and its Members have accepted and agreed to any such modification(s).

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

1. For the Group's nonpayment of the appropriate premiums when due. A payer financial institution's return of or refusal to honor a check or draft constitutes nonpayment of premiums.
2. For the Group's fraud or intentional misrepresentation of a material fact.
3. For the Group's failure to maintain the enrollment percentage specified in the Application for Group Coverage. BCI may randomly audit enrollment to insure compliance. Failure to provide information requested in the audit may also result in termination.
4. For the Group's failure to make the employer premium contribution specified in the Application for Group Coverage.
5. If the Group no longer qualifies as a Large Employer under this Contract or any applicable statutes, rules or regulations.
6. In the case where this Contract is available to the Group only through an association as defined in Idaho Code §41-2202, the membership of the Group in the association (on the basis of which the coverage of this Contract is provided) ceases but only if the coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any Member.

7. If BCI elects not to renew all of its Benefit Plans delivered or issued for delivery to Large Employers in the state of Idaho. In which case, BCI will provide notice to the Group and its Members of such nonrenewal at least one hundred eighty (180) days in advance of the date of nonrenewal.

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

IV. Termination or Modification of a Member's Coverage Under This Contract

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

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

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

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

E. If BCI discovers that a Member has made any misrepresentation, omission, or concealment of fact in obtaining coverage under this Contract which was or would have been material to BCI's acceptance of a risk, extension of coverage, provision of benefits or Covered Dental Services, or payment of any reimbursement benefit, BCI may take action against the Group, including but not limited to increasing the Group's premiums.

F. Prior to legal finalization of an adoption, the coverage provided in this Contract for a child placed for adoption with an Enrollee continues as it would for a naturally born child of the Enrollee until the first of the following events occurs:

1. The date the child is removed permanently from placement and the legal obligation terminates, or
2. The date the Enrollee rescinds, in writing, the agreement of adoption or the agreement assuming financial responsibility.

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

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

V. Benefits After Termination of Coverage

A. When this Contract remains in effect but a Member's coverage terminates for reasons other than those specified in General Provisions IV.E. benefits will be continued:

1. If the Member is eligible for and properly elects continuation coverage in accordance with the applicable provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any amendments thereto.
   Most employers who employ twenty (20) or more people on a typical business day are subject to COBRA. If the Group is subject to COBRA, a Member may be entitled to continuation coverage. Members should check with the Group for details.

VI. Transfer Privilege

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

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

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

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

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

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

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

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

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

VIII. Applicable Law

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

IX. Notice

Any notice required under this Contract must be in writing. BCI's notices to the Group will be sent to the Group's address as it appears on BCI's records, and mailing or delivery to the Group constitutes complete and conclusive notice to the Members. Notice given to BCI must be sent to BCI's address contained in the Group Application. The Group must give BCI immediate written notice of any change of address for the Group or any of its Members. BCI shall give the Group immediate written notice of any change in BCI's address. When BCI is required to give advice or notice, the depositing of such advice or notice with the U.S. Postal Service, regular mail, or the other delivery conclusively constitutes the giving of such advice or notice on the date of such mailing or delivery.

X. Benefits to Which Members are Entitled

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

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

XI. Release and Disclosure of Health Records and Other Information

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

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

XII. Exclusion of General Damages

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

XIII. Member/Provider Relationship

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

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

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

XIV. Participating Plan

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

XV. Coordination of This Contract's Benefits With Other Benefits

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

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

A. Definitions

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

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

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

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

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

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

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

   b) If a Member is covered by two (2) or more Contracts that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any

amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

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

d) If a Member is covered by one (1) Contract that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Contract that provides its benefits or services on the basis of negotiated fees, the Primary Contract's payment arrangement shall be the Allowable Expense for all Contracts. However, if the provider has contracted with the Secondary Contract to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Contract's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Contract to determine its benefits.

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

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

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

B. Order of Benefit Determination Rules

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a) can determine the order of benefits.

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

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

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

C. Effect On The Benefits Of This Contract

A. When This Contract is secondary, it may reduce its benefits so that the total benefits paid or provided by all contracts during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any Covered Dental Service, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Contract that is unpaid by the Primary Contract. The Contract may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Contract, the total benefits paid or provided by all contracts for the Covered Dental Service do not exceed the total Allowable Expenses for that Covered Dental Service. In addition, the Secondary Contract shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

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

D. Right to Receive and Release Needed Information

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

E. Facility of Payment

A payment made under another Contract may include an amount that should have been paid under This Contract. If it does, Willamette Dental Group may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Contract. Willamette Dental Group will not have to pay that amount again. The term "payment

made" includes providing benefits in the form of services, in which case "payment made" means the Reasonable Cash Value of the benefits provided in the form of services.

F. Right of Recovery

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

G. Coordination of Benefits Administration

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

XVI. Subrogation and Reimbursement Rights and Obligations

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

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

Willamette Dental Group may at its option elect to enforce either or both of its rights of subrogation and reimbursement.

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

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

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

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

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

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

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

XVII. Indemnity by the Group and Blue Cross of Idaho

The Group and BCI agree to defend, indemnify, and hold the other party harmless from and against any claim, demand, expense, loss, damage, cost, judgement, fee, or liability the other party may receive, incur, or sustain that is caused by or arises by reason of any misstatement, misrepresentation, oversight, error, omission, delay, or mistake in providing the other party or any Member notice or advice of any relevant fact, event, or matter pertinent to claims, benefits, or coverage under this Contract.

XVIII. Incorporated by Reference

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

XIX. Inquiry and Appeals Procedures

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

A. Informal Inquiry

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

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

B. Formal Appeal of Adverse Benefit Determination

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

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

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

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

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

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

XX. Plan Administrator—COBRA and ERISA

BCI is not the plan administrator for compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any amendments to it; nor is BCI the plan administrator for the Employee Retirement Income Security Act (ERISA) and any amendments to it. Except for services BCI has agreed to perform regarding COBRA, the Group is responsible for satisfaction of notice, disclosure, and other obligations if these laws are applicable to the Group.

XXI. Independent Blue Cross and Blue Shield Plans

The Group (on behalf of itself and its participants), hereby expressly acknowledges its understanding this Contract constitutes a contract solely between the Group and BCI, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, as association of independent

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

XXII. Statements

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

XXIII. Membership, Voting, Annual Meeting And Participation

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

XXIV. Replacement Coverage

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

XXV. Coverage and Benefits Determination

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

XXVI. Covered Dental Services Obtained Outside the United States

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

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

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

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

Paul Zurlo
Sr. Vice President Consumer & Commercial
Insurance Markets

Attachment A - List Of Covered Dental Services and Copayments

Reimbursement for Covered Dental Services by a Non-Contracting Provider

	Reimbursement Amount
Out of Area Emergency Care Reimbursement (For Dental Emergency services provided by a Noncontracting Provider)	Up to $100
Noncontracting Provider Reimbursement (For services by a Noncontracting Provider without a referral from a Contracting Provider. The Enrollee is responsible for all other charges and fees charged by the Noncontracting Provider, to the extent such amount exceeds $10.)	$10 per visit

Code	Procedure	In Network Copayment
	1. Office Visits	
	General Office Visit	$15
	Specialist Office Visit	$30
	Emergency Office Visit	$15
	2. Diagnostic and Preventative Services	
D0120	Periodic oral evaluation - established patient	$0
D0140	Limited oral evaluation - problem focused	$0
D0145	Oral evaluation for patient under 3 and counseling with primary caregiver	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0160	Detailed and extensive oral evaluation - problem focused, by report	$0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$0
D0210	Intraoral - complete series (including bitewings)	$0
D0220	Intraoral - periapical 1st film	$0
D0230	Intraoral - periapical film additional film	$0
D0240	Intraoral - occlusal film	$0
D0250	Extraoral - 1st film	$0
D0260	Extraoral - each additional film	$0
D0270	Bitewings - 1 film	$0
D0272	Bitewings - 2 films	$0
D0273	Bitewings - 3 films	$0
D0274	Bitewings - 4 films	$0
D0277	Vertical bitewings - 7 to 8 films	$0
D0330	Panoramic film	$0
D0340	Cephalometric film	$0
D0350	Oral/facial photographic images	$0
D0425	Caries susceptibility tests	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D1110	Prophylaxis - adult	$0
D1120	Prophylaxis - child	$0
D1203	Topical application of fluoride - child	$0
D1204	Topical application of fluoride - adult	$0
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	$0
D1310	Nutritional counseling for control of dental disease	$0
D1320	Tobacco counseling for control of dental disease and prevention of oral disease	$0
D1330	Oral hygiene instruction	$0
D1351	Sealant - per tooth	$0

3. Space Maintainers

D1510	Space maintainer - fixed - unilateral	$0
D1515	Space maintainer - fixed - bilateral	$0
D1520	Space maintainer - removable - unilateral	$0
D1525	Space maintainer - removable - bilateral	$0
D1550	Re-cementation of space maintainer	$0
D1555	Removal of fixed space maintainer	$0

4. Restorative Dentistry

D2140	Amalgam - 1 surface, primary or permanent	$0
D2150	Amalgam - 2 surfaces, primary or permanent	$0
D2160	Amalgam - 3 surfaces, primary or permanent	$0
D2161	Amalgam - 4 or more surfaces, primary or permanent	$0
D2330	Resin-based composite - 1 surface, anterior	$0
D2331	Resin-based composite - 2 surfaces, anterior	$0
D2332	Resin-based composite - 3 surfaces, anterior)	$0
D2335	Resin-based composite - 4 surfaces or involving incisal angle (anterior)	$0
D2390	Resin-based composite crown, anterior	$0
D2391	Resin-based composite - 1 surface, posterior primary	$0
D2391	Resin-based composite - 1 surface, posterior permanent	$0
D2392	Resin-based composite - 2 surfaces, posterior primary	$0
D2392	Resin-based composite - 2 surfaces, posterior permanent	$52
D2393	Resin-based composite - 3 surfaces, posterior primary	$0
D2393	Resin-based composite - 3 surfaces, posterior permanent	$52
D2394	Resin-based composite - 4 or more surfaces, posterior primary	$0
D2394	Resin-based composite - 4 or more surfaces posterior permanent	$52
D2510	Inlay - metallic - 1 surface	$200
D2520	Inlay - metallic - 2 surfaces	$200
D2530	Inlay - metallic - 3 or more surfaces	$200
D2542	Onlay - metallic - 2 surfaces	$200
D2543	Onlay - metallic - 3 surfaces	$200
D2544	Onlay - metallic - 4 or more surfaces	$200
D2610	Inlay - porcelain/ceramic - 1 surface	$200
D2620	Inlay - porcelain/ceramic - 2 surfaces	$200
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	$200
D2642	Onlay - porcelain/ceramic - 2 surfaces	$200
D2643	Onlay - porcelain/ceramic - 3 surfaces	$200
D2644	Onlay - porcelain - 4 or more surfaces	$200

5. Crowns

D2710	Crown - resin-based composite (indirect)	$200
D2740	Crown - porcelain/ceramic substrate	$200
D2750	Crown - porcelain fused to high noble metal	$200
D2782	Crown - ¾ noble metal	$200
D2792	Crown - full cast noble metal	$200
D2910	Recement inlay, onlay, or partial coverage restoration	$0
D2920	Recement crown	$0
D2930	Prefabricated stainless steel crown - primary tooth	$0
D2931	Prefabricated stainless steel crown - permanent tooth	$0
D2932	Prefabricated resin crown	$0
D2933	Prefabricated stainless steel crown with resin window	$0
D2940	Protective restoration	$0
D2950	Core buildup, including any pins	$0
D2951	Pin retention - per tooth, in addition to restoration	$0
D2954	Prefabricated post and core in addition to crown	$0

Code	Description	Copayment
D2955	Post removal (not in conjunction with endodontic therapy)	$0
D2957	Each additional prefabricated post - same tooth	$0
D2970	Temporary crown (fractured tooth)	$0
D2980	Crown repair, by report	$0

6. Endodontics

Code	Description	Copayment
D3110	Pulp cap - direct (excluding final restoration)	$0
D3120	Pulp cap - indirect (excluding final restoration)	$0
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$0
D3221	Pulpal debridement, primary and permanent teeth	$0
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$0
D3240	Pulpal therapy (resorbable filling) - posterior, primary (excluding final restoration)	$0
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$75
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	$125
D3330	Endodontic therapy, molar (excluding final restoration	$175
D3331	Treatment of root canal obstruction; non-surgical access	$0
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$0
D3333	Internal root repair of perforation defects	$0
D3346	Retreatment of previous root canal therapy - anterior	$75
D3347	Retreatment of previous root canal therapy - bicuspid	$125
D3348	Retreatment of previous root canal therapy - molar	$175
D3351	Apexification/recalcification/pulpal regeneration - initial visit	$175
D3352	Apexification/recalcification/pulpal regeneration - interim medication replacement	$0
D3353	Apexification recalcification/pulpal regeneration - final visit	$0
D3410	Apicoectomy/periradicular surgery - anterior	$75
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$125
D3425	Apicoectomy/periradicular surgery - molar (first root)	$175
D3426	Apicoectomy/periradicular surgery - each additional root	$0
D3430	Retrograde filling - per root	$0
D3450	Root amputation - per root	$175
D3920	Hemisection (including any root removal), not including root canal therapy	$175
D3950	Canal preparation and fitting of preformed dowel or post	$0

7. Periodontics

Code	Description	Copayment
D4210	Gingivectomy or gingivoplasty - 4 or more contiguous teeth or tooth bounded spaces per quadrant	$150
D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	$50
D4240	Gingival flap procedure, including root planing - 4 or more contiguous teeth or tooth bounded spaces per quadrant	$150
D4241	Gingival flap procedure, including root planing - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	$150
D4249	Clinical crown lengthening - hard tissue	$150
D4260	Osseous surgery (including flap entry and closure) - 4 or more contiguous teeth or tooth bounded spaces per quadrant	$150
D4261	Osseous surgery (including flap entry and closure) - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	$150
D4263	Bone replacement graft - first site in quadrant	$0
D4264	Bone graft - each additional site in quadrant	$0
D4270	Pedicle soft tissue graft procedure	$150
D4271	Free soft tissue graft procedure (including donor site surgery)	$150
D4273	Subepithelial connective tissue graft procedures, per tooth	$150
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$150
D4341	Periodontic scaling and root planing - 4 or more teeth per quadrant	$50

Code	Description	Copayment
D4342	Periodontic scaling and root planing - 1 to 3 teeth per quadrant	$50
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$0
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	$0
D4910	Periodontic maintenance	$0

8. Prosthodontics - Removable

Code	Description	Copayment
D5110	Complete denture- maxillary	$250
D5120	Complete denture - mandibular	$250
D5130	Immediate denture - maxillary	$250
D5140	Immediate denture - mandibular	$250
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$250
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$250
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$250
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$250
D5281	Removable unilateral partial denture - 1 piece cast metal (including clasps and teeth)	$250
D5410	Adjust complete denture - maxillary	$0
D5411	Adjust complete denture - mandibular	$0
D5421	Adjust partial denture - maxillary	$0
D5422	Adjust partial denture - mandibular	$0
D5510	Repair broken complete denture base	$0
D5520	Replace missing or broken teeth - complete denture (each tooth)	$0
D5610	Repair resin denture base	$0
D5620	Repair cast framework	$0
D5630	Repair or replace partial clasp	$0
D5640	Replace broken teeth - per tooth	$0
D5650	Add tooth to existing partial denture	$0
D5660	Add clasp to existing partial denture	$0
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$0
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$0
D5710	Rebase complete maxillary denture	$0
D5711	Rebase complete mandibular denture	$0
D5720	Rebase maxillary partial denture	$0
D5721	Rebase mandibular partial denture	$0
D5730	Reline complete maxillary denture (chairside)	$0
D5731	Reline complete mandibular denture (chairside)	$0
D5740	Reline maxillary partial denture (chairside)	$0
D5741	Reline mandibular partial denture (chairside)	$0
D5750	Reline complete maxillary denture (laboratory)	$0
D5751	Reline complete mandibular denture (laboratory)	$0
D5760	Reline maxillary partial denture (laboratory)	$0
D5761	Reline mandibular partial denture (laboratory)	$0
D5810	Interim complete denture (maxillary)	$125
D5811	Interim complete denture (mandibular)	$125
D5820	Interim partial denture (maxillary)	$125
D5821	Interim partial denture (mandibular)	$125
D5850	Tissue conditioning, maxillary	$0
D5851	Tissue conditioning, mandibular	$0
D5860	Overdenture - complete, by report	$250
D5861	Overdenture - partial, by report	$250
D5986	Fluoride gel carrier	$0

9. Prosthodontics - Fixed

Code	Description	Copayment
D6210	Pontic - cast high noble metal	$200

Code	Description	Copayment
D6240	Pontic - porcelain fused to high noble metal	$200
D6241	Pontic - porcelain fused to predominately base metal	$200
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$200
D6720	Crown - resin with high noble metal	$200
D6750	Crown - porcelain fused to high noble metal	$200
D6780	Crown - ¾ cast high noble metal	$200
D6790	Crown - full cast high noble metal	$200
D6930	Recement fixed partial denture	$0
D6972	Prefabricated post and core in addition to fixed partial denture retainer	$0
D6973	Core build up for retainer, including any pins	$0
D6975	Coping - metal	$0
D6980	Fixed partial denture repair, by report	$0

10. Oral Surgery

Code	Description	Copayment
D7111	Extraction, coronal remnants - deciduous tooth	$0
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$0
D7210	Surgical extraction of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$75
D7220	Removal of impacted tooth - soft tissue	$75
D7230	Removal of impacted tooth - partial bony	$75
D7240	Removal of impacted tooth - completely bony	$75
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$75
D7250	Surgical removal residual roots (cutting procedure)	$75
D7260	Oroantral fistula closure	$75
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$75
D7280	Surgical access of an unerupted tooth	$75
D7283	Placement of device to facilitate eruption of impacted tooth	$75
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$75
D7310	Alveoloplasty in conjunction with extractions - 4 or more tooth spaces, per quadrant	$0
D7311	Alveoloplasty in conjunction with extractions - 1 to 3 tooth spaces, per quadrant	$0
D7320	Alveoloplasty not in conjunction with extractions - 4 or more tooth spaces, per quadrant	$0
D7321	Alveoloplasty not in conjunction with extractions - 1 to 3 tooth spaces, per quadrant	$0
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	$75
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$75
D7471	Removal of lateral exostosis (maxilla or mandible)	$75
D7510	Incision and drainage of abscess - intraoral soft tissue	$0
D7520	Incision and drainage of abscess - extraoral soft tissue	$0
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$0
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$0
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$0
D7670	Alveolus - closed reduction, may include stabilization of teeth	$0
D7910	Suture of recent small wounds up to 5 cm	$0
D7911	Complicated suture - up to 5 cm	$0
D7953	Bone replacement graft for ridge preservation - per site	$75
D7960	Frenulectomy - also known as frenectomy or frenotomy – separate procedure not incidental to another	$75
D7970	Excision of hyperplastic tissue - per arch	$75
D7971	Excision of pericoronal gingiva	$75

11. Anesthesia

Code	Description	Copayment
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$40

12. Miscellaneous

Code	Description	Copayment
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$0
D9120	Fixed partial denture sectioning	$0

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

ATTACHMENT B–Orthodontia Treatment

I. General Provisions

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

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

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

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

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

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

II. Pre-Orthodontia Treatment Copayment

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

III. Orthodontia Treatment Copayment

A.	Comprehensive Orthodontia Treatment Copayment	$1,800

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

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