2024 Plan Document and Summary Plan Description

Plan Sponsor: Idaho School District Cooperative Services Council

Trust: Idaho School Benefit Trust

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

ASC Vision

Participating School District: Lapwai School District #341

Effective Date: September 1, 2024

Benefit Period: January 1 through December 31

This is a self-funded plan and is not an insurance policy and the Idaho School Benefit Trust does not participate in the Idaho Life and Health Guaranty Association.

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

ISBT Vision (09012024)

PLAN UPDATES

To Your
Group Plan

Please Read Carefully

This *Plan Update* is a summary of the changes to your health insurance coverage effective on September 1, 2024. We encourage you to review this carefully. For reference, the words and terms capitalized in this document are defined in your Summary Plan Description.

Item	Vision Summary of Change
Summary Plan Description	Clarified the definition of **Provider** to state that all Providers and Facilities must be licensed, certified, accredited and/or registered, where required, to render Covered Services.
	Removed definitions that were not used in the Summary Plan Description.
	Updated the Plano Lenses definition.
	Added the following exclusions: • Contact lens insurance policies or service agreements. • Refitting of Contact Lenses after the initial ninety (90) day fitting period. • Contact lens modification, polishing or cleaning. • Local, state and/or federal taxes, except where the VCSV is required by law to pay. • Professional services associated with Corneal Refractive Therapy (CRT), Orthokeratology, or myopia management.

The information in this Summary of Changes is for informational and comparison purposes only. It is not a complete summary or description of benefits and is subject to the provisions of the corresponding Summary of Health Care Benefits, which contains the detailed terms and conditions of coverage. If there is a difference or conflict between this Summary of Change and its corresponding Summary of Health Care Benefits, the Summary of Health Care Benefits will control.

BENEFITS OUTLINE

The Plan is exempt from the requirements of the Employee Retirement Income Security Act of 1974 ("ERISA") because the Plan is established or maintained by a governmental entity. Any usage of a word or phrase defined in ERISA is not intended to cause the plan to become subject to ERISA.

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

If Participants receive this document and/or any other Plan notices electronically, Participants have the right to receive paper copies of the electronic documents, including Summary Plan Descriptions and plan amendments, upon request at no additional charge.

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

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 Customer Service Department. Call 1-800-627-1188 (TTY: 711), or call the customer service phone number on the back of your card.

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

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

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

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

Language Assistance

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). ATTENTION: If you speak Arabic, Bantu, Chinese, Farsi, French, German, Japanese,

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

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

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

Farsi: هجوت: رگا هب نابزیسراف وگتفگ یم دیک یهارف یم
تالیهست ینابز ترصب ناگیارا اربشم ا (711
1-800-627-1188 (TTY: اب دشاب
دیریگب سامت.

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

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

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

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

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

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).

ELIGIBILITY AND ENROLLMENT
To qualify as an Eligible Employee under this Summary Plan Description, a person must be and remain a full-time employee of a Participating School District who regularly works at least 20 hours per week and is paid on a regular, periodic basis through the school district's payroll system. Pre-65 retirees may also be eligible. *(see the Summary Plan Description for additional Eligibility and Enrollment provisions)*
PROBATIONARY PERIOD
The Participating School District will determine if there are certain probationary periods that must be satisfied before a new Eligible Employee can qualify for coverage under this Summary Plan Description.

<table>
<tr><th colspan="2">HEALTHY SIGHT PREFERRED $130 (CII)
VISION CARE BENEFITS (VCSV)
BENEFITS OUTLINE
Visit our Website at www.bcidaho.com to locate a Participating Provider.
*The Participating Provider is responsible for verifying benefits with the VCSV prior to rendering services. A Participant must provide the Participating Provider sufficient information to verify eligibility. Failure of the Participant to provide sufficient information may delay services and may affect benefit payment under the Plan.</th></tr>
<tr><td>For Covered Providers and Services

Copayment</td><td>Participant pays $10 per eye exam and/or $25 per Frame and Lenses or Medically Necessary Contact Lenses</td></tr>
<tr><td>Service Frequency Limitations</td><td>Participant may receive:
• one (1) eye exam every twelve (12) months.
• one (1) pair of Lenses or an annual supply of Medically Necessary Contact Lenses (in lieu of eyeglasses) or up to the allowance towards an annual supply of Elective Contact Lenses (in lieu of eyeglasses) every twelve (12) months.
• one (1) Frame every twelve (12) months.</td></tr>
<tr><th colspan="2">IN-NETWORK SERVICES (*PARTICIPATING PROVIDERS)
Payment For Services Rendered and Allowances:</th></tr>
<tr><td colspan="2">Exam—Participant pays Copayment, as applicable, then Plan pays 100% of Maximum Allowance.

Prescription Glasses—Participant pays Copayment, as applicable, then Plan pays 100% of Maximum Allowance for Basic Lenses and Medically Necessary Contact Lenses (in lieu of glasses). Includes Frame allowance of $130.

Elective Contact Lenses—Includes a Contact Lens fitting and evaluation and $130 allowance for materials in place of benefits for Prescribed Lenses and Frame.</td></tr>
</table>

OUT-OF-NETWORK SERVICES (NONPARTICIPATING PROVIDER) Reimbursement Allowances:
Professional Fees Eye Exam: Plan pays up to $45 **Materials—Lenses per pair** Frame: Plan pays up to $47 Single Vision Lenses: Plan pays $45 Lined Bifocals Lenses: Plan pays up to $65 Lined Trifocals Lenses: Plan pays up to $85 Progressives Lenses: Plan pays up to $85 **Contact Lenses per pair:** $105 **Medically Necessary, up to Maximum Allowance:** $210 **Elective Contact Lenses**—includes a Contact Lens fitting and evaluation and an allowance for materials in place of benefits for Prescribed Lenses and Frame.

Benefits for Covered Services received from a Participating Provider will be paid in full, after any required Copayment, up to the Maximum Allowance for standard lenses and/or frames.

Plan Document and Summary Plan Description

Plan Sponsor: Idaho School District Cooperative Services Council

Trust: Idaho School Benefit Trust

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

ASC Vision

This is a self-funded plan and is not an insurance policy and the Idaho School Benefit Trust does not participate in the State Guaranty Association.

Effective Date: September 1, 2024

Blue Cross of Idaho has been hired as the Contract Administrator by the Trust 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.

ISBT-Vision-09012024

TABLE OF CONTENTS

CONTRACT INFORMATION FOR THE CONTRACT ADMINISTRATOR 1
HOW TO SUBMIT CLAIMS 2
VISION CARE BENEFITS SECTION 3
Copayment and Limitations on Frequency of Services 3
Covered Providers 3
Procedures for Obtaining Covered Services 3
Covered Services 3
Additional Amount of Payment Provisions 4
Participants Options 5
ELIGIBILITY AND ENROLLMENT FOR EMPLOYEES SECTION 6
Eligibility and Enrollment 6
Leave of Absence for Participating Employees 6
Participating School District Contribution for Participating Employees 7
Eligible Employees Changing to Other Participating School Districts 9
Retirement 9
Qualified Medical Child Support Order 9
ELIGIBILITY AND ENROLLMENT SECTION FOR RETIREES SECTION 11
Eligibility and Enrollment 11
Loss of Eligibility if a Participating School District Cancels 11
Payment of Contribution and Effective Date 11
Qualified Medical Child Support Order 13
DEFINITIONS 15
EXCLUSIONS AND LIMITATIONS 19
General Exclusions and Limitations 19
GENERAL PROVISIONS SECTION 21
Termination or Modification of a Participant's Coverage 21
Benefits After Termination of Coverage 22
Contract Between the Contract Administrator and the Trust 23
Benefits to Which Participants are Entitled 24
Notice of Claim 24
Release and Disclosure of Medical Recordsand Other Information 24
Exclusion of General Damages 24
Payment of Benefits 25
Participant/Provider Relationship 26
Participating Plan 26
Coordination of the Plan's Benefits with Other Benefits 26
Benefits for Medicare Eligibles Who are Covered Under the Plan 30
Incorporated by Reference 31
Inquiry and Appeals Procedures 31
Reimbursement of Benefits Paid by Mistake 33
Subrogation and Reimbursement Rights 33
Statements 35
Coverage and Benefits Determination 35

CONTRACT INFORMATION FOR THE CONTRACT ADMINISTRATOR

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

The Contract Administrator ("Blue Cross of Idaho") is the Contract Administrator. The Contract Administrator may act on behalf of the Trust as directed. The Plan document and Summary Plan Description will be used to administer and determine the benefits under the Plan.

For general information, please contact a local the Contract Administrator's office:

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

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

Mailing Address
PO Box 7408
Boise, ID 83707
(208) 331-7347 (Boise Area)
1-800-627-1188

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

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

Idaho Falls
3630 S. 25th E., Suite 1
Idaho Falls, ID 83404
(208) 522-8813

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

HOW TO SUBMIT CLAIMS

A Participant must submit a claim to the Contract Administrator (Blue Cross of Idaho) designated Vision Care Services Vendor (VCSV), Vision Service Plan (VSP) in order to receive benefits for Covered Services. There are two (2) ways for a Participant to submit a claim:

1. The vision service Provider can file the claim for the Participant. In-Network (Participating) Providers will submit a claim on a Participant's behalf if the Participant shows them the identification card before services are rendered and tells them they have coverage through VSP.

2. The Participant can send the claim to VSP.

I. To File a Participant's Own Claims

In-Network (Participating) vision service Providers will submit a claim for the Participant. This will ensure the Participant receives the highest benefits from the Plan. If the Participant receives services from an Out-of-Network (Nonparticipating) vision service Provider, the Participant can file the claim directly to VSP. To submit an Out-of-Network claim:

1. The Participant can visit VSP’s Web site at www.vsp.com and sign in as a Member. Click on the “Benefits” link and then the “Submit a Claim” under the heading “Oops! Did You Go Out of Network” Instructions for completing the form are described. Once completed, mail the form to VSP at the address listed below.

2. Include a copy of the itemized billing statement or receipts and be sure to include the following information:
   a. Doctor’s name or office name
   b. Name of patient
   c. Date of Service
   d. Each service received and the amount paid

   Mail to:

   Vision Service Plan
   Attention: Claims Services
   P O Box 385018
   Birmingham, AL 35238-5018

For assistance with claims or vision benefit information, please call VSP Customer Service at 1-800-877-7195 Monday through Friday 6 a.m. – 7 p.m. MT.

II. How the Participant is Notified

If the Participant receives services from an In-Network Provider (Participating), the Provider will provide a statement explaining the cost of the services. If the Participant receives services from an Out-of-Network Provider (Nonparticipating), VSP will provide a statement of costs to the Participant with a reimbursement check.

VISION CARE BENEFITS SECTION

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

I. Copayment and Limitations on Frequency of Services

The Copayment amount and limitations on frequency of services are shown in the Benefits Outline.

II. Covered Providers

The following are Covered Providers under this section:

- Optometrist (OD)
- Ophthalmologist (MD)

III. Procedures for Obtaining Covered Services

A. A Participant must contact the Vision Care Services Vendor (VCSV) Participating Provider to make an appointment to receive Covered Services. No preauthorization or special benefit form is required. The doctor is responsible for verifying eligibility and obtaining the necessary authorization from the VCSV prior to the delivery of service. Each authorization is valid for fifteen (15) days. A Participant must provide the VCSV Participating Provider sufficient information to verify eligibility. Failure of the Participant to provide sufficient information may delay services and may affect benefit payment under the Plan.

B. Should the Participant obtain services from a Provider who is not a VCSV Participating Provider, the Participant is responsible for making payment in full to the Provider and will be reimbursed by VCSV in accordance with the benefits available for Covered Services under this section.

IV. Covered Services

When rendered by a Covered Provider, benefits are provided for the following services:

A. Eye Examination
B. Frame
C. Single Vision Lenses
D. Lined Bifocal Lenses
E. Lined Trifocal Lenses
F. Contact Lens fitting and evaluation and Contact Lenses in place of eyeglasses

A. Eye Examination

A vision examination regardless of its Medical Necessity, including but not limited to, the following services:
(NOTE: Each test may not be indicated for every patient.)

1. **Comprehensive Examination**—evaluation of the complete visual system with or without cycloplegia or mydriasis.
2. **Intermediate Examination**—brief or limited routine check-up or vision survey.
3. **Vision Analysis**—various tests for prescription Lenses.
4. **Tonometry**—measurement of eye tension for glaucoma.
5. **Biomicroscopy**—examination of the living eye tissue.
6. **Central and/or Peripheral Field Study**—measurement of visual acuity in the central and/or peripheral field of vision.
7. **Dilation**—allows for a better view inside the eye, i.e., optic nerve blood vessels, etc.

B. Prescribed Lenses and Frames

When an eye examination indicates that new Lenses or a new Frame or both are necessary for the proper visual health and welfare of a Participant, they will be supplied, together with such professional services as necessary, which include but are not limited to:

1. Prescribing and ordering proper Lenses.
2. Assisting in the selection of a Frame.
3. Verifying the accuracy of the finished Lenses.
4. Proper fitting and adjustment of the eyeglasses.

The VCSV reserves the right to limit the cost of Frames provided by a Participating Provider. The allowance is published periodically by the VCSV to its Participating Providers and is set at a level to cover the majority of Frames in common use. If a Participant wishes to select a more expensive Frame than allowed in this section, the difference in cost is not the responsibility of the VCSV or the Plan.

C. Contact Lenses

1. **Medically Necessary Contact Lenses**—Medically Necessary Contact Lenses are covered for Participants when specific benefit criteria are satisfied and when prescribed by Participant's doctor.

   When the Participating Provider receives prior approval for such cases, they are fully covered by the VCSV and are in place of the benefits described for Prescribed Lenses and Frames.

   Medically Necessary Contact Lenses may be prescribed only for certain medical conditions.

2. **Elective Contact Lenses**—if a Participant chooses Contact Lenses from a Participating Provider for reasons other than those mentioned above, benefits are provided as follows: The initial basic examination will be covered in full (as described under Eye Examination) and an allowance will be paid toward a contact lens evaluation fee, fitting costs, and materials in place of the benefits described for Prescribed Lenses and Frames. The allowance amount is shown in the Benefits Outline.

3. **Reimbursement Allowance**—For Covered Services rendered by a Provider who is not a Participating Provider, a determination of Medically Necessary versus Elective Contact Lenses will be consistent with Participating Provider services. Reimbursement allowances for Medically Necessary and Elective Contact Lenses include a contact lens evaluation fee, fitting costs, and materials and is in place of all other benefits for materials, including eyeglass Lenses and Frame.

V. Additional Amount of Payment Provisions

A. The Participant will pay the Copayment, if any, to the Participating Provider for Covered Services and will pay for any additional services received not covered by the Plan. The VCSV will pay the Participating Provider directly in accordance with the agreement between the VCSV and the Participating Provider.

Subject to the applicable Copayment(s), the VCSV shall pay or otherwise secure the discharge of the cost of Covered Services rendered by a Participating Provider. A Participating Provider shall not make an additional charge to a Participant for amounts in excess of the VCSV's payment except for Copayments, noncovered services and amounts above the allowance for elective Contact Lenses.

B. If Covered Services are rendered by a Provider who is not a VCSV Participating Provider:

1. The Participant is responsible for paying the Provider in full. The Participant will be reimbursed in accordance with the benefits available, if any, as shown in the Benefits Outline.
2. The Nonparticipating Provider is not obligated to accept the VCSV's payment as payment in full. The VCSV and the Plan are not responsible for the difference, if any, between the VCSV's payment and the actual charge; any such difference is the Participant's responsibility.
3. Benefits for Covered Services are subject to the same time limits and Copayments as those described for Covered Services received from a Participating Provider. Covered Services obtained from a Nonparticipating Provider are in place of obtaining services from a Participating Provider.

C. **Reimbursement Allowance**—The amounts shown in the Benefits Outline under Payment for Services Rendered by a Nonparticipating Provider are maximums. The actual amount paid in reimbursement to the Participant is either the amount indicated in the Benefits Outline or, the amount actually charged, whichever is less.

VI. Participants Options

When a Participant selects any of the following options, the VCSV pays the basic cost of the allowed Lenses, and the Participant is responsible for paying the additional costs for the following options:

1. Blended Lenses.
2. Contact Lenses, except as provided in this section.
3. Oversize Lenses.
4. Progressive multi-focal Lenses.
5. Coating of the lens or Lenses.
6. Laminating of the lens or Lenses.
7. A Frame that costs more than the VCSV's allowance.
8. Cosmetic Lenses.
9. Optional cosmetic processes.
10. UV (ultraviolet) protected Lenses.
11. Polycarbonate Lenses (except for Eligible Dependent Children).
12. Low vision aids.

13 Lens Materials other than plastic or glass.

ELIGIBILITY AND ENROLLMENT FOR EMPLOYEES SECTION

I. Eligibility and Enrollment

All Eligible Employees will have the opportunity to apply for coverage under this Summary Plan Description. All applications submitted to the Contract Administrator by the Participating School District now or in the future, will be for Eligible Employees or Eligible Dependents only.

A. Eligible Employee

Qualifications for eligibility are shown in the Benefits Outline.

B. Eligible Dependent

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

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

2. The Participating Employee's or the Participating Employee's spouse's natural child, stepchild, legally adopted child, child placed with the Participating Employee for adoption, or child for whom the Participating Employee or the Participating Employee's spouse has court-appointed guardianship or custody. The child must be under the age of twenty-six (26).

3. A child as described in the first sentence of subparagraph two (2) who has attained age twenty-six (26) provided:
   a) The child is medically certified as incapable of self-sustaining employment due to an intellectual disability or physical handicap that began prior to age twenty-six (26);
   b) The child is chiefly dependent upon the Participating Employee or the Participating Employee's spouse for support and maintenance; and
   c) The Participating Employee submits proof of such child's incapacity and dependency as described in this subparagraph three (3) within thirty-one (31) days of such child's attainment of age twenty-six (26) and as subsequently required by the Contract Administrator and/or the employer at reasonable intervals.

A Participating Employee must notify the Participating School District within thirty (30) days when a dependent no longer qualifies as an Eligible Dependent. Coverage for the former Eligible Dependent will terminate on the last day of the month in which the change in eligibility occurred.

II. Leave of Absence for Participating Employees

A. Participating Employees who subsequently fail to fulfill the twenty (20) or thirty (30) hour-per-week employment requirement and who have been enrolled for nine (9) months or more, may retain coverage and receive benefits defined in this Summary Plan Description while on a paid, approved leave of absence for a period not to exceed one (1) year; provided the Participating School District continues to pay not less than fifty dollars ($50.00) per month for each Participant and remits the entire Contribution due with the payment for the other Participants. Coverage for an employee on a paid leave of absence in excess of twelve (12) months will be permitted only on an exception basis approved by the Plan.

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

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

III. Participating School District Contribution for Participating Employees

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

IV. Miscellaneous Eligibility and Enrollment Provisions

A. The Participating School District will collect Participating Employee Contributions through payroll withholding and be responsible for making the required payments to the Trust through the Contract Administrator on or before the first of each month. Unless required by state or federal law or unless agreed to in writing by the Trustees, the Participating School District will not offer to its employees any other hospital, medical, dental or surgical coverage that is not provided by or through this Summary Plan Description, including but not limited to, coverage under a fee for service/indemnity plan, managed care organization or other similar program or plan, if such coverage is available to the Participating School District through the Plan during the 12 month period from September 1 through August 31 of each year.

B. It is understood that no Plan will be in effect unless 85% of all Eligible Employees enroll. Employees who certify enrollment under another employer health benefit plan and for whom no cash-in-lieu payment is made are not included in the 85% calculation. Should the total enrollment of Eligible Employees fall below the required 85% the Plan will be subject to surcharge or discontinued at the next renewal date. Existing districts that do not meet this criteria must submit to the Trust a written plan showing how and when compliance will be accomplished.

C. 1. For an Eligible Employee to enroll themself and any Eligible Dependents for coverage (or for a Participating Employee to enroll Eligible Dependents for coverage) the Eligible Employee or Participating Employee must complete an enrollment application and submit it and any required Contributions to the Contract Administrator in a manner approved by both the Contract Administrator and the Trust.

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

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

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

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

In order to continue coverage beyond the sixty (60) days outlined above, the Participating Employee must complete an enrollment application within sixty (60) days of date of birth and submit the required Contribution, for the first sixty (60) days, within thirty-one (31) days of the date monthly billing is received and a notice of Contribution is provided to the Enrollee from the Trust.

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 Summary Plan Description, '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 Summary Plan Description, "placed for adoption" means physical placement in the care of the adoptive Participating Employee, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it means when the adoptive Participating Employee signs an agreement for adoption of the child and signs an agreement assuming financial responsibility for the child.

3. The initial enrollment period is thirty (30) days for an Eligible Dependent who becomes eligible because of marriage. The initial enrollment period begins on the date of such marriage. The Effective Date of coverage is the first day of the month following the month of enrollment.

E. Late Participating Employee

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

F. Special Enrollment Periods

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

1. Participants Losing Other Coverage — An Eligible Participating Employee or Eligible Dependent losing other coverage may enroll for coverage if each of the following conditions is met:
   a) The Eligible Participating Employee or Eligible Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the Eligible Person or Eligible Dependent.
   b) The Eligible Participating Employee's or Eligible Dependent's coverage described in subparagraph a):
      (1) was under a COBRA continuation provision and the coverage under such provision was exhausted; or
      (2) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer Contributions toward such coverage were terminated.
   c) Under the terms of this Summary Plan Description, the Eligible Participating Employee requests such enrollment not later than thirty (30) days after the date of exhaustion of coverage described in subparagraph b)(1) or termination of coverage or employer Contribution described in subparagraph b)(2).

2. For Dependent Beneficiaries
   a) If a person becomes an Eligible Dependent of an Participating Employee (or of an Eligible Employee who failed to enroll during a previous enrollment period) through marriage, birth, adoption before age eighteen

(18) or placement for adoption before age eighteen (18), the Eligible Dependent (or, if not otherwise enrolled, the Eligible Person) may enroll, and in the case of the birth or adoption of a child, the spouse of the Participating Employee or Eligible Employee may enroll as an Eligible Dependent if such spouse is otherwise eligible for coverage.

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

c) If a Participating Employee enrolls an Eligible Dependent during the dependent special enrollment period described in this subparagraph 2, the Effective Date of coverage shall be:
   (1) in the case of marriage, the first day of the month beginning after the date a completed application and any required Contribution is received by the Contract Administrator;
   (2) in the case of an Eligible Dependent's birth, as of the date of such birth; or
   (3) in the case of an Eligible Dependent's adoption or placement for adoption, the date of birth for an Eligible Dependent adopted or placed for adoption within sixty (60) days of the Eligible Dependent's date of birth; and the date of such adoption or placement for adoption for an Eligible Dependent adopted or placed for adoption more than sixty (60) days after the Eligible Dependent's date of birth.

3. The Eligible Employee and/or Eligible Dependent become eligible for financial assistance under Medicaid or the Children's Health Insurance Program (CHIP) and coverage 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.

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

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

V. Eligible Employees Changing to Other Participating School Districts

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

VI. Retirement

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

VII. Qualified Medical Child Support Order

A. If this Summary Plan Description provides for Family Coverage, the Contract Administrator will comply with a Qualified Medical Child Support Order (QMCSO) according to the provisions of applicable federal or state laws. A medical child support

order is any 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 a Participating Employee or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law) and relates to benefits under this Summary Plan Description**,** or
2. Enforces a law relating to medical child support described in Section 1908 of the Social Security Act with respect to a group health plan.

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

1. The name and the last known mailing address (if any) of the Participating Employee and the name and mailing address of each child covered by the order.
2. A reasonable description of the type of coverage to be provided by this Summary Plan Description 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, the Contract Administrator will notify the party who sent the order and each affected child of the receipt and of the criteria by which the Contract Administrator determines if the medical child support order is a QMCSO. In addition, the Contract Administrator 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 the Contract Administrator. 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, the Contract Administrator will determine if the medical child support order is a QMCSO and will notify the Participating Employee, the party who sent the order, and each affected child of such determination.

D**.** The Contract Administrator, on behalf of the Trust, will make benefit payments to the respective party for reimbursement of eligible expenses paid by an enrolled affected child or by an enrolled affected child’s custodial parent, legal guardian, or the Idaho Department of Health and Welfare.

ELIGIBILITY AND ENROLLMENT FOR RETIREES SECTION

I. Eligibility and Enrollment

All Eligible Retirees will have the opportunity to apply for coverage under this Summary Plan Description. All applications submitted to the Contract Administrator by the Participating School District now or in the future, will be for Eligible Employees or Eligible Dependents only.

A. Eligible Retiree

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

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

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

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

B. Eligible Dependent

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

1. The Participating Employee's spouse under a legally valid marriage.
2. The Participating Employee's or the Participating Employee's spouse's natural child, stepchild, legally adopted child, child placed with the Participating Employee for adoption, or child for whom the Participating Employee or the Participating Employee's spouse has court-appointed guardianship or custody. The child must be under the age of twenty-six (26).
3. A child as described in the first sentence of subparagraph two (2) who has attained age twenty-six (26) provided:
   a) The child is medically certified as incapable of self-sustaining employment due to an intellectual disability or physical handicap that began prior to age twenty-six (26);
   b) The child is chiefly dependent upon the Participating Employee or the Participating Employee's spouse for support and maintenance; and
   c) The Participating Employee submits proof of such child's incapacity and dependency as described in this subparagraph three (3) within thirty-one (31) days of such child's attainment of age twenty-six (26) and as subsequently required by the Contract Administrator and/or the employer at reasonable intervals.

A Participating Employee must notify the Participating School District within thirty (30) days when a dependent no longer qualifies as an Eligible Dependent. Coverage for the former Eligible Dependent will terminate on the last day of the month in which the change in eligibility occurred.

II. Loss of Eligibility if a Participating School District Cancels

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

III. Payment of Contribution and Effective Date

A. All Eligible Retirees will have the opportunity to apply for coverage. In order to be eligible for retiree benefits, the Eligible Retiree must have continuous coverage from their former Participating School District's benefit schedule. All applications submitted to the Contract Administrator now or in the future, must be for Eligible Retirees or Eligible Dependents only.

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

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

C. For a person who is an Eligible Retiree and who applies for Single, Two-Party or Family Coverage on or before the first day he or she first becomes eligible as provided herein, the Effective Date is either the Participating School District's Plan Date, or the first day of the month after the person first becomes eligible, whichever is earlier. A Retiree may not add a Dependent who was not enrolled when the Retiree was an active employee under the Idaho School Benefit Trust Program, except as provided for Eligible Dependents under paragraph III.F.

D.

1. For an Eligible Retiree to enroll themself and any Eligible Dependents for coverage (or for A Participant to enroll Eligible Dependents for coverage) the Eligible Person or Participant, as the case may be, must complete an application and submit it and any required Contributions to the Contract Administrator.
2. Except as provided otherwise in this section, the Effective Date of coverage for an Eligible Retiree or an Eligible Dependent will be the first day of the month following the month of enrollment.
3. The Effective Date of coverage for an Eligible Retiree and any Eligible Dependents listed on the Eligible Retiree's application is the Participating School District's Plan Date if the application is submitted to the Contract Administrator by the Participating School District on or before the Plan Date.

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

1. Except as stated otherwise in subparagraphs E2. and 3. below, the initial enrollment period is thirty (30) days for Eligible Employees and Eligible Dependents. The initial enrollment period begins on the date the Eligible Employee or Eligible Dependent first becomes eligible for coverage.
2. A Participant's newborn Dependent, including adopted newborn children who are placed with the adoptive Participant within sixty (60) days of the adopted child's date of birth, are covered under this Summary Plan Description from and after the date of birth for sixty (60) days.

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

   When a newborn child is added and the monthly Contribution changes, a full month's Contribution is required for the child if the child's date of birth falls on the

1st through the 15th day of the month. No Contribution for the first month is required if the child's date of birth falls on the 16th through the last day of the month.

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

If the date of adoption or the date of placement for adoption of a child is more than sixty (60) days after the child's date of birth, the Effective Date of coverage will be the date of adoption or the date of placement for adoption. In this Summary Plan Description, '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 Summary Plan Description, "placed for adoption" means physical placement in the care of the adoptive Participant, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it means when the adoptive Participant signs an agreement for adoption of the child and signs an agreement assuming financial responsibility for the child.

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.

IV. Qualified Medical Child Support Order

A. If this Summary Plan Description provides for Family Coverage, the Contract Administrator, will comply with a Qualified Medical Child Support Order (QMCSO) according to the provisions of applicable federal or state laws. A medical child support order is any 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 a Participating Employee or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law) and relates to benefits under this Summary Plan Description**,** or
2. Enforces a law relating to medical child support described in Section 1908 of the Social Security Act with respect to a group health plan.

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

1. The name and the last known mailing address (if any) of the Participating Employee and the name and mailing address of each child covered by the order.
2. A reasonable description of the type of coverage to be provided by this Summary Plan Description 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, the Contract Administrator will notify the party who sent the order and each affected child of the receipt and of the criteria by which the Contract Administrator determines if the medical child support order is a QMCSO. In addition, the Contract Administrator 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 the Contract Administrator. 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, the Contract Administrator will determine if the medical child support order is a QMCSO and will notify the Participating Employee, the party who sent the order, and each affected child of such determination.

D. The Contract Administrator, on behalf of the Trust, 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 the Plan. Other terms may be defined where they appear in this Summary Plan Description. All Providers and Facilities must be licensed, certified, accredited and/or registered, where required, to render Covered Services. For the purposes of this Summary of Health Care Benefits, 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 Summary Plan Description shall control over any other definition or interpretation unless the context clearly indicates otherwise.

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

Administrative Services Agreement—a formal agreement between the Contract Administrator and the Trust outlining responsibilities, general administrative services and benefit payment services.

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 Plan.

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

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

Benefits Outline—a listing of certain Covered Services specifying Cost Sharing, Copayments and Benefit limitations and maximums under this Summary Plan Description.

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

Blended Lenses—bifocals that do not have a visible dividing line.

Board of Trustees—the Board of Trustees of the Idaho School Benefit Trust has all discretionary authority to interpret and apply the terms and provisions of the Plan and to control the operation and administration of the Plan within applicable law. The Board of Trustees may adopt such rules as it deems necessary, desirable, or appropriate. All determination, interpretations, rules, and decisions of the Board of Trustees shall be made in its sole discretion and shall be conclusive and binding upon all persons having or claiming to have an interest or right under the Plan. The Board of Trustees may contract with one or more service agents, including the Contract Administrator, to assist in the handling of claims under the Plan and/or to provide advice and assistance in the general administration of the Plan. Such agent(s) may also be given limited authority to determine claims and make payments of benefits under the Plan on behalf of the authority of the Board of Trustees. The Board of Trustees also reserves and has the right to amend, modify or terminate the Plan at any time or in any manner.

Coated Lenses—a substance added to a finished lens on one (1) or both surfaces.

Contact Lenses—ophthalmic corrective Lenses (either glass or plastic, ground or molded). They must be prescribed by an Optometrist or Ophthalmologist to be directly fitted to the Participant's eye.

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

Contribution—the amount paid or payable by the Participating School District or Eligible Employee into the Trust fund.

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

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

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

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

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

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

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

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

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

Eligible Employee—an employee of a Participating School District who is entitled to apply as a Participating Employee.

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

Frame—a standard eyeglass Frame adequate to hold Lenses.

Idaho School Benefit Trust Program—the self-funded program for the pool of Participating School Districts who provide benefits for Eligible Employees and Eligible Retirees by selecting benefit options provided in the Plan.

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).

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

Investigational—any technology (service, supply, procedure, treatment, drug, device, facility, equipment or biological product), which is in a developmental stage or has not been proven to improve health outcomes such as length of life, quality of life, and functional ability. A technology is considered investigational if, as determined by VCSV, it fails to meet any one of the following criteria:

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

4. The technology must be as beneficial as any established alternatives.
5. The technology must show improvement that is attainable outside the investigational setting. Improvements must be demonstrated when used under the usual conditions of medical practice.

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

Lenses—ophthalmic corrective Lenses (either glass or plastic, ground or molded). They must be prescribed by an Optometrist or Ophthalmologist/Physician to improve visual acuity or performance and to be fitted to a Frame. Amounts payable are based on a lens blank not more than sixty-one (61) millimeters in diameter, tinted no darker than the equivalent of Pink #1 or #2 and without photosensitive or anti-reflective properties.

Maximum Allowance—for Covered Services under the terms of the Plan, Maximum Allowance is the lesser of the billed charge or the amount established as the highest level of compensation for a Covered Service as established by the VCSV.

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 to be:

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

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

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

In determining whether a service is Medically Necessary, the Contract Administrator considers the medical 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 Plan Reference Manual as adopted by the Contract Administrator, and Blue Cross of Idaho Medical Policies. The Contract Administrator also considers, current published medical literature and peer review publications based upon scientific evidence, and evidence-based guidelines developed by national organizations and recognized authorities.

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

Nonparticipating or Noncontracting Provider—a Provider that has not entered into a written agreement with the VCSV regarding payment for Covered Services rendered to a Participant under the Plan.

Ophthalmologist—a Doctor of Medicine (M.D.) who is both a medical doctor and a surgeon. The ophthalmologist is licensed to exam, diagnose and treat disorders and diseases of the eye and visual system of the brain, as well as prescribe corrective lenses (glasses or contacts).

Optometrist—a person who is licensed and specializes in optometry to examine, measure and treat certain visual defects by means of corrective lenses or other methods that do not require a license as a physician.

Orthoptics—the teaching and training process for improvement of visual perception and coordination of the two (2) eyes for efficient and comfortable binocular vision.

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

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

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

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

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

Participating Provider—a Provider that has entered into a written agreement with the VCSV regarding payment for Covered Services rendered to a Participant under the Plan.

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

Physician—a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) licensed to practice medicine.

Plan(s)—a multiple employer plan under which payment for medical, surgical, hospital, and other services for prevention, diagnosis, or treatment of any disease, injury, or bodily condition of an Eligible Employee is, or is to be, regularly provided for or promised from funds created or maintained in whole or in part by Contributions or payments thereto by the Participating School District and Eligible Employees.

Plan Date—the date specified in this Summary Plan Description on which coverage commences for the Participating School District.

Plan Sponsor—Idaho School District Cooperative Services Council.

Plano Lenses—lenses with refractive correction of less than ± .50 diopter.

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

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

Provider—a person or entity that is licensed, certified, accredited and/or registered, where required, to render Covered Services. For the purposes of this Summary Plan Description, Providers include only Ophthalmologist and Optometrists.

Summary Plan Description—this description of the benefits provided under the Plan.

Surgery—within the scope of a Provider's license, the performance of:
1. Generally accepted operative and cutting procedures.
2. Invasive procedures using specialized instruments.
3. Customary preoperative and postoperative care.

Tinted Lenses—Lenses that have an additional substance added to produce constant tint.

Trust—the Idaho School Benefit Trust, also the Board of Trustees.

Trustee—the trustee, whether a single or multiple trustees of the Trust.

Vision Care Services Vendor (VCSV)—an entity contracting with the Contract Administrator to provide Vision Care Services to Participants.

EXCLUSIONS AND LIMITATIONS SECTION

The following exclusions and limitations apply to the entire Summary Plan Description, unless otherwise specifically listed as a Covered Service in this Summary Plan Description.

I. General Exclusions and Limitations

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

A. Not Medically Necessary.

B. In excess of the Maximum Allowance.

C. Not prescribed by or upon the direction of an Optometrist or Ophthalmologist or other professional Provider; or which are furnished by any individuals or facilities other than Physicians, and other Providers.

D. Investigational in nature.

E. 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.

F. Provided or paid for by any federal governmental entity or unit except when payment under the Plan 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 this Summary Plan Description.

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

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

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

J. Rendered prior to the Participant's Effective Date.

K. For telephone consultations, and all computer or Internet communications; 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 Physician or other Professional Provider.

L. 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.

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

In the event the Contract Administrator for any reason makes payment for or otherwise provides benefits excluded by the above provisions, the Trust 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 Contract Administrator in connection with such Illness, Disease, Accidental Injury or other condition.

N. For which a Participant would have no legal obligation to pay in the absence of coverage under this Summary Plan Description 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.

O. 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.

P. Provided outside the United States, which if had been provided in the United States, would not be a Covered Service.

Q. Furnished by a Provider or caregiver that is not listed as a Covered Provider.

R. For the purchase of Therapy or Service Dogs/Animals and the cost of training/maintaining said animals.

S. Orthoptics or other vision training and any associated supplemental testing.

T. Plano Lenses.

U. Two (2) pair of eyeglasses in place of bifocals.

V. Replacement of Lenses, Frames or Contact Lenses furnished hereunder that are lost or broken (Lenses, Frames or Contact Lenses are only replaced at the normal intervals when Covered Services are otherwise available).

W. Medical or surgical treatment of the eye(s).

X. Any eye examination or any corrective eyewear required by an employer as a condition of employment.

Y. Solutions and/or cleaning products for eyeglasses or Contact Lenses.

Z. Contact lens insurance policies or service agreements.

AA Refitting of Contact Lenses after the initial ninety (90) day fitting period.

BB. Contact lens modification, polishing or cleaning.

CC. Local, state and/or federal taxes, except where the VCSV is required by law to pay.

DD. Professional services associated with Corneal Refractive Therapy (CRT), Orthokeratology, or myopia management.

GENERAL PROVISIONS SECTION

I. Termination or Modification of a Participant's Coverage

A. If a Participating Employee ceases to be an Eligible Employee or the Participating School District does not remit the required Contribution, the Participating Employee's coverage and the coverage of any and all enrolled Eligible Dependents will terminate on the last day of the last month for which payment was made. If the Participating School District does not remit the required payments as required by the Administrative Services Agreement and the Contract Administrator elects to terminate this Agreement, the Participating Employee's coverage and the coverage of any and all enrolled Eligible Dependents will terminate on the last day for which the Participating School District reimbursed the Contract Administrator for the payment of claims and administrative fees.

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

C. Termination or modification of this Summary Plan Description automatically terminates or modifies all of the Participant's coverage and rights hereunder. It is the responsibility of the Participating School District to notify all of its Participants of the termination or any modification of this Summary Plan Description, and the Contract Administrator's notice to the Participating School District, upon mailing or any other delivery, constitutes complete and conclusive notice to the Participants.

D. No benefits are available to a Participant for Covered Services rendered after the date of termination of a Participant's coverage.

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

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

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

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

G. Coverage under this Summary Plan Description will terminate for an Eligible Dependent on the last day of the month the Participant no longer qualifies as an Eligible Dependent due to a change in eligibility status.

II. Benefits After Termination of Coverage

A. Continuation of Coverage Under Federal Law

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

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

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

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

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

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

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

To choose this continuation of coverage, an individual must be a Participating Employee or an enrolled Eligible Dependent under this Summary Plan Description on the day before the qualifying event.

B. Notification Requirement

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

The Participating School District has the responsibility of notifying the Contract Administrator of your death, termination of employment, reduction in hours, or entitlement to Medicare within thirty (30) days of the qualifying event.

The Contract Administrator, on behalf of the Trust, will notify a qualifying individual of continuation coverage rights with respect to those health care benefits under the Plan that are administered by the Contract Administrator within fourteen (14) days of notification from the Participating School District. The qualifying individual then has sixty (60) days to elect continuation coverage. Failure to elect continuation coverage within sixty (60) days after being notified by the Contract Administrator, on behalf of the Trust, will result in loss of continuation of coverage rights.

C. Cost of Continuation Coverage

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

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

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

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

D. Maximum Period of Continuation Coverage

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

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

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

E. Multiple Qualifying Events

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

F. When Continuation Coverage Ends

Continuation Coverage ends on the earliest of:

1. The date the maximum continuation period expires.
2. The date the qualifying individual becomes entitled to coverage under Medicare.
3. The last period for which payment was made when coverage is cancelled due to nonpayment of the required cost.
4. The date the Trust no longer offers a group health plan to any of its employees.
5. The date the qualifying individual becomes covered under another group health plan that does not exclude or limit coverage for a pre-existing condition the qualifying individual may have.

III. Contract Between the Contract Administrator and the Trust

This Summary Plan Description is part of the Administrative Services Agreement between the Contract Administrator and the Trust. The Contract Administrator will provide the Participating School District with copies of the Summary Plan Description to give to each Participating Employee as a description of coverage or provide electronic access to the Summary Plan

Description, but this Summary Plan Description shall not be construed as a contract between the Contract Administrator and any Participating Employee. The Contract Administrator's mailing or any electronic delivery of the Plan to the Participating School District constitutes complete and conclusive issuance and delivery thereof to each Participating Employee.

IV. Benefits to Which Participants are Entitled

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

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

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

The Contract Administrator will provide benefits for Covered Services incurred following the Effective Date of coverage reduced by the benefits paid by the outgoing carrier.

C. The Contract Administrator will be provided only if Covered Services are prescribed by, or performed by, or under the direction of a Physician or other Professional.

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

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

V. Notice of Claim

The Contract Administrator will process claims for benefits on behalf of the Participating School District according to the Administrative Services Agreement between the parties. A claim for Covered Services must be submitted within one year from the date of service and must include all the information necessary for the Contract Administrator to determine benefits.

VI. Release and Disclosure of Medical Records and Other Information

A. In order to effectively apply the provisions of the Plan, the Contract Administrator may obtain information from Providers and other entities pertaining to any health related services that the Participant may receive or may have received in the past. The Contract Administrator may also disclose to Providers and other entities, information obtained from the Participant's transactions, Contributions, payment history and claims data necessary to allow the processing of a claim and for other health care operations. To protect the Participant's privacy, the Contract Administrator treats all information in a confidential manner.

VII. Exclusion of General Damages

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

VIII. Payment of Benefits

The Contract Administrator (Blue Cross of Idaho) 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 Trust, 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 Trust, 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 Trust, 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 Trust, nor may the right to receive benefits for Covered Services under this Summary Plan Description 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. The Contract Administrator and the Trust prohibits direct or indirect payment by third parties unless it meets the standards set below.

Family, friends, religious institutions, private, not-for-profit foundations such as Indian tribes, tribal organizations, urban Indian organizations, state and federal government programs or grantees or sub-grantees such as the Ryan White HIV/AIDS Program and other similar entities are not prohibited from paying contribution on behalf of an individual receiving medical treatment. Cost Sharing contributions made from permitted third parties will be applied to the Participants applicable Deductible and/or Out-of-Pocket Limit.

Each of the following criteria must be met for the Contract Administrator or the Trust to accept a third party payment:

1. the assistance is provided on the basis of the Participant’s financial need;
2. the institution/organization is not a healthcare Provider; and
3. the institution/organization is not financially interested. Financially interested institutions/organizations include institutions/organizations that receive the majority of their funding from entities with a pecuniary interest in the payment of health insurance claims, or institutions/organizations that are subject to direct or indirect control of entities with a pecuniary interest in the payment of health insurance claims.

To assist in appropriately applying Cost Sharing contributions made from a permitted third party to the Participants applicable Deductible and/or Out-of-Pocket Limit, the Participant is encouraged to provide notification to the Contract Administrator if they receive any form of assistance for payment of their contribution, Cost Sharing, Copayment or Deductible amounts.

Contributions submitted in violation of this provision will not be accepted and the Eligible Employee’s Plan may be terminated for non-payment. Cost Sharing contributions made from non-permitted third parties will not be applied to the Participants applicable Deductible and/or Out-of-Pocket Limit. The Contract Administrator will inform the Participant in writing of the reason for rejecting or otherwise refusing to treat a third party payment as a payment from the Participant.

C. Once Covered Services are rendered by a Provider, the Contract Administrator, on behalf of the Trust, shall not be obliged to honor Participant requests not to pay claims submitted by such Provider, and the Contract Administrator, on behalf of the Trust, 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 Trust, may nonetheless deny all or any part of any Provider claim.

IX. 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 Trust 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.

X. Participating Plan

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

XI. Coordination of the Plan's Benefits with Other Benefits

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

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

A. Definitions

1. A Contract is any of the following that provides benefits or services for medical or dental care or treatment. If separate Contracts are used to provide coordinated coverage for members of a group, the separate Contracts are considered parts of the same Contract and there is no COB among those separate contracts.

   a) Contract includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

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

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

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

only with similar benefits, any may apply under COB provision to coordinate other benefits.

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

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

   The following are examples of expenses that are not Allowable Expenses:

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

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

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

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

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

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

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

B. Order of Benefit Determination Rules

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

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

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

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

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

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

   a) Non-Dependent or Dependent. The Contract that covers the Participant other than as a dependent, for example as an employee, member, planholder, subscriber or retiree is the Primary Contract and the Contract that covers the Participant as a dependent is the Secondary Contract. However, if the Participant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Contract covering the Participant as a dependent; and primary to the Contract covering the Participant as other than a dependent (e.g. a retired employee); then the order of benefits between the two Contracts is reversed so that the Contract covering the Participant as an employee, member, planholder, 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 Participant as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Contract. The Contract covering that same Participant as a retired or laid-off employee is the Secondary Contract. The same would hold true if a Participant is a dependent of an active employee and that same Participant is a dependent of a retired or laid-off employee. If the other Contract does not have this rule, and as a result, the Contracts do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a) can determine the order of benefits.

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

e) Longer or Shorter Length of Coverage. The Contract that covered the Participant as an employee, member, policyholder, subscriber, or retiree

longer is the Primary Contract and the Contract that covered the Participant the shorter period of time is the Secondary Contract.

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

C. Effect on the Benefits of this Contract

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

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

D. Facility of Payment

A payment made under another Contract may include an amount that should have been paid under this Contract. If it does, the Contract Administrator 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. The Contract Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

E. Right of Recovery

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

XII. Benefits for Medicare Eligibles Who are Covered Under the Plan

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

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

C. A Participant eligible for Medicare based solely on end stage renal Disease is entitled to receive the benefits of the Plan as primary for eighteen (18) months only, beginning with the month of Medicare entitlement, if Medicare entitlement is effective before March 1, 1996. If Medicare entitlement is effective on or after March 1, 1996, the Participant is entitled to receive the benefits of the Plan as primary for thirty (30) months only, beginning with the month of Medicare entitlement. Medicare is secondary during the thirty (30)-month period, known as the coordination period. When the Plan is primary, it pays in accordance with the terms of the Plan. In certain circumstances, such as when using a Noncontracting Provider, Participants may be responsible for amounts in excess of the Maximum Allowance. Medicare does not typically permit billing for amounts in excess of the Maximum Allowance, when it is primary. Participants should contact Medicare for more information about their options.

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

XIII. Incorporated by Reference

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

XIV. Inquiry and Appeals Procedures

A. Informal Inquiry

The Contract Administrator has delegated certain activities, including Appeals, to the VCSV, though the Contract Administrator retains ultimate responsibility over these activities. For any initial questions concerning a claim, a Participant should call the VCSV phone number 844-348-0848. If the VCSV cannot resolve the Participant's concern to their satisfaction, the Participant or the Participant's authorized representative may submit a written request to the VCSV for review. A written request can be made by completing the form available on www.vsp.com Website or by sending the written request by mail to the VCSV at: Vision Service Plan, Attention: Complaint and Grievance Unit, P.O. Box 997100, Sacramento, CA 95899-7100. Verbal requests can be made by calling the VCSV phone number.

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

B. Formal Appeal

A Participant 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 Contract Administrator requires that a Participant execute an "Appointment of Authorized Representative" form before the Contract Administrator, on behalf of the Trust 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 the Contract Administrator's Medical Director or physician designee, or a designee. For non-urgent claim appeals, the Contract Administrator or a VCSV designee will mail a written reply to the Participant within fifteen (15) days after receipt of the written appeal. Urgent claim appeals will be notified orally within seventy-two (72) hours. If the original decision is upheld, the reply will state the specific reasons for denial and the specific provisions on which the decision is based. Each appeal will be processed as quickly as possible taking into account the medical exigencies of each claim.

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 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 or its VCSV designee's mailing of the initial reconsideration decision. The Contract Administrator's Medical Director or its VCSV designee who is not subordinate to the Medical Director or physician designee who decided the initial appeal, will issue a final decision after consideration of all relevant information. A final decision on the appeal will be made within fifteen (15) days of its receipt.

C. A Participant who wishes to formally appeal a Post-Service Claims decision 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 Contract Administrator requires that a Participant execute an "Appointment of Authorized Representative" form before the Contract Administrator, on behalf of the Trust 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 Contract Administrator's or a VCSV designee's 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 Medical Director, or physician designee if the appeal requires medical judgment. The Contract Administrator or a VCSV designee's 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 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 (or a VCSV designee's) mailing of the initial reconsideration decision. A Medical Director of the Contract Administrator who is not subordinate to the Medical Director physician designee, or a VCSV designee who decided the initial appeal, will issue a final decision after consideration of all relevant information, if the appeal requires medical judgment. A final decision on the appeal will be made within thirty (30) days of its receipt. If the appeal does not require medical judgment, a Vice President of the Contract Administrator who did not decide the initial appeal will issue the decision.

D. External Review

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

XV. Reimbursement of Benefits Paid by Mistake

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

The reimbursement is due and payable as soon as the Contract Administrator notifies the Participating Employee and requests reimbursement. The Contract Administrator, on behalf of the Trust, 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 Trust, may reduce benefits or reduce an allowance for benefits as a set-off toward reimbursement.

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

XVI. Subrogation and Reimbursement Rights

The benefits of this Summary Plan Description 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 Trust under this Summary Plan Description, agreement, certificate, contract or plan, the Contract Administrator, on behalf of the Trust 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 Trust 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 Trust 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 Trust may initiate litigation at its sole discretion, in the name of the Participant, against any third party or parties. Furthermore, the Participant shall fully cooperate with 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 Contract Administrator's subrogation rights and efforts. The Contract Administrator, on behalf of the Trust 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 Trust 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 Trust.

Additionally, the Contract Administrator, on behalf of the Trust may at its option elect to enforce its 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 Trust in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm or loss and shall do nothing whatsoever to prejudice the Plans reimbursement rights and efforts.

The Participant shall pay the Contract Administrator, on behalf of the Trust as the first priority, and the Contract 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 Trust under this Summary Plan Description, regardless of how the recovery is allocated (i. e., pain and suffering) and whether the recovery makes the Participant whole. Thus, the Contract 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 Trust 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 Trust.

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

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, and for benefits to be provided or payments to be made by the Contract 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’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 Contract Administrator' s subrogation and reimbursement rights, and shall constitute a Special Credit applicable to such future benefits and payments that would otherwise be owed by the Plan, or any subsequent group health plan provided by the Trust. Thereafter, the Contract Administrator, on behalf of the Trust, shall have no obligation to provide any further benefits or make any further payments until the Participant has incurred medical expenses in treatment of such injury, harm or loss equal to such Special Credit.

XVII. Statements

In the absence of fraud, all statements made by an applicant, or the planholder, or by an enrolled person shall be deemed representations and not warranties, and no statement made for the purpose of acquiring coverage under the Plan shall void such coverage under this Summary Plan Description or reduce benefits unless contained in a written instrument signed by the Participating School District or the enrolled person.

XVIII. Coverage and Benefits Determination

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