2025 Benefit Summary and Dental Program Document

J.R. Simplot Company
Group Health and Welfare Plan
Dental Program

Contract Administrator: Blue Cross of Idaho Health Service, Inc.

PPO Dental

Effective Date: January 1, 2025

Benefit Period: January 1 through December 31

SIMPLOT DENTAL PROGRAM BENEFITS OUTLINE AND PROGRAM DOCUMENT

IMPORTANT INFORMATION ABOUT THIS OUTLINE

This booklet is a description of the benefits covered by the J.R. Simplot Company Group Health and Welfare Plan Dental Program and serves as the Dental Program Document. This Document, together with the J.R. Simplot Company Group Health and Welfare Plan Summary Plan Description Booklet (SPD), constitute the summary plan description for the Dental Program. Together, they describe in detail the rights and obligations of both the Participant and the Plan. It is important that you read the SPD and this Dental Program Document carefully. If you receive this document electronically, you may request a paper copy at any time at no additional charge by contacting the Contract Administrator's (Blue Cross of Idaho) Customer Service.

Throughout this Document references to Blue Cross of Idaho (BCI) are referring to the Contract Administrator. For Covered Services under the terms of the Dental Program, Maximum Allowance is the amount established as the highest level of compensation for a Covered Service. There is more detailed information on how Maximum Allowance is determined and how it affects out-of-state coverage in the Definitions Section.

To locate an In-Network Provider in your area, please visit the Contract Administrator's Website at www.bcidaho.com. You may also call the Customer Service Department at 208-286-3813 or 855-216-6850 for assistance in locating a Provider.

ELIGIBILITY AND ENROLLMENT
Please refer to the J.R. Simplot Company Group Health and Welfare Plan's Summary Plan Description Booklet for information regarding Eligibility and Enrollment.

DISCRIMINATION IS AGAINST THE LAW

Blue Cross of Idaho and Blue Cross of Idaho Care Plus, Inc., (collectively referred to as Blue Cross of Idaho) complies with applicable Federal civil rights laws and does not discriminate, exclude or treat less favorably on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)).

Blue Cross of Idaho:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Blue Cross of Idaho Civil Rights Coordinator at 1-800-627-1188 (TTY: 711).

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 at:

Civil Rights Coordinator
3000 E. Pine Ave., Meridian, ID 83642
Telephone: 1-800-274-4018
Fax: 208-331-7493
Email: ***grievancesandappeals@bcidaho.com***
TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator 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 (TDD). Complaint forms are available at ***http://www.hhs.gov/ocr/office/file/index.html .***

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

Arabic انتبه: إذا كنت تتحدث اللغة العربية ، فإن خدمات المساعدة اللغوية متاحة لك مجانًا اتصل على 1188-627-800-1 (للصم والبكم: 711).

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

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

Farsi توجه: اگر به زبان فارسی صحبت می کنید، خدمات رایگان پشتیبانی زبان، در دسترس شما است. شماره تماس 1188-627-800-1 (711:TTY).

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

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

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

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

Nepali: ध्यान दनिुहोस्: तपार्इंले नेपाली बोलनुहुनछ भने तपार्इंको नमिति भाषा सहायता सेवाहरू नःिशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-627-1188 (टटिविइ: 711) ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 711).

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

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

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

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: 711.

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

Form No. 3-1187 (05-24)

PREFERRED DENTAL PLAN BENEFITS (PPO)		
For Covered Providers and Services:	**In-Network**	**Out-of-Network**
Benefit Limit *(Excludes orthodontic services)*	$2,000 per Participant, per Benefit Period	
Orthodontic Lifetime Limit	$2,000 per Participant	
Deductible: Individual	Participant pays $50 per Benefit Period (Deductible does not apply to Preventive Dental Covered Services or Orthodontic Services)	
PREFERRED DENTAL PLAN BENEFITS (PPO)	**In-Network**	**Out-of-Network**
Preventive Dental Services	Plan pays 100% of Maximum Allowance	
Basic Dental Services	Plan pays 80% of Maximum Allowance after Deductible	
Major Dental Services	Plan pays 50% of Maximum Allowance after Deductible	
Orthodontic Services (for Eligible Dependent children and enrolled adults) Twelve (12) month Waiting Period for Orthodontic Services, except dependents covered under the dental benefit portion of the Pinnacle Agriculture Distribution, Inc. Health and Welfare Plan immediately prior to becoming eligible for the Simplot Plan.	Plan pays 50% of Maximum Allowance	

J.R. SIMPLOT COMPANY GROUP HEALTH AND WELFARE PLAN
DENTAL PROGRAM DOCUMENT

Blue Cross of Idaho has been hired as the Contract Administrator by the Plan Administrator to perform claims processing and other specified administrative services in relation to the Plan. Blue Cross of Idaho is a trade name for Blue Cross of Idaho Health Service, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

TABLE OF CONTENTS

HOW TO SUBMIT CLAIMS

A Participant must submit a claim to the Dental Program's Contract Administrator in order to receive benefits for Covered Services. There are two ways for a Participant to submit a claim:

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

2. The Participant can send the Contract Administrator the claim.

To File a Participant's Own Claims
If a Dentist or other Covered Provider prefers that a Participant file the claim, here is the procedure to follow:

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

2. Obtain a Member Claim Form from the Contract Administrator's Website, www.bcidaho.com, from the Covered Provider or any of the Contract Administrator's offices, and follow the instructions. Use a separate billing and Member Claim Form for each patient involved.

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

   Blue Cross of Idaho Claims Control
   Blue Cross of Idaho
   PO Box 7408
   Boise, ID 83707

For assistance with claims or health information, please call the Contract Administrator Customer Service at 208-286-3813 or 855-216-6850.

How the Participant is Notified
The Contract Administrator, on behalf of the Plan Administrator, makes its claim payment decisions based on the information it has when a claim is received. The Contract Administrator makes every effort to process claims as quickly as possible. The Contract Administrator will send a Participant an Explanation of Benefits (EOB) by mail or electronically, if the Participant has consented to electronic delivery, once the claim is processed. The Explanation of Benefits will show all of the payments the Contract Administrator made on behalf of the Plan and to whom the Contract Administrator sent the payment. It will also explain any charges the Contract Administrator did not pay in full. See the Inquiry and Appeals Procedures section for information on how to appeal charges the Contract Administrator did not pay in full. If a Participant would like a paper copy of their EOB, they may request one from the Contract Administrator's Customer Service.

CONTACT INFORMATION FOR THE CONTRACT ADMINISTRATOR

For assistance with claims or benefit information, please contact your local Contract Administrator's Customer Service.

Phone:	855-216-6850 or 208-286-3813
Mail:	Blue Cross of Idaho PO Box 7408 Boise, ID 83707
Physical address:	Blue Cross of Idaho 3000 East Pine Avenue Meridian, ID 83642
Online:	www.bcidaho.com

DEFINITIONS SECTION

For reference, most terms defined in this section are capitalized throughout this Dental Program Document ("Document"). Other terms may be defined where they appear in this Document. All Providers and Facilities must be licensed, certified, accredited and/or registered, where required, to render Covered Services. For the purposes of this Document, Providers include any facility or individual who provides a Covered Service while operating within the scope of their license, certification, accreditation and/or registration under applicable state law, unless exempted by federal law. Definitions in this Document 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 Participant's foresight or expectation, which requires medical attention at the time of the accident. Contact with an external object must be unexpected and unintentional, or the results of force must be unexpected and sudden. The force may be the result of the injured party's actions, but must not be intentionally self-inflicted. Accidental injuries caused by a medical condition or domestic violence are not subject to exclusion under this Program.

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

Benefit Period—the specified period of time during which a Participant's benefits for Covered Services accumulate toward annual benefit limits, Deductible amounts and out-of-pocket limits. The Benefit Period for the Dental Program is a calendar year from January 1 through December 31.

Benefits Outline—a listing of certain Covered Services specifying Cost Sharing, Copayments, Deductibles, and benefit limitations and maximums under the Dental Program.

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

Contract Administrator—BCI has been hired as the Contract Administrator by the Plan Administrator to perform claims processing and other specified administrative services in relation to the Dental Program. The Contract Administrator is not an insurer of health benefits under the Plan, is not a fiduciary of the Plan, and does not exercise any of the discretionary authority and responsibility granted to the Plan Administrator. The Contract Administrator is not responsible for Plan financing and does not guarantee the availability of Plan benefits.

Contracting Provider—a Dentist who has entered into a written agreement with the Contract Administrator regarding payment for Dental Covered Services rendered to a Participant under a PPO Dental Option. This is not the same as an In-Network Provider.

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

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

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

Cost Sharing—the percentage of the Maximum Allowance or the actual charge, whichever is less, a Participant pays out-of-pocket for Covered Services after satisfaction of any applicable Deductibles.

Covered Provider—a Provider licensed to perform Covered Services specified in this Document from whom a Participant must receive Covered Services in order to be eligible to receive benefits.

Covered Services—services listed in the Closed List of Dental Covered Services.

Deductible—the amount a Participant pays Out-of-Pocket before the Dental Program begins to pay benefits for Covered Services. The amount credited to the Deductible is based on the Maximum Allowance or the actual charge, whichever is less.

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

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

Dental Program—the self-funded program of the J.R. Simplot Group Health and Welfare Plan that provides dental benefits for eligible Participants on the terms and conditions set forth in this Dental Program Document and in the Plan's Summary Plan Description booklet.

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

1. Itemizes dental procedures by American Dental Association (ADA) code and description for the care of a Participant.
2. Lists the charges for each procedure.
3. Is accompanied by supporting most current preoperative x-rays and any other appropriate diagnostic materials reasonably required by the Contract Administrator to help make a benefit decision.

Dentist—an individual licensed to practice Dentistry.

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

Denturist—a person licensed in the state where service is rendered to engage in the practice of denturism. For the Dental Program to provide benefits, the Denturist must be performing within the scope of their license.

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

Effective Date—the date when coverage for a Participant begins under the Dental Program.

Eligible Dependent—a person eligible for enrollment under an Enrollee's coverage as specified in the Plan's Summary Plan Description booklet.

Eligible Employee—an employee who is entitled to become an Enrollee.

Employer—J.R. Simplot Company.

Enrollee—an Eligible Employee who has satisfied the eligibility requirements of the Plan as described in the Plan's Summary Plan Description booklet and who has properly enrolled in the Dental Program through a process determined by the J.R. Simplot Company.

Explanation of Benefits (EOB)—a statement sent to the Participant explaining what medical and/or dental treatments and/or services were paid for by the Dental Program.

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

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

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

In-Network Provider—A Contracting Provider or a Non-Contracting Provider who is contracted under the Contract Administrator affiliate program.

In-Network Services—Covered Services provided by an In-Network Provider.

Inpatient—a Participant who is admitted as a bed patient in a licensed general hospital or other facility provider and for whom a room and board charge is made.

Investigational—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.

Maximum Allowance— For Covered Services under the terms of this Document, Maximum Allowance is the lesser of the billed charge or the amount established by the Contract Administrator, in its sole discretion, as the highest level of compensation for a Covered Service, which may differ for Contracting and Noncontracting Dentists. If the Covered Services are rendered outside the state of Idaho by a Noncontracting or Contracting Dentist with a Blue Cross and/or Blue Shield affiliate in the location of the Covered Services, the Maximum Allowance is the lesser of the billed charge or the amount established by the affiliate in its sole discretion as compensation, as communicated by the affiliate to the Contract Administrator.

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

Medically Necessary (or Medical Necessity)—the Covered Service or supply recommended by the treating Covered Provider to identify or treat a Participant's condition, Disease, Illness or Accidental Injury and which is determined by the Contract Administrator, on behalf of the Plan Administrator to be:

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

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

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

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

Noncontracting Provider—a Dentist who has not entered into a written agreement with the Contract Administrator regarding payment for Dental Covered Services rendered to a Participant under a PPO Dental Option.

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) and improve function.

Out-of-Network Provider—a Provider who meets both of the following criteria:

- A Noncontracting Provider, and
- A Provider who does not participate in the Contract Administrator affiliate program.

Out-of-Network Services—Covered Services that are rendered by an Out-of-Network Provider.

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

Participant—an Enrollee or an enrolled Eligible Dependent covered under the Dental Program.

Physician—a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) licensed to practice medicine by the state where services are rendered.

Plan—J.R. Simplot Group Health and Welfare Plan.

Plan Administrator—the Plan Administrator, J.R. Simplot Company, the sole fiduciary of the Plan, has all discretionary authority to interpret the provisions and control the operation and administration of the Plan within the limits of the law.

Plan Sponsor—J.R. Simplot Company.

Post-Service Claim—any claim for a benefit that does not require prior authorization before services are rendered.

PPO Dental Option—a Preferred Provider Organization (PPO) Dental Option in which a Participant receives the highest level of benefits for In-Network Services.

Predetermination of Benefits—a proposed Dental Treatment Plan and anticipated benefits for the Participant should the proposed Dental Treatment Plan be completed.

Pre-Service Claim—any claim for a benefit that requires prior authorization before services are rendered.

Provider—a Dentist, Dental Hygienist or Denturist who provides services and is acting within the scope of their license.

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.

Waiting Period—a specified period of enrollment that must be completed before benefits are available for certain Covered Services.

DENTAL PLAN BENEFITS SECTION
PREFERRED DENTAL PLAN *(PPO Option)*

This section specifies the benefits a Participant is entitled to receive for the Dental Covered Services described, or conditions that must be satisfied to qualify for benefits, subject to other provisions of the Dental Program.

I. Benefit Period and Benefit Limits

The Benefit Period and the Benefit limits are shown in the Benefits Outline. Please see the cover page of the Dental Program for the Benefit Period.

II. Covered Providers

The following are Covered Providers under this section:

- Dentist
- Denturist
- Dental Hygienist

III. Deductibles

The Benefits Outline will show applicable individual and family Deductibles.

IV. Predetermination of Benefits

A recommended Dental Treatment Plan should be submitted to the Contract Administrator for a Predetermination of Benefits before treatment begins if the Dental Treatment Plan includes one (1) or more of the following procedures:

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

The Dental Treatment Plan must be accompanied by supporting the most current preoperative x-rays and any other appropriate diagnostic materials requested by the Contract Administrator or the Dental Consultant(s) to help make a benefit decision.

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

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

A Predetermination of Benefits is valid for six (6) months from the date it is issued, as long as the Participant remains covered by the Dental Program and that six (6) months is within the same Benefit Period. After six (6) months, or when a new Benefit Period begins, if earlier, a Dental Treatment Plan must be resubmitted for a new Predetermination of Benefits before treatment begins. A Predetermination of Benefits will be processed without taking into consideration dental benefits that may be paid under another benefit program or certificate of insurance. A Predetermination of Benefits is not a guarantee of payment and payment of benefits will be subject to the terms and conditions of the Dental Program.

V. Amount of Payment

Except as stated elsewhere in this document, the Dental Program will pay benefits for Preventive, Basic, and Major Dental Covered Services after a Participant has satisfied their Deductible, if applicable. The reimbursement schedule is shown in the Benefits Outline.

Benefits for Orthodontic Services are paid as follows:

1. The Dental Program will pay benefits on the patient's initial banding.
2. Thereafter, the Dental Program will pay benefits up to the Orthodontic Lifetime Benefit Limit as Covered Services are performed so long as the Participant continues orthodontic treatment and remains covered under the Dental Program.

A. Dental Services Outside Idaho

For Dental Covered Services furnished by a Covered Provider outside the state of Idaho, the Contract Administrator, on behalf of the Plan Administrator, will provide benefit payments according to the following:

1. If the Covered Provider has a PPO or Traditional agreement for claims payment with the Blue Cross and/or Blue Shield plan or an affiliate in the area where the Covered Services were rendered, the Contract Administrator will base the payment on the local plan's payment arrangement and allow In-Network benefits. However, a Covered Provider may not be obligated to accept the Plan's payment as payment in full for services provided after the Participant has reached any Benefit Period limit or lifetime maximum limit or has exceeded a frequency limitation. In this instance, Participants are responsible for payment of the full amount charged by the Covered Provider.
2. If the Covered Provider does not have a PPO or Traditional agreement for claims payment with the Blue Cross and/or Blue Shield plan or an affiliate in the area where the Covered Services are rendered, the Contract Administrator will base the payment on the Maximum Allowance and allow Out-of-Network benefits. The Covered Provider is not obligated to accept the Maximum Allowance as payment in full. The Contract Administrator, or the Plan Administrator is not responsible for the difference, if any, between the Dental Program's payment and the actual charge, unless otherwise specified. Participants are responsible for any such difference, including Deductibles, Cost Sharing, Copayments, charges for noncovered services, and the amount charged by the Covered Provider that exceeds the Maximum Allowance.

B. Dental Services from an In-Network Provider

An In-Network Provider rendering Covered Services as provided in this section shall not make an additional charge to a Participant for amounts in excess of the Maximum Allowance except for Deductible, Cost Sharing, and charges for noncovered services, if any. However, an In-Network Dentist in Idaho, is not obligated to accept the Contract Administrator's Maximum Allowance for services provided after the Participant has reached any Benefit Period limit or lifetime maximum limit or has exceeded a frequency limitation. In this instance, Participants are responsible for payment of the full amount charged by the In-Network Dentist.

C. Dental Services from an Out-of-Network Provider

An Out-of-Network Provider is not obligated to accept the Maximum Allowance as payment in full. The Contract Administrator or the Plan Administrator is not responsible for the difference, if any, between the Dental Program's payment and the actual charge, unless otherwise specified. Participants are responsible for any such difference, including Deductibles, Cost Sharing, Copayments, charges for noncovered services, and the amount charged by the Out-of-Network Provider in excess of the Maximum Allowance.

VI. Closed List of Dental Covered Services

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

Refer to Benefits Outline for applicable Waiting Periods.

A. Type I: Preventive Dental Services

1. Oral examination—limited to two (2) per Benefit Period.
2. Emergency oral examination—limited to one (1) per Benefit Period, covered for trauma, acute infection, or acute pain.
3. Complete mouth series or panoramic x-ray—limited to one (1) time in any five (5) consecutive Benefit Period, unless requested by the Contract Administrator for verification of treatment claimed.

4. Individual periapical x-rays—limited to the same benefit as a complete mouth series or panoramic x-ray. Individual periapical x-rays are not covered when performed during or at the completion of a root canal therapy as an intra-operative procedure.
5. Occlusal l x-rays—limited to once per Benefit Period.
6. Extraoral x-rays – limited to once per Benefit Period.
7. Bitewing x-rays—limited to once per Benefit Period. Limited to the same benefit as a complete mouth series or panoramic x-ray.
8. Dental prophylaxis—limited to two (2) per Benefit Period.
9. Fluoride treatments—limited to two (2) applications per Benefit Period and limited to Participants who are under age nineteen (19).
10. Palliative treatment—paid as a separate benefit only if no other treatment is rendered during the visit.
11. Topical application of sealants per tooth—limited to permanent posterior first (1^{st}) and second (2^{nd}) molars unrestored of Participants under age nineteen (19). Also limited to one (1) time per tooth in any three (3) years.

B. Type II: Basic Dental Services

1. Amalgam restorations—posterior restorations involving multiple surfaces will be combined for benefit purposes and paid according to the number of unique surfaces treated. Same tooth surface restoration is covered once in a two (2) year period.
2. Pin retention.
3. Resin-Composite restorations—posterior restorations involving multiple surfaces will be combined for benefit purposes and paid according to the number of unique surfaces treated. Same tooth surface restoration is covered once in a two (2) year period.
4. Simple extractions.
5. Surgical removal of an erupted or partially erupted tooth or mucoperiosteal flap or incision of soft tissue.
6. Alveoloplasty and alveolectomy—not separately payable if performed on the same date as an extraction.
7. General anesthesia.
8. I.V. sedation.
9. Pulp cap (direct or indirect).
10. Pulpotomy.
11. Root canal therapy—multiple endodontic treatments, on the same tooth within a period of one (1) year, are subject to review and approval by the Contract Administrator.
12. Scaling and root planing—limited to once per area of the mouth, every two (2) years.
13. Periodontal maintenance—limited to four (4) per Benefit Period. Requires prior periodontal treatment.
14. Gingivectomy—one (1) such surgical procedure per area, once every three (3) years.
15. Osseous Surgery—one (1) such surgical procedure per area, once every three (3) years.
16. Osseous grafts—only autogenous grafts are covered every three (3) years per area. Synthetic grafting techniques are not covered.
17. Pedicle grafts—once every three (3) years per area.
18. Free soft tissue grafts—once every three (3) years per area.
19. Occlusal guard—covered for erosion or abrasion for one (1) appliance every two (2) years.
20. Space maintainers—limited to Participants who are under age sixteen (16). Benefits limited to deciduous teeth. Includes all adjustments made within six (6) months of installation.
21. Full Mouth Debridement—limited to one time in a three (3) year period.
22. Sedative Fillings.
23. Localized delivery of chemotherapeutic/antimicrobial agents—up to a maximum of four (4) teeth at once per visit. Not allowed on the initial scaling and root planing visit.

C. Type III: Major Dental Services

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

1. Synthetic bone grafting procedures.
2. Periodontal splinting procedures.
3. Recement inlays; recement crowns; recement bridges.
4 Crown build-up—cover to support and retain a crown.

5. Tissue conditioning—limited to repairs or adjustments performed more than twelve (12) months after the initial insertion of prosthesis.
6. Repairs to full dentures, repairs to partial dentures, and/or repairs to bridges—limited to repairs performed more than twelve (12) months after the initial insertion of prosthesis.
7. Repairs to crowns.
8. Inlays and onlays—covered only when the teeth cannot be restored by a filling, and only if more than seven (7) years have elapsed since the last placement. If a tooth can be restored with a filling, the benefit will be limited to the allowable benefit for an amalgam or composite restoration.
9. Crowns and laminate veneers—covered only when the tooth has visible destruction of tooth surface from decay and the tooth cannot be restored by a filling. Benefits will not be allowed when placement of the crown or veneer is for micro fractures, stress fractures, or craze lines. Coverage is available if more than one-third (1/3) of the tooth is missing due to accident or erosion. Coverage is allowed if more than seven (7) years have elapsed since the last placement. For Participants under age sixteen (16), benefits are limited to plastic/resin-based or stainless steel crowns.
10. Stainless steel crowns—covered only when the tooth has visible destruction of tooth surface from decay and the tooth cannot be restored by a filling. Benefits will not be allowed when placement of the crown or veneer is for micro fractures, stress fractures, or craze lines. Coverage is available if more than one-third (1/3) of the tooth is missing due to accident. Coverage is allowed if more than seven (7) years have elapsed since the last placement.
11. Post and core.
12. Full dentures—includes all adjustments within six (6) months of installation. Replacement of a denture is covered only if the existing denture is more than seven (7) years old and cannot be repaired. There are no additional benefits for overdentures or customized dentures.
13. Partial dentures—includes all clasps and rests, all teeth, and all adjustments within six (6) months of installation. Replacement of a partial denture with another denture is eligible for benefits only if the existing denture is more than seven (7) years old and cannot be repaired.
14. Denture adjustments—one (1) adjustment per Benefit Period and only if performed more than six (6) months after the insertion of the denture.
15. Relining dentures—Relines performed twelve (12) months after initial placement and no more than once in two (2) years.
16. Fixed bridges—upgrading from a partial denture to fixed bridgework is covered only if the patient's arch cannot be adequately restored with a partial denture. Replacement of an existing fixed bridge or partial denture is eligible only if the existing appliance is more than seven (7) years old and cannot be repaired.
17. Implants, including the implant body, implant abutment and implant crown.

    Implant body—limited to once per tooth, per seven (7) years. Coverage is allowed if more than seven (7) years has elapsed since the last placement of a prosthetic of any type on the tooth.

    Implant abutment—limited to once per tooth, per seven (7) years. Coverage is allowed if more than seven (7) years has elapsed since the last placement of a prosthetic of any type on the tooth.

    Implant Crown – Coverage is allowed if more than seven (7) years has elapsed since the last placement of a prosthetic of any type on the tooth.
18. Biopsy of soft or hard oral tissue (for removal of specimen only).
19. Impaction that requires incision of overlying soft tissue, elevation of a flap and either removal of bone and tooth or sectioning and removal of the tooth (extraction of tooth, partial bony impaction).
20. Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone, and sectioning of the tooth for removal (extraction of tooth, complete bony extraction).
21. Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone, sectioning of the tooth for removal, and/or presents unusual difficulties and circumstances (including report).
22. Root recovery.
23. Excision of pericoronal tissues.
24. Tooth reimplantation.
25. Tooth transplantation—separate benefits are not payable for donor site charges.
26. Removal of exostosis.
27. Frenectomy (frenulectomy).
28. Excision of hyperplastic tissue.

29. Incision and drainage.
30. Radical excision (lesion diameter up to or greater than 1.25 cm)—not payable in addition to extraction performed in same site on same date.
31. Excision pericoronal gingiva (operculectomy).
32. Excision of benign tumor (lesion diameter up to or greater than 1.25 cm) —not payable in addition to extraction performed in same site on same date.
33. Removal of odontogenic cyst or tumor (diameter up to or greater than 1.25 cm)—not payable in addition to extraction performed in same site on same date.
34. Suture of small wounds.
35. Apicoectomy and retrograde filling.
36. Hemisection.
37. Ridge augmentation.
38. Bone graft.
39. Cone beam image.

D. Type IV: Orthodontic Services

1. Orthodontia or Orthodontic Treatment.

EXCLUSIONS AND LIMITATIONS SECTION

In addition to any other exclusions and limitations of the Dental Program, the following exclusions and limitations apply to the entire Document, unless otherwise specified.

I. General Exclusions and Limitations

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

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

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

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

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

D. Replacement of an existing crown, inlay or onlay that was installed within the preceding seven (7) years or replacement of an existing crown, inlay or onlay that can be repaired.

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

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

G. In excess of the Maximum Allowance.

H. A replacement of a partial or full removable denture for fixed bridgework, or the addition of teeth thereto, if involving a replacement or modification of a denture or bridgework that was installed during the preceding seven (7) years.

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

J. Replacement of lost or stolen appliances.

K. Ridge augmentation procedures unless otherwise specifically listed in the Closed List of Dental Covered Services.

L. Any procedure, service or supply other than alveoloplasty or alveolectomy required to prepare the alveolus, maxilla or mandible for a prosthetic appliance. Excluded services include, but are not limited to, vestibuloplasty, stomatoplasty and bone grafts (either synthetic or autogenous) to the alveolars, maxilla or mandible, unless otherwise specifically listed in the Closed List of Dental Covered Services.

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

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

O. Temporary dental services. Charges for temporary services are considered an integral part of the final dental services and are not separately payable. Provisional services will be considered permanent and will have standard replacement frequencies applied.

P. Any service, procedure or supply for which the prognosis for success is not reasonably favorable as determined by the Contract Administrator, on behalf of the Plan Administrator at least three (3) years.

Q. Myofunctional therapy and biofeedback procedures.

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

S. Diagnostic casts.

T. Occlusal adjustments.

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

V. Investigational in nature.

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

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

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

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

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

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

AC. For telephone consultations, and all computer or Internet communications, except as specified as a Covered Service.

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

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

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

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

AG. For which a Participant would have no legal obligation to pay in the absence of coverage under the Dental Program or any similar coverage; or for which no charge or a different charge is usually made in the absence of health coverage or insurance coverage; or charges in connection with work for compensation or charges; or for which reimbursement or payment is contemplated under an agreement with a third party.

AH. Provided to a person enrolled as an Eligible Dependent, but who no longer qualifies as an Eligible Dependent due to a change in eligibility status that occurred after enrollment.

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

AJ. For acupuncture or Hypnosis.

AK. Repair, removal, cleansing or reinsertion of Implants, unless otherwise specifically listed in the Closed List of Dental Covered Services.

AL. Denture duplication.

AM. Oral hygiene instruction.

AN. Treatment of jaw fractures.

AO. Charges for acid etching.

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

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

AR. Drugs and medicines, except for antibiotic or other therapeutic injections.

AS. Services for which benefits are payable under the Medical Program of the Plan.

AT. Support service(s) provided for a non-Covered Service.

II. Conditions

A. Right to Review Dental Work

Before providing benefits for Covered Services, the Contract Administrator, on behalf of the Plan Administrator, has the right to refer the Participant to a Dentist of its choice and at its expense to verify the need, quantity, and quality of dental work claimed as a benefit.

B. Care Rendered by More Than One (1) Dentist

If a Participant transfers from the care of one (1) Dentist during a Dental Treatment Plan, or if more than one (1) Dentist renders services for one (1) dental procedure, the Contract Administrator, on behalf of the Plan Administrator, will pay no more than the amount that it would have paid if only one (1) Dentist had rendered the service.

C. Alternate Treatment Plan

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

GENERAL PROVISIONS SECTION

I. Participant/Provider Relationship

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

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

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

II. Coordination of Benefits

The intent of this Coordination of Benefits provision is to provide that the sum of benefit payments from all "Other Plans" and the Dental Program will not exceed the normal benefit allowance from Dental Program when no Other Plan(s) are involved.

A. Definitions, as used in this section:

1. **This Plan** will mean the Dental Program.
2. **Other Plans** will mean any medical or dental expense benefits provided under:
   a. Any insured or noninsured group, service, prepayment, or other program arranged through an employer, trustee, union, or association;
   b. Any program required or established by federal or state law, including Medicare Parts A, B, C and D; and
   c. Any program sponsored by or arranged through a school or other educational agency. (Note: the term "Other Plan" will not include benefits provided under a student accident policy, nor will the term "Other Plan" include benefits provided under a state medical assistance program where eligibility is based on financial need.)

   If the Other Plan contains several programs and some of those programs dictate rules for Coordination of Benefits and other programs do not dictate rules for Coordination of Benefits, Coordination of Benefits will apply separately.
3. **Primary Plan/Secondary Plan** describes the order of how payments are made according to benefit determination rules when more than one plan covers the person. When this Plan is Primary, its benefits are determined before those of any Other Plan and without considering any Other Plan's benefits. When this Plan is Secondary, its benefits are determined after those of any Other Plan and may be reduced because of the Primary.
4. **Allowable Expense** will mean a health care Covered Service or expense, including Deductibles and Copayments, if any, that is covered at least in part by any of the plans covering the person for whom benefits are claimed. When a plan 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 or service that is not covered by any of the plans is not an Allowable Expense.

B. Order of Benefit Determination

Benefits payable by a plan that does not have a Coordination of Benefits provision as described in this section will be determined before a plan that does have such a provision except as described below in the "Medicare Exception—Order of Benefit Determination" subsection. In all other instances, the order of determination will be:

1. Non-Dependent/Dependent. The benefits of a plan that covers the person for whom benefits are claimed as an Enrollee (non-dependent) are determined before the benefits of a plan that covers the person as an Eligible Dependent.
2. Dependent Child
   a. Parents not Separated or Divorced—The benefits of the plan of the parent whose birthday falls earlier in a calendar year are determined before those of the plan of the parent whose birthday falls later in that year; but if both parents have the same birthday, the benefits of the plan that covered a parent longer are determined before those of the plan that covered the other parent for a shorter period of time. However, if another plan does not have the rule described above, but instead has a rule based on the gender of the parent, and if, as a

result, the plans do not agree on the order of benefits, the rule in the Other Plan will determine the order of benefits.

b. Separated or Divorced Parents—Single Custody. If two or more plans cover an Eligible Dependent child of divorced or separated parents, benefits for the child are determined in this order:
   1) First, the plan of the parent with custody of the child;
   2) Then, the plan of the spouse of the parent with custody of the child; and
   3) Finally, the plan of the parent not having custody of the child.
   However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any period during which any benefits are actually paid or provided before the entity has that actual knowledge.

c. Separated or Divorced Parents—Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules for Eligible Dependent children of parents who are not separated or divorced.

d. Active/Inactive Employee. The benefits of a plan that covers a person as an Enrollee who is neither laid off nor retired, or as that active Enrollee's Eligible Dependent, are determined before the benefits of a plan that covers that person as a laid-off or retired Enrollee or as that inactive Enrollee's Eligible Dependent. If the Other Plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

e. Continuation of Coverage. If coverage is provided for a person under a right of continuation according to federal or state law and the person is also covered under the Other Plan, the following will be the order of benefit determination:
   1) First, the benefits of a plan covering the person as an active (non-COBRA participant (or as that person's dependent);
   2) Second, the benefits under the continuation coverage.
   3) If the Other Plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

f. Longer/Shorter Length of Coverage. If none of the above rules determine the order of benefits, the benefits of the plan that covered a person longer are determined before those of the plan that covered that person for the shorter time.

g. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the plans. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

C. Medicare Exception—Order of Benefit Determination

This Plan will be primary over Medicare only when federal law requires it to be primary. This Plan will be secondary to Medicare to the fullest extent allowed by federal law.

The rules governing coordination of benefits with Medicare are set by the federal government and are quite complex. The summary that follows is not a comprehensive account of those rules nor is it intended to change the basic Medicare rule described in the previous paragraph.

1. Medicare is primary for a person who is eligible for Medicare on the basis of age or disability unless the person is covered under this Plan because of his/her current employment status or that of their spouse. COBRA continuation coverage is not considered coverage based on current employment status, i.e., Medicare is primary for a person who is eligible for Medicare on the basis of age or disability and has COBRA continuation coverage under this Plan.

2. Medicare is primary for a person who is eligible for Medicare on the basis of end stage renal disease (ESRD) after the thirtieth (30) month of Medicare eligibility unless Medicare was already primary on the basis of age or disability on the date the person became eligible on the basis of ESRD.

When this Plan would be secondary to Medicare, it will reduce benefits based on what Medicare would pay under Part A and Part B, even if you or your Dependent are not enrolled in Part A or Part B. The Claims Administrator may make a good faith estimate of the amount Medicare would pay. This estimate will be deemed a benefit paid for purposes of determining benefits.

D. Effect on Benefits

Benefits payable by this Plan will not duplicate benefits already paid by any Other Plan(s) for Allowable Expenses.

Benefits payable under this Plan will be adjusted appropriately by the benefits payable under the Other Plan(s), if the Other Plan(s) benefits are determined to be primary payers before this Plan.

When this Plan is secondary, the regular benefit payment will be calculated. If the Other Plan's payment is less than this Plan's normal benefit allowance, then this Plan will pay the difference up to the normal benefit allowance for this Plan.

Example 1:	**Allowable Expense**	**Plan Pays**	**Benefit**
Other Plan (Primary Plan)	$100	70%	$70
This Plan (Secondary Plan)	$100	80%	$80
Difference Paid by Simplot Plan		$10	

If the Other Plan's payment is equal to or more than this Plan's normal benefit allowance, then this Plan pays no additional benefits.

Example 2:	**Allowable Expense**	**Plan Pays**	**Benefit**
Other Plan (Primary Plan)	$100	80%	$80
This Plan (Secondary Plan)	$100	80%	$80
Difference Paid by this Plan		$0	

Deductibles, maximums and other benefit limits of this Plan will be adjusted as if benefits had been paid.

E. General Coordination of Benefits Provisions

1. Exchange of Information. Any person who claims benefits under this Plan is required, upon request, to provide all information that is needed to coordinate benefits. In addition, all information that is needed to coordinate benefits may be exchanged with other companies, organizations, or persons.

2. Plan Reimbursement. The Plan may reimburse any Other Plan if:
   a. Benefits were paid by that Other Plan; but
   b. Should have been paid under this Plan in accordance with this section.
   In such instances, the reimbursement amounts will be considered benefits paid under this Plan and, to the extent of those amounts, will discharge this Plan from liability.

3. Integration with Individual Medical Expense Automobile Policies. The amount payable under this Plan for covered medical and dental expenses shall be reduced by the amounts payable for such Services under an individual medical expense automobile policy.
4. Right of Recovery. If it is determined that benefits paid under this Plan should have been paid by any Other Plan or policy, this Plan will have the right to recover those payments from:
   a. The person to or for whom the benefits were paid; and/or
   b. The other companies or organizations liable for the benefit payments.

F. Prescription Drug Benefit

This Plan shall not pay additional prescription drug benefits secondary to another plan, regardless of whether a claim is made to the primary plan.

III. Inquiry and Appeals Procedures

If the Participant's claim for benefits is denied and an Adverse Benefit Determination, the Participant must first exhaust any applicable internal appeals process described below prior to pursuing legal action. Any legal action must be filed within two (2) years after the final internal appeal decision and must be filed in Federal court in Boise, Idaho.

A. Informal Inquiry

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

B. Formal Appeal

A Participant, or their authorized representative, as defined by the Plan, who wishes to formally appeal a Pre-Service Claim decision may do so through the following process:

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

2. A written appeal must be sent to the Appeals and Grievance Coordinator within one hundred eighty (180) days after receipt of the notice of Adverse Benefit Determination. Urgent claim appeals, and the documents in support of such appeals may be submitted by phone or facsimile. The appeal should set forth the reasons why the Participant contends the 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 by a Contract Administrator's Dental Director or designee. For non-urgent claim appeals, the Contract Administrator will mail a written reply to the Participant within fifteen (15) days after receipt of the written appeal. Urgent claim appeals will be notified orally within seventy-two (72) hours. If the original decision is upheld, the reply will state the specific reasons for denial and the specific provisions on which the decision is based. Each appeal will be processed as quickly as possible taking into account the medical and/or dental exigencies of each claim.

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

5. If the original, non-urgent claim decision is upheld upon reconsideration, the Participant or their authorized representative may send an additional written appeal to the Appeals and Grievance Coordinator requesting further review. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within thirty (30) days of the Contract Administrator's mailing of the initial reconsideration decision. The Contract Administrator Dental Director or designee who is not subordinate to the Dental Director or designee who decided the initial appeal, will review and make a recommendation to the Plan Administrator who will issue a final decision after consideration of all relevant information. A final decision on the appeal will be made within fifteen (15) days of its receipt. There are no further internal appeals available for urgent claims.

C. A Participant, or their authorized representative, as defined by the Plan, who wishes to formally appeal a Post-Service Claims decision may do so through the following process:

1. A Participant may have an authorized representative pursue a benefit claim or an appeal of an Adverse Benefit Determination on their behalf. The Plan Administrator requires that a Participant execute an "Appointment of Authorized Representative" form before the Contract Administrator, on behalf of the Plan Administrator determines that an individual has been authorized to act on behalf

of the Participant. The form can be found on the Contract Administrator's Website at www.bcidaho.com.

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

3. After receipt of the written appeal, all facts, including those originally used in making the initial decision and any additional information that is sent or that is otherwise relevant, will be reviewed by the Contract Administrator's Dental Director or designee if the appeal requires medical and/or dental judgment. The Contract Administrator shall mail a written reply to the Participant within thirty (30) days after receipt of the written appeal. If the original decision is upheld, the reply will list the specific reasons for denial and the specific provisions on which the decision is based. Each appeal will be processed as quickly as possible.

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

5. If the original decision is upheld upon reconsideration, the Participant or their authorized representative may send an additional written appeal to the Appeals and Grievance Coordinator requesting *further review*. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within sixty (60) days of the Contract Administrator's mailing of the initial reconsideration decision. If the appeal requires medical and/or dental judgment, a Dental Director of the Contract Administrator or designee who is not subordinate to the Dental Director or designee who decided the initial appeal, will review and make a recommendation to the Plan Administrator, who will issue a final decision after consideration of all relevant information. A final decision on the appeal will be made within thirty (30) days of its receipt.

IV. Reimbursement of Benefits Paid by Mistake

If the Contract Administrator, on behalf of the Plan Administrator, mistakenly makes payment for benefits on behalf of an Enrollee or their Eligible Dependent(s) that the Enrollee or their Eligible Dependent(s) is not entitled to under the Dental Program, the Enrollee must reimburse the erroneous payment to the Contract Administrator, on behalf of the Plan Administrator.

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

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

V. Subrogation and Reimbursement Rights

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

As a condition of receiving benefits for Covered Services in such an event, the Participant or their personal representative shall furnish the Contract Administrator 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 Participant or their personal representative concerning the injury, harm or loss. In addition, the Participant shall furnish the name and contact information of the liability insurer and its adjuster of the third party, including the policy number, of any liability insurance that covers, or may cover, such injury, harm, or loss.

The Contract Administrator, on behalf of the Plan Administrator, may, at its option elect to enforce either or both of its rights of subrogation and reimbursement.

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

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

The Participant shall pay the Contract Administrator, on behalf of the Plan Administrator, as the first priority, and the Contract Administrator, on behalf of the Plan Administrator, 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 the Contract Administrator, on behalf of the Plan Administrator under the Plan, regardless of how the recovery is allocated *(i. e.*, pain and suffering) and whether the recovery makes the Participant whole. Thus, the Contract Administrator, on behalf of the Plan Administrator, will be reimbursed by the Participant, or their legal representative, from monies recovered as a result of the injury, harm or loss, for all benefits paid even if the Participant is not made whole or fully compensated by the recovery. Moreover, the Contract Administrator and the Plan Administrator are not responsible for any attorney's fees, other expenses or costs incurred by the Participant without the prior written consent of the Contract Administrator and, therefore, the "common fund" doctrine does not apply to any amounts recovered by any attorney the Participant hires regardless of whether amounts recovered are used to repay benefits paid by the Contract Administrator, on behalf of the Plan Administrator.

To the extent that the Contract Administrator, on behalf of the Plan Administrator provides or pays benefits for Covered Services, the Contract Administrator's rights of subrogation and reimbursement extend to any right the Participant has to recover from the Participant's insurer, or under the Participant's "Medical Payments" coverage or any "Uninsured Motorist," "Underinsured Motorist," or other similar coverage provisions, and workers' compensation benefits.

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

The Contract Administrator's subrogation and reimbursement rights shall take priority over the Participant's rights both for benefits provided and payments made by the Contract Administrator, on behalf of the Plan Administrator, for Covered Services and for benefits to be provided or payments to be made by the Contract Administrator on behalf of the Plan Administrator, in the future on account of the injury, harm or loss giving rise to the Contract Administrator's subrogation and reimbursement rights. Further, the Plan Administrator'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

Participant, even if there are deficiencies in any recovery or insufficient financial resources available to the third party or parties to totally satisfy all of the claims and judgments of the Participant and the Contract Administrator.

Collections or recoveries made by a Participant for such injury, harm or loss in excess of such benefits provided and payments made shall first be allocated to such future benefits and payments that would otherwise be owed by the Plan on account of the injury, harm or loss giving rise to the Plan's subrogation and reimbursement rights, and shall constitute a special Deductible applicable to such future benefits and payments that would otherwise be owed by the Plan, or any subsequent group health plan provided by the Plan Sponsor. Thereafter, the Contract Administrator, on behalf of the Plan Administrator, shall have no obligation to provide any further benefits or make any further payment until the Participant has incurred medical expenses in treatment of such injury, harm or loss equal to such special Deductible.

VI. Individual Benefits Management

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

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

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

VII. Health Care Providers Outside the United States

The benefits available under the Dental Program are also available to Participants traveling or living outside the United States. Reimbursement for Covered Services will be made directly to the Participant. The Contract Administrator will require the original claim along with an English translation. It is the Participant'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 Service under the Dental Program.

VIII. Payment of Benefits

The Contract Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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

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

IX. Notice of Claim

The Contract Administrator must receive a written notice of claim for payment for a Covered Service no later than one year from the date a Covered Service is rendered, except if it is not reasonably possible to give notice of proof within this timeframe. The Contract Administrator will deny any claim not received within this time limit.