Idaho School Benefit Trust

Lakeland School District S272
Group #10034591
Renewal Rates Effective 09/01/2025--08/31/2026

Medical Benefit	HMO Blue N-1	Blue Value 500	HSA 3300
Product	HMO Blue	Blue Value	HSA
Deductible IN (Indiv/Fam)	N/A	$500/$1,000	$3,300/$6,600
Deductible OON (Indiv/Fam)	$750/N/A	$1,000/$2,000	Combined w/ IN
Medical OOP Max IN (Indiv/Fam)	$1,500/N/A	$3,500/$7,000	$5,800/$11,600
Medical OOP Max OON (Indiv/Fam)	N/A	$6,000/$12,000	Combined w/ IN
Member Coinsurance (IN/OON)	N/A/50%	20%/40%	30%/50%
Physician Copay	$20	$20	Ded, Coin
Specialist Copay	$40	$40	Ded, Coin
Prescription Drugs	10/30/50 250 Ded	10/30/50 250 Ded	30% coin aft Ded, $0 prev
Prescription Drugs OOP (Indiv/Fam)	$2,000/N/A	$2,000/$4,000	Subject to Medical
Commission PEPM	$9.75		

Dental Benefit	N/A
Enrollment	
Deductible	
Coinsurance	
Benefit Max	
Ortho	
DBC Benefit	Plan 1
Commission PEPM	N/A

Vision Benefit	N/A
Enrollment	
Exam Copay	
Frame Frequency	
EAP Benefit	6 Visits
Cobra	N
Wellness	None

Current Rates

	HMO Blue N-1	Blue Value 500	HSA 3200	Dental	Dental Blue Connect Plan 1	Vision	EAP	Wellness
Enrollee	$796.25	$714.10	$562.20	$0.00	$54.39	$0.00	$2.30	$0.00
Ee + Spouse	$1,739.95	$1,558.70	$1,211.35	$0.00	$117.61	$0.00	$2.30	$0.00
Ee + 1 Child	$1,220.90	$1,094.20	$854.25	$0.00	$104.56	$0.00	$2.30	$0.00
Ee + Children	$1,417.70	$1,270.15	$989.55	$0.00	$155.50	$0.00	$2.30	$0.00
Ee + Sp + Child(ren)	$2,015.40	$1,805.00	$1,400.70	$0.00	$208.58	$0.00	$2.30	$0.00

Renewal Rates

	HMO Blue N-1	Blue Value 500	HSA 3300	Dental	Dental Blue Connect Plan 1	Vision	EAP	Wellness
Enrollee	$852.90	$764.80	$599.85	$0.00	$58.03	$0.00	$2.30	$0.00
Ee + Spouse	$1,864.50	$1,670.20	$1,293.25	$0.00	$125.49	$0.00	$2.30	$0.00
Ee + 1 Child	$1,308.10	$1,172.30	$911.80	$0.00	$111.57	$0.00	$2.30	$0.00
Ee + Children	$1,519.05	$1,360.90	$1,056.30	$0.00	$165.92	$0.00	$2.30	$0.00
Ee + Sp + Child(ren)	$2,159.80	$1,934.25	$1,495.50	$0.00	$222.55	$0.00	$2.30	$0.00

Current Enrollment

	HMO Blue N-1	Blue Value 500	HSA 3300	Dental	DBC	Vision
Enrollee	295	70	27	0	111	0
Ee + Spouse	4	11	4	0	20	0
Ee + 1 Child	24	14	7	0	12	0
Ee + Children	29	36	2	0	11	0
Ee + Sp + Child(ren)	25	25	5	0	30	0

The quote conditions along with the rate page(s) together comprise the entire quote.
By signing you are agreeing to all Underwriting conditions and quote assumptions provided herein.

Authorized Representative: Signed by: Jessica Grantham 0BBC54DF0FEB437...

Printed Name: Jessica Grantham

Date: 6/20/2025 | 11:29 AM EDT

Idaho School Benefit Trust

Underwriting Quote Conditions

* Unless stated otherwise, this proposal assumes the current plan of benefits remains in place.
* For dual/multiple plan offerings, each plan must have at least 5% of the total group enrollment.
* Rates are effective from 09/01/2025--08/31/2026. This offer must be accepted at least 15 days prior to the effective date. No
* Rates are based on the assumption of participation of at least 75% of all eligible employees.
* Dependent eligibility must flow through the enrolled subscriber.
* The attached rates assume common eligibility between all lines of coverage.
* Rates assume at least 50% employer contribution for employees.
* We are not issuing a renewal rate guarantee.
* No member is allowed to opt off coverage in lieu of compensation.
* The broker/agent, if applicable, is acting as the representative of the group/employer.

Idaho School Benefit Trust reserves the right to adjust the quoted rates if:

* The actual number of enrollees changes by more than 10% from the number of enrolled contracts noted above.
* Deductibles, coinsurance and/or co-payments will be self-funded by the employer and this was not disclosed during the
* New or revised State or Federal mandated benefits or fees/taxes become effective during the group's contract period.
* New or revised reports are to be received by the group/broker.
* Changes to the benefit plan(s) are requested by the group and agreed to by Blue Cross of Idaho.
* Changes are made to the employer contribution, employee eligibility, or probationary period.
* Enrollee participation falls below 75%.
* Any of the conditions listed above need to be changed.

~ Important Summary of Benefits and Coverage Information ~

To view and print a copy of the Summary of Benefits and Coverage (SBC) for your groups current coverage options
and the uniform glossary, please log in to the employer portal of our website at bcidaho.com/employers.
If you need assistance registering on the Blue Cross of Idaho website, please contact your Account Representative.

If you have questions about the SBC, need language assistance or would like a paper copy free of charge,
please refer to the Customer Service number on the back of your Blue Cross of Idaho ID cards or call 1-800-627-1188.
You can also visit our website at bcidaho.com/SBC for more information.

The quote conditions along with the rate page(s) together comprise the entire quote.

IDAHO SCHOOL BENEFIT TRUST
EMPLOYER PARTICIPATION AGREEMENT

Plan Year: September 1, 2025 – August 31, 2026

This is a 12-Month Binding Contract

The Idaho School Benefit Trust (the "Trust") provides certain medical, dental, and vision benefits to active employees and pre-65 retirees of participating Employers. These medical, dental and vision benefits are not fully insured coverage. The Trust does not participate in the state guaranty association. Rather, the Trust funds the payment of claims through Employer and employee contributions up to a certain limit and then has an agreement for stop-loss coverage that pays for all 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.

1. Participating School District (the "Employer")

School District Name: Lakeland School District
Mailing Address: 15506 N Washington Street City: Rathdrum Zip: 83858
District Superintendent: Lisa Arnold
Email: larnold@lakeland272.org Phone: 208-687-0431 Fax: 208-687-1884

2. Benefit Programs Selected for the Upcoming Year. The Employer will offer the benefit options selected in the accompanying Trust Benefit Selection Agreement(s), which show the plan type, deductible, coinsurance, copayment, and rates selected by the Employer for the upcoming 12-month Plan Year. The Employer's superintendent or official designee must sign the Trust Benefit Selection Agreement(s).

3. Trust Contributions. The Employer understands and agrees that continued participation in the Trust and the continued coverage of employees and dependents is conditioned on the Employer making full and timely contributions to the Trust (or its designee) each month of the Plan Year. Failure to make full and timely contribution payments will result in claims payments being delayed and may result in termination of the Employer's participation in the Trust. In addition, the Trustees may terminate an Employer's participation in the Trust for a material failure to comply with the terms of this Agreement. Any early termination of the Employer's participation, either by the Trust or by the Employer, will be subject to the Delinquent Contribution Policy in Appendix A.

4. Additional Required Information. The Trust (or its designee) may request additional information from the Employer to satisfy certain compliance requirements. The Employer agrees to cooperate in a timely manner to provide such requested information.

5. Additional Terms & Conditions. By entering into this Agreement, you agree to abide by the additional terms and conditions in Appendix A, which is attached hereto. The Trust's delay in exercising or failure to exercise any right, power or privilege under this Agreement on any occasion shall not operate as a waiver; nor shall any single or partial exercise of any right, power or privilege preclude any other or further exercise thereof.

6. Broker Commissions and Disclosure. The Trust (or its designee) will honor an Employer's written request to pay compensation in the form of a commission to the Employer's broker. Such commissions will be included in the Employer's rates.

7. Acknowledgement. I have reviewed this Agreement, including the Trust Benefit Selection Agreement(s) and the Additional Terms & Conditions, which are incorporated herein and made part of this Agreement. On behalf of my District, I agree to the terms herein for September 1, 2025, through August 31, 2026, Plan Year.

Signature of Employer Representative (as authorized by the Superintendent):

Signed: Signed by: Jessica Grantham 0BBC54DF0FEB437... Date: 6/20/2025 | 11:29 AM EDT

APPENDIX A

IDAHO SCHOOL BENEFIT TRUST
EMPLOYER PARTICIPATION AGREEMENT

Plan Year: September 1, 2025 – August 31, 2026

This Appendix is incorporated into and part of the Employer Participation Agreement. Defined terms (i.e. capitalized terms such as Trust, and Employer) in this Appendix have the same meanings as in the Employer Participation Agreement.

Employee Participation Requirements

You must offer participation in the Trust to at least **85%** of your eligible employees. An eligible employee is one who works the required number of hours (on average) per week and who has completed the Employer's required probationary period (not to exceed 90 calendar days). Should the total enrollment of eligible employees fall below the required **85%**, you will be subject to a surcharge or discontinuation at the next renewal date. Existing districts that do not meet this criterion must submit to the Trust office a written plan showing how and when compliance will be accomplished. Eligibility for participation in the plan may be audited at any time.

Monthly Contributions

The Trustees approve the annual amount of the contributions, as determined by a qualified actuary, that are payable by participating Employers. The Trustees have the right to change the contribution amounts and how the amount is determined. By entering into this Agreement, you agree to the amounts that the Trustees have established for your group. You further agree to pay all contributions for the 12-month Plan Year by the due date in each month's invoice and to abide by the Trust's Delinquent Contributions Policy below.

Delinquent Contribution Policy

Employer and employee contributions are due from the Employer in a timely manner each month. The Employer's account will be considered delinquent if payment is not received, in full, by the due date on the monthly invoice. If payment is 30 days late, benefit coverage for the entire Employer group may be terminated back to the last day of the month in which a full contribution was paid. Contributions are due in full; partial payments will not be accepted as full payment. If an Employer leaves the Trust at the end of a Plan Year and has outstanding payments, the Trust is authorized to collect the outstanding payments. If an Employer is terminated during the Plan Year for non-payment or other material failure to comply with the terms of the Employer Participation Agreement, the Employer will still be responsible for paying the remaining contributions through the end of the Plan Year. If an Employer breaches this Employer Participation Agreement by leaving the Trust during the Plan Year, the Employer will still be responsible for paying the remaining contributions through the end of the Plan Year. The obligation to pay all contributions for the full 12-month Plan Year exists to protect the other Employers participating in the Trust and to protect the financial integrity of the Trust. If there is an outstanding balance and the Employer does not bring the account current within 30-days, the Trust is authorized to take legal action to collect the outstanding payments. If an Employer is delinquent or terminated due to non-payment of all or a portion of its contribution, employees and former employees may lose their coverage rights, and such liability will be the responsibility of the Employer.

Changes to Benefit Options

The Trustees have the right to make changes to the benefits from time to time, as they deem necessary in the operation and administration of the Trust. You will be notified of such changes, and you agree to notify your covered employees and their dependents within 30 days of receipt of such notice of changes to the benefits.

Plan Summaries, Policies and Procedures

The Trustees have the authority and right to establish plan documents (including summary plan descriptions and benefit outlines), policies and procedures, as they deem necessary, for the operation and administration of the Trust. Such policies and/or procedures may include rules for minimum waiting periods applied to Employers that leave the Trust and for reserve contributions from Employers that were not recently participating in the Trust. By entering into this Agreement, you agree to abide by the terms and conditions of these documents, policies and procedures.

Summary of Benefits and Coverage (SBC)

Employers must complete and return all enrollment/renewal materials, including an SBC attestation of delivery, in a prompt and timely manner to the Trust office (or its designee). Incomplete or delayed enrollment/renewal materials may cause delays in processing and affect the Employer's ability to view SBCs. The Employer must register for access to the Blue Cross of Idaho Employer portal if you are new to the Trust or don't currently have a login. Employers must deliver the SBCs to all eligible employees (even those not enrolled) and dependents for all selected plan options 30 days prior to the start of the new Plan Year. The Employer must promptly notify the Trust office of any changes to coverage or issues regarding SBCs.

Employer Benefit Selections

Group enrollment in the benefit options is available annually for a September 1 effective date of coverage. Employer changes between benefit options are not available during the Plan Year, unless allowed by law and approved by the Trustees.

Employer Changes

You will notify the Trust office in writing within 30 days of any changes to your waiting periods, eligibility requirements, or other information described in this Agreement. These changes, if approved by the Trustees (or their designee), will be effective the first of the month following receipt of the notice to the Trust office. Employees hired before the effective date of the change will remain subject to the previous rules set by the Employer for the remainder of the Plan Year.

Changes in Employee Information, Eligibility or Enrollment

Within 30 days following the event, you must notify the Trust office (or its designee) of any of the following changes:

- Change to an employee's or dependent's address.
- Change in enrollment or eligibility, including but not limited to:
    - termination of employment or reduction in hours.
    - employee's death or entitlement to Medicare.
    - ineligible dependents if participating Employer is notified.
    - newly eligible dependents due to marriage, birth, or adoption.
- Leave of absence, including when an employee takes an FMLA leave or a USERRA leave, or fails to return to covered employment from an FMLA leave or a USERRA leave.
- Receipt of Qualified Medical Child Support Orders.

The Employer will be responsible to reimburse the Trust for any claims paid on behalf of ineligible employees and/or their dependents that result from a failure of the Employer to notify the Trust in a timely manner of changes or terminations. In addition, the Employer will be responsible to reimburse the Trust for any claims paid on behalf of ineligible employees and/or their dependents that are covered because of incorrect information.

Leaves of Absence

The Trust office must receive notified, in writing, containing the employee's name, the date the leave was granted, and the length of the leave within 30 days of the date of the leave event. A leave of absence can only be allowed when an employee is experiencing a personal or medical situation that is requiring the employee to be off the job for an extended period or for an employee that is working reduced hours, but not separated from the Employer. The Employer is responsible for contribution payments for the entire length of the leave of absence.

Open Enrollment

The Employer agrees to provide an open enrollment each year to all eligible employees prior to a September 1 effective date. During open enrollment, an employee or dependent who was not enrolled when he or she first became eligible, or as allowed under special enrollment conditions, may be enrolled, and enrollees may change plans if the Employer offers a dual choice.

COBRA

An Employer is subject to COBRA during the current calendar year if the Employer employed 20 or more employees on more than 50% of its typical business days in the preceding calendar year. This number is based on the total number of employees, not the number of employees covered. Part-time employees are included in the total employee count expressed as a fraction. The Trust's third-party administrator will send the required COBRA election notice and collect COBRA payments. However, the Employer will be required to comply with COBRA by, for example, properly providing the applicable COBRA general notice, timely notifying the Trust or its designee of COBRA qualifying events and satisfying other COBRA compliance requirements.

Legal Compliance

You understand and agree that as an Employer sponsoring an employee benefit plan for your employees you have certain legal obligations under state and federal law. By entering into this Agreement, you agree that you or your staff employees are familiar with or will become familiar with your compliance requirements under COBRA, FMLA, HIPAA, USERRA, PPACA and other applicable laws and regulations. Also, you agree that you will take the necessary steps and actions to comply with these laws and regulations and to cooperate with the Trust (or its designee) in satisfying its obligations to comply with applicable laws and regulations.

Trustees and Trust Agreement

By entering into this Agreement, you accept the appointment of the current Trustees of the Trust. By entering into this Agreement, you agree to abide by the terms and conditions of the Trust Agreement and the terms and conditions of the benefit options offered under the Trust, including the information described in this Agreement.

Miscellaneous

This Agreement supersedes any previous Employer participation or similar agreement. The laws of the State of Idaho shall govern this Agreement.

NORTHWEST
DENTAL BENEFITS

Dear Lakeland School District:

April 14, 2025

As our contract term nears its end on August 31,2025, our team warmly thanks you for a successful year of partnership. We are excited to see how many of your employees and dependents took advantage of their benefits, and we look forward to serving your smiles for another year.

For the term of September 1, 2025 – August 31, 2026, please find Lakeland School District's renewal rates below. Important Plan updates can be found in your Agreement, and a summary will be included with this Renewal Sheet.

TOP 10 SERVICE CODES

Code	Description	Count
D0120	Recare Examination	164
D1110	Adult-Prophylaxis	138
D0220	Intraoral-Periapical First Film	108
D0230	Intraoral-Pa Additional	93
D1206	Therapeutic Fl Varnish	86
D0274	Bitewings-Four Films	68
D1120	Child-Prophylaxis	53
D2392	Resin-Two Surfaces, Post-Perm	39
D1351	Sealant-Per Tooth	36
D0150	Comprehensive Oral Evaluation	32

CURRENT MEMBERSHIP

260

EE	44
E + S	26
E + C	22
E + Cx	66
E + F	102

In 2024, NWDB focused on greater access to care across the state while staying true to our roots and the amazing service we're known for.

12 NEW PRACTICES

28 ADDED DOCTORS

$8,800 DONATED LOCALLY

RENEWAL RATES	2024 Rates	2025 Rates
Employee Only	$42.77	$45.33
Employee + Spouse	$83.85	$88.88
Employee + Child	$96.23	$102.01
Employee + Children	$119.99	$127.19
Employee + Family	$164.84	$174.73

With gratitude,
The Northwest Dental Benefits Team

NORTHWEST
DENTAL BENEFITS

LAKELAND SCHOOL DISTRICT

GROUP UTILIZATION INFORMATION

$61,212.70
NWDB
ADDED VALUE

$109,222.40
TOTAL VALUE OF SERVICES PROVIDED

$66,899.90
ORTHODONTIA BENEFIT UTILIZED

$114,909.60
PREMIUMS PAID

288
TOTAL MEMBER VISITS

MEMBERSHIP INFORMATION

April 2024 MEMBERSHIP
228

CURRENT MEMBERSHIP
260

MOST VISITED OFFICE
Avondale Dental

NWDB UPDATES

Network Office Additions in:

Lewiston

Twin Falls

Idaho Falls

Blackfoot

Pocatello

Shelley

Orthodontia Update

Members must be seen at an In-Network Provider to be eligible for the full $2,500 Lifetime Orthodontia Maximum. Any orthodontist within a 5-mile radius of the nearest In-Network Provider is considered Out-of-Network and therefore not eligible for any benefit.

Members can see an Orthodontia Provider outside the 5-mile radius to be eligible for a reduced Lifetime Orthodontia Maximum of $2,000.

For a complete list of In-Network Providers:

Visit our website by scanning the QR Code or by searching NorthwestDentalBenefits.com.

EMPLOYER GROUP DENTAL SERVICES AGREEMENT
MANAGED CARE DENTAL PLAN

THIS EMPLOYER GROUP DENTAL SERVICES AGREEMENT - MANAGED CARE DENTAL PLAN ("Contract") is made this 14th of April, 2025 and is between NORTHWEST DENTAL BENEFITS, LLC, an Idaho limited liability company ("NWDB"), and Lakeland School District, (hereinafter referred to as "Group").

NWDB Number: 5272

Effective Date: September 1, 2025

Termination Date: August 31, 2026

Managed Care Service Area: North Idaho

Plan: Blue Square 2025

Term: This Contract will have a Term of one (1) year (the "**Term**") and will be renewed with updated terms from year-to-year, unless this Contract is terminated in accordance with the terms of this Contract prior to the anniversary of this Contract (the "**Termination Date**").

Cost for Services: Please refer to Schedule of Benefits and Copayments for all Covered Services and the associated member co-pays.

Monthly Premium Options:

Blue Square Plan 2025

Covered Employee Only:	$45.33 per month
Covered Employee + Spouse:	$88.88 per month
Covered Employee + Child:	$102.01 per month
Covered Employee + Children:	$127.19 per month
Covered Employee + Family:	$174.73 per month

Maximum Annual Benefit for non-Orthodontia Covered Services: $2,500. The term of this benefit extends the full calendar year, resetting January 1 of each year for Covered Services.

Lifetime Maximum Orthodontia Benefit: Up to $2,500 for treatment from an In-Network Orthodontist.

Out-of-Network Orthodontia: If a Member seeks treatment from an Orthodontist outside of a 5 mile radius from NWDB's nearest In-Network Orthodontist, the Member is eligible for up to $2,000 benefit. If an Out-of-Network Orthodontist is inside the 5 mile radius from the nearest In-Network Orthodontist, no benefit is available. If a practice has multiple locations, the visited location will be used for the geographic boundary determination. No benefit is available for Invisalign outside of NWDB's network of In Network Dental Practices.

When booking Invisalign® or HealthyStart® treatment from a Participating Provider, or traditional treatment from an In-Network Orthodontist, the Member is eligible for a lifetime maximum benefit up to $2,500.

In consideration of the application of the Group and of the payment of the Cost for Services as provided herein, NWDB accepts such application and agrees to provide benefits under the terms of this Contract.

1. GROUP DEFINED INFORMATION (GDI)

A. ELIGIBILITY FOR BENEFITS

The Covered Employee must meet the Group's requirements for Benefit Eligibility. NWDB will honor the Group's nternal classifications, departments, and statuses .

B. CONTINUATION OF SERVICES

A. **Is Group eligible for COBRA: Yes or No (choose one) Yes**

B. **If 'Yes', what entity is Administering COBRA:** Acrisure

C. **If a third party to the Group, does Group authorize NWDB to work directly with this Administrator: Yes or No (choose one) Yes**

C. COMMUNICATION

Point of Contacts. Please include a primary and secondary point of contact.

If to Group: NO CHANGES TO CURRENT

Billing and Group Administration:

1)_Name:_____Email:_____Phone:_____

2)_Name:_____Email:_____Phone:_____

3) Mailing Address:_____

Eligibility:

1)_Name:_____Email:_____Phone:_____

2)_Name:_____Email:_____Phone:_____

3) Mailing Address:_____

If to Broker:

Primary Point(s) of Contact:

1)_Name:_____Email:_____Phone:_____

2)_Name:_____Email:_____Phone:_____

3) Mailing Address:_____

What communications should Brokers be included on? (Choose all that apply):

Invoices Eligibility Questions Billing Questions Changes to Administration

Other:_____

If to NWDB:

Billing, Eligibility and Group Administration:

email: admin@northwestdentalbenefits.com

phone: 208-618- NWDB (6932)

website: https://northwestdentalbenefits.com

mail: PO Box 2317
Hayden, Idaho 83835

2. DEFINITIONS

A. “Approved Specialist” shall mean a licensed specialized dentist who is board eligible, board qualified, or board certified in one of the specialty areas of periodontics, oral surgery, orthodontics, endodontics, and pediatrics, and whose office has executed a contract with the Provider Network.

B. “Copay”, or copayment, shall mean the designated dollar amount that a Member is responsible for and must pay to the Provider at the time Covered Services are rendered.

C. "Covered Employee” shall mean an Eligible Employee of the Group, who has enrolled for this coverage and Cost for Services of NWDB has been paid prior to the period of coverage, including payment for Dependents as hereinafter defined.

D. “Covered Employee Copayments” shall mean the cost of dental services to be paid by the covered Employee directly to the Participating Providers.

E. “Cost for Services” shall mean amounts payable on a regular prepayment basis by or for the Covered Employee to NWDB.

F. “Coverage Period” shall mean the month for which the Cost for Services has been prepaid by the Group for each Covered Employee and/or Dependent.

G. “Covered Services” shall mean the list of procedures described in the Schedule of Benefits and Schedule of Copayments.

H. “Dependents” shall mean the lawful spouse or domestic partner of a Covered Employee and/or children of the Covered Employee from and after birth to age twenty-six (26). A legally adopted child of the Covered Employee or spouse or legal domestic partner, shall be treated as a child of the Covered Employee or spouse or legal domestic partner for purposes of this Contract, and the effective date of coverage for a newly adopted child is the date of adoptive or parental placement with the Covered Employee or spouse or legal domestic partner.

I. “Eligible Employee” shall mean an employee or participant of the Group who satisfies the requirements in the Group Application form.

J. “Fees” shall mean the portion of the cost for Covered Services outlined in the Schedule of Benefits separate from Copays. Fees are reviewed and set annually by the Provider Network. Members request a detailed billing statement or estimate at any point of treatment by contacting the Provider Office.

K. “Group” shall mean the organization or employing unit with which the Covered Employee is associated and which has executed this Contract.

L. “In-Network Orthodontist” shall mean the licensed orthodontia providers with an executed contract with NWDB and whose names appear on the list of Participating Providers.

M. “Lifetime Maximum Orthodontia Benefit” shall mean the set dollar amount specified by the Group’s plan for use towards orthodontia services. This lifetime benefit does not reset on an annual basis. Refer to the Schedule of Benefits for complete description of services and coverage.

N. “Maximum Annual Benefit for non-Orthodontia Covered Services” shall mean the maximum benefit allotted through the full calendar year. Covered Services Fees are deducted from the Maximum Annual Benefit until the maximum outlined by the Group’s plan is reached. If the sum of the Member’s dental procedures is less than the amount

outlined in the Group's plan, 100% of the Fees are covered. If the sum of the Member's dental procedures exceeds the amount outlined in the Group's plan, the Member is responsible for the amount of Fees exceeding the maximum benefit.

O. "Member" shall refer to either the Covered Employee or Dependents.

P. "Out-of-Network Provider" shall mean any Provider, including Orthodontists, who has not contracted with the Provider Network to provide dental services to Covered Employees or Dependents under NWDB.

Q. "Participating Providers" shall mean those licensed dentists or denturists who have contracted with the Provider Network to provide dental services to Covered Employees and Dependents under NWDB and whose names appear on the list of Participating Providers. The Participating Providers are independent contractors and are not employees or agents of NWDB. The Provider Networks are separate corporate entities delegated by NWDB to provide dental care services.

R. "Provider Network" shall mean the separate corporate entity consisting of NWDB Participating Providers and other entities delegated by NWDB to provide dental care services. NWDB is licensed solely in the state of Idaho and the network reflects accordingly.

S. "Qualifying Event" refers to Covered Employees and Dependents under NWDB. Common events include: marriage, divorce, birth or adoption of a child, adult children 26yrs or older, death, change of Eligible Employee status. These Qualifying Events either allow for coverage, or a cancelation of coverage.

T. "Specialty Services" shall mean services rendered by a board certified specialist.

3. ELIGIBILITY FOR BENEFITS

A. Eligibility requirements for Covered Employees are referenced above in section 1(A). Any information submitted by the Group or its Broker on behalf of the Member must have Member consent and authorization prior to submittal to NWDB. To enroll as a Covered Employee, the individual must reside or work in the Managed Care Service Area.

B. All Eligible Employees who have enrolled in NWDB on or before the fifteenth (15th) day of the month and for which the Group has fulfilled the terms of Section 4(B) below shall be eligible for benefits commencing on the first (1st) day of the following month.

C. All Covered Employees become eligible for services on the Effective Date determined from the terms of Section 3(A) and 3(B) above.

D. Any newly eligible spouse, domestic partner, and/or a newly eligible child of the Covered Employee who is not a newborn or adoptee may be added to the Covered Employee's coverage if the Covered Employee notifies the Group and NWDB within sixty (60) days of the Qualifying Event by submitting a signed Change in Coverage Form. The Group must add the newborn or adoptee to the NWDB plan at Employee's request. The due date for payment of any additional premium, if required, shall not be less than thirty-one (31) days following receipt by the Covered Employee from the Group of a billing for the required premium.

E. A newborn child is covered at birth and adopted children at time of placement. Newborn and adopted children must be added to the plan within sixty (60) days of birth or placement. "Placement" means physical placement in the care of the adopting Covered Employee. If physical placement is prevented due to the medical needs of the child, "placement" means the date the adopting Covered Employee signs an agreement for adoption of the child and

assumes financial responsibility for the child.

F. All congenital anomalies of such children are not excluded under the policy. “Congenital anomaly” means a condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. The term “significant deviation” is defined as a deviation that impairs the function of the body and includes but is not limited to the conditions of cleft lip, cleft palate, and other conditions that are medically diagnosed to be congenital anomalies.

G. Time is of the Essence.

1. Any Qualifying Event must be submitted by the Group to NWDB within 60 days of the Qualifying Event.

4. TERMINATION OR CANCELLATION: Coverage shall cease as follows:

A. On the date of expiration of the Coverage Period for which the last payment of Cost for Services was made, but in no event shall coverage cease earlier than the last day of the grace period as defined in Section 5(B).

B. Any applicable Qualifying Event which causes coverage to end.

C. If a Covered Employee cancels their Policy, this must be completed within 60 days by Group. No retroactive adjustments will be made beyond this period of time. Any liability associated with open treatments or claims after this date of cancelation will be the sole responsibility of the Covered Employee.

D. The end of the Term unless the contract is renewed. NWDB will notify the Group within thirty-one (31) days of the termination of coverage.

E. The Group may terminate this Contract by notifying NWDB in writing at least thirty-one (31) days prior to the Termination Date.

F. If a Participating Provider refuses service to a Member or asks a Member not to return, the Provider Network will review the case, make a final determination, and notify NWDB of the verdict. NWDB reserves the right to terminate coverage upon the decision of the case.

G. In the event a Covered Employee terminates coverage and does not elect COBRA, any liability or outstanding balances associated with open treatments or claims after the date of cancelation will be the sole responsibility of the Covered Employee.

5. COST FOR SERVICES / PREMIUMS

A. Premiums shall be paid by the Group to NWDB each month. The Group is responsible for collecting any premiums from Covered Employees. No coverage under this Contract shall commence until the total Cost for Services for the Group for one (1) month is received by NWDB.

B. All Premiums are billed on the 20th of the month preceding coverage and are due and payable on or before the 1st day of the month of the Coverage Period in which services may be rendered. A grace period of thirty-one (31) days will be granted for the payment by the Group of each monthly payment of Cost for Services (exclusive of the first monthly Cost for Services), during which grace period this Contract shall continue in force. Failure to pay the Premiums within the grace period shall cause the termination of the Contract and Coverage at the end of the grace period. No deviation from this waives any enforcement or collections rights.

C. Covered Employee Copayments (as listed in the attached Schedule of Benefits and

Schedule of Copayments) are payable to the Provider Network office by the Covered Employee at the time of service.

D. If the Group would like multiple invoices sent to sub entities, an authorized representative must complete and submit Exhibit A to the NWDB team for review and approval. The Group can request an Exhibit A form at any time.

6. DUTIES PERFORMED BY GROUP

Group distributes NWDB brochures, information, etc. to all Eligible Employees. Group will forward applications, additions, terminations, and all other enrollment modifications to NWDB by the 15th of each month. Group is also responsible for fulfilling Premium Payment requirements outlined in Section 5(B). Group will deliver Schedule of Benefits, Schedule of Copayments, Group Certificate of Coverage, and all other plan materials to each Covered Employee upon the Effective Date of coverage.

7. LIST OF MANAGED CARE PROVIDERS:

A. All Providers employed by the Provider Network. A current registry of Active Providers is listed on the following website:

https://northwestdentalbenefits.com

B. All Specialist dentists and denturists contracted by the Provider Network for referral care.

8. OUT-OF-NETWORK PROVIDERS

If a Non-Participating Provider provides treatment within 100 miles of a Participating Provider, NWDB will reimburse up to Twenty Five ($25) per visit for a maximum of One Hundred Dollars ($100) per year.

9. COVERED SERVICES AND BENEFITS

A. All dental procedures listed under the attached Schedule of Benefits and Schedule of Copayments will be provided, if, in the opinion of the Participating Provider, they are necessary for the patient's dental health. NWDB exclusions and limitations are listed in the Schedule of Benefits.

B. Only a Participating Provider shall have the right to examine and to determine the professional services to be performed, except in the instance of out-of-area dental emergency care as specified under Section 17 or in the instance of referral to an Approved Specialist.

C. If a conflict arises regarding the quality and extent of work, the case in question will be submitted to NWDB for resolution.

D. Coverage of Covered Employee or Dependent(s) will not be terminated or discontinued solely because of a clerical error on the part of the Group or NWDB.

E. For coordination of benefits between Primary and Secondary Plans, refer to Section (M) of the Group Certificate.

F. Northwest Dental Benefits Double Coverage: No patient may be covered by more than one NWDB Plan.

10. REFERRALS

In order for Covered Employees or Dependents to obtain Specialty Services outside of the Provider Network, a written referral from a Participating Provider is required. The written referral is necessary prior to the date of the initial consultation and authorizes up to One Hundred Dollars ($100) towards an initial consultation with the Speciality Provider. All further services deemed necessary by the Specialty Provider will need to be submitted via a claim or treatment plan to the NWDB team for evaluation and approval per the Group's plan.

11. RENEWAL

NWDB will provide Group with a written notification of any changes to Schedule of Benefits and Copayments and/or Cost for Services (monthly premium) sixty (60) days prior to Termination Date. If the Group does not reject the changes, in writing, thirty (30) days prior to the Termination Date, the Contract will be amended to include the changes to Schedule of Benefits and Copayments and/or Cost for Services.

12. DENTAL RECORDS

The dental records of all Covered Employees and Dependents concerning services performed hereunder shall remain the property of the Participating Provider. The Covered Employee and/or Dependent(s) may be subject to a charge for the duplication of dental records and radiographs in accordance with Idaho law.

13. PROTECTED HEALTH AND PERSONAL INFORMATION

NWDB agrees to use, disclose, and request Protected Health Information (PHI) only to the minimum extent necessary as permitted in this Contract or as Required by Law. NWDB also agrees to implement reasonable and appropriate technical and administrative safeguards for PHI to protect against risks to the security, confidentiality, and integrity of PHI in paper and electronic form. NWDB and the Provider Network comply with all HIPAA requirements and obligations.

14. CONTINUATION OF SERVICES

When Covered Employee ceases to be an Eligible Employee of the Group. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, in certain circumstances, called qualifying events, generally requires employers with 20 or more employees in the prior year to offer Members and some Dependents the right to continue coverage beyond the time it would ordinarily end. Federal law governs COBRA continuation rights and obligations. If applicable, the Group is responsible for administering COBRA continuation coverage and informing Covered Employees of their COBRA continuation rights. For Group Specific COBRA administration, NWDB will follow the outline provided by the Group in section 1(B).

In the event the Group has a change in COBRA Administrator, the Group must notify NWDB by completing the Exhibit B form. The Group can request a copy of this form from the NWDB team at any time.

15. APPEALS OF DENIED CLAIMS

If there are questions about a denied claim, call NWDB at (208) 618-NWDB (6932) or contact admin@northwestdentalbenefits.com. You have a right to file an appeal to request a formal review of benefit decisions within the plan year or six months of the denied claim.

16. CHANGING DENTISTS

Covered Employees may transfer coverage for themselves and Dependents to another Participating Provider within the Provider Network.

17. BROKEN APPOINTMENTS

If a Participating Provider chooses to charge a fee for a broken or cancelled appointment, the Covered Employee or Dependent is responsible for the payment of that fee.

17. OUT-OF-AREA EMERGENCY CARE

When temporarily more than one hundred (100) miles from a Participating Provider, Covered Employees and Dependents may have emergency care rendered by any licensed dentist. Emergency care is defined as “emergency dental treatment to alleviate acute pain, along with treatment arising from accidental injury or illness.” NWDB pays for emergency out-of-area One Hundred Dollars ($100) per person per emergency. NWDB will reimburse care up to Covered Employee upon presentation of bona fide documentation of emergency care expenses. Written notice to NWDB of a claim is required before twenty (20) days after the occurrence or commencement of the loss covered by the Policy. NWDB may not invalidate or reduce a claim if it is shown that it was not reasonably possible to give notice within twenty (20) days, and notice was given as soon as was reasonably possible.

18. MAJOR DISASTERS AND OTHER CATASTROPHES

In the event of major disaster or epidemic, Participating Providers shall render dental services as provided in this Contract insofar as is practical, according to their best judgment, within the limitations of such facilities and personnel as are then available, but NWDB and the Participating Providers shall have no liability or obligation for the delay or failure to provide or arrange for such services if such delay or failure is the result of such disaster or epidemic.

19. REMEDIES IN CASE OF DEFAULT

In the event a Participating Provider is unable to provide care and treatment to a Covered Employee or Dependent during the Coverage Period, the Covered Employee shall select another Participating Provider from the list of Participating Providers.

20. REPRESENTATIONS AND NOT WARRANTIES

In the absence of fraud, all statements made by Covered Employees or the Group shall be deemed to be representations and not warranties. No statement made for the purpose of obtaining coverage shall void such coverage or reduce benefits unless contained in a written instrument signed by the Group or the Covered Employee, a copy of which has been furnished to NWDB. This contract may not be contested, except for nonpayment of premiums or fraud after it has been in force for two (2) years from its date of issue. A statement, unless the statement was material to the risk and was contained in a written application, made by any person covered under this Contract relating to insurability may not be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force before the contest for a period of two (2) years during the person’s lifetime.

21. INDEMNITY BY THE GROUP

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

22. ENTIRE CONTRACT; CHANGES

A. This Contract includes the Schedule of Benefits, Schedule of Copayments, this Contract, any endorsements, amendments, and other attachments, if any, and constitutes the entire Contract between the parties. No change in this Contract shall be valid until approved by an executive officer of NWDB and unless such approval be endorsed hereon or attached

hereto. No agent has any authority to change this Contract or to waive any of its provisions.

B. This Contract shall be construed according to the laws of the State of Idaho.

C. Any provision of this Contract which, on its Effective Date, is in conflict with the laws of the State of Idaho is hereby amended to conform to the minimum requirements of such laws.

D. Upon any anniversary of the Effective Date, the Contract shall be automatically revised to conform to minimum statutory requirements of applicable statutes enacted subsequent to the prior anniversary.

23. HOW TO RECEIVE BENEFITS

In order to make an appointment, the Covered Employee must contact an office within the Provider Network. The Covered Employee must pay the Copays listed on the Schedule of Copayments and any remaining Fees directly to the Provider Network office where dental care is completed. For complete details on how schedule an appointment and other important information regarding benefits, refer to the Member Enrollment Packet.

24. COMMUNICATION

Point of Contacts. NWDB will follow the communication protocols outlined in section 1(C). For communication regarding NWDB Billing, Eligibility, and Group requirements:

email: admin@northwestdentalbenefits.com

phone: 208-618- NWDB (6932)

website: https://northwestdentalbenefits.com

25. LEGAL ACTION

An action at law or in equity may not be brought to recover on this Contract before the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the notification requirements of this Contract and after the expiration of two (2) years after the written proof of loss is required to be furnished.

26. USE OF NAME

Either party allows the verbal or written use of the other party's name without prior written consent. Use of logos, trademarks, or other marks from either party may be permissible with written consent prior to use. No protected or personal employee information will be disclosed or used per HIPAA compliance.

27. REGULATORY AUTHORITY

NWDB is subject to regulation by the Idaho Department of Insurance.

28. UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT ("USERRA")

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the Natural Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services and applicants to the uniformed services. If an Eligible Employee leaves his or her job to perform military service, the Eligible Employee has the right to elect to continue his or her Group coverage including any Dependents for up to twenty- four (24) months while in the military. Even if continuation of coverage was not elected during the Eligible Employee's military service, the Eligible Employee has the right to be reinstated in his or her Group coverage when reemployed, without any waiting periods or pre- existing condition exclusions except for service connected illnesses or injuries. If an Eligible Employee has any

questions regarding USERRA, the Eligible Employee should contact NWDB.

The parties have caused this Contract to be executed the day, month, and year first written above.

Lakeland School District

Signed by:
Jessica Grantham
0BBC54D50EB437...

By: Jessica Grantham
Its: Chief Finance Officer

NORTHWEST DENTAL BENEFITS, LLC

By: _____
Its: _____

Schedule of Benefits

1. **Maximum Annual Benefit for non-Orthodontia Covered Services:** $2,500, the term of which is the calendar year, resetting January 1 of each year.

2. **Co-Pay**. This is a copay-based plan in which the total cost of services rendered is equivalent to the co-pay plus the deducted fee. The difference between the co-pay and the associated fee will count toward each individual's $2,500 annual maximum dental benefit when seen by a Participating Provider. When an approved referral is made and an Approved Specialist completes the procedure, the co-pay will remain the same as listed below; however, the NWDB Fee will be 20% higher than the Participating Provider fees listed.

3. **Time is of the Essence:** For benefits to be eligible, claims related to out-of-network, emergency, orthodontia, and in-network care requiring authorization must be submitted in writing by the Member or Provider Office to NWDB within 180 days of the treatment date.

4. **Lifetime Maximum Orthodontia Benefit:** $2,500, pursuant to Section 7 and Section 8 below.

5. There is a six (6) month benefit waiting period from the Member Effective Date for orthodontia. Approved treatment may begin in advance of the benefit waiting period; however, the approved benefit payment schedule will become eligible for payout six (6) months after the Member Effective Date. If a Member terminates coverage prior to payment completion as outlined by the approved benefit payment schedule, the Covered Employee or Dependent assumes all responsibility for any and all remaining payments, including those estimated to be covered by NWDB.

6. There is a six (6) month waiting period from the Member Effective Date for implants and dentures. Members are not eligible for these services in advance of the waiting period.

7. There is up to $2,500 lifetime maximum benefit per enrolled member for In-Network Orthodontia services in the absence of limitations outlined in Section 8. For Orthodontia services obtained at an Out-of-Network Orthodontist more than 5 miles from the nearest In-Network Orthodontist, up to $2,000 is available in lifetime benefit. Upon treatment plan receipt, NWDB will assess coverage and pay a maximum of 50% of the orthodontia cost up to the lifetime maximum. After NWDB has paid up to the lifetime maximum, the Covered Employee will pay all remaining costs of orthodontia.

8. If a Covered Employee or its Dependent has orthodontia in progress on the Effective Date, NWDB will pay a portion of the cost of such orthodontia pursuant to the following stipulations outlined in the following sections 8(a) and 8(b). In the instance of 8(b), Covered Employees and their Dependents must be treated by an In-Network Orthodontist. If orthodontia is in progress with an Out-of-Network Orthodontist, the case must be transferred to an In-Network Orthodontist to be eligible for benefit.

   (a) the Covered Employee or its Dependent had orthodontia coverage under a prior plan. The prior plan covered a portion of the cost of orthodontia and the total benefit was not exhausted.

   If each of these conditions are met, NWDB will pay 50% of the cost of orthodontia care up to the lesser of the following amounts:

   The lifetime maximum; or
   the total amount of the remaining benefit the Covered Employee or its Dependent would have received under the prior plan.

   Example #1: if the Covered Employee had $1,500 of coverage for orthodontia and received a benefit of $1,000, NWDB will pay $500.

   Example #2: if the Covered Employee had $2,000 of coverage for orthodontia and received a

benefit of $500, NWDB will pay $1,500.

(b) the Covered Employee or its Dependent did not have orthodontia coverage under the prior plan.

If this condition is met, NWDB will pay 50% of the cost of orthodontia care up to a reduced benefit of $1,000.

Example #1: if the Covered Employee has $1,000 remaining on an orthodontia case, NWDB will pay $500.

Example #2: if the Covered Employee has $2,500 remaining on an orthodontia case, NWDB will pay $1,000.

The following services are not covered.

1. Cosmetic dentistry services or supplies, including cosmetic work done on dentures.
2. Injuries or conditions covered under Workers' Compensation or Employer's Liability laws; services provided by any government agency; or any services that are provided free of charge.
3. Temporomandibular joint (TMJ) services or supplies.
4. Prescription drugs.
5. Pain relievers like euphoric drugs or injections.
6. Any dental services performed or started before this coverage took effect or after coverage ends.
7. Appliances, surgical procedures, and restorations for increasing vertical dimension; or restoring occlusion; for replacing tooth structure loss resulting from attrition, abrasion, or erosion.
8. Repair, relines, or adjustments of occlusal guards.
9. Replacement or duplicate dentures, bridges or any other appliance.
10. Myofunctional therapy.
11. Hospitalization and related charges.
12. General Anesthesia, and intravenous sedation, and the services of a special anesthesiologist, except that coverage will be provided for general anesthesia and intravenous sedation services in conjunction with any covered dental procedure performed in a dental office if such anesthesia services are medically necessary for enrolled members through age 6, or physically or developmentally disabled.
13. Laboratory tests and/or laboratory examinations.
14. Broken appointment fees.
15. Any other service not specifically listed in this Contract as a benefit.

Noncovered Services, listed or not listed, can be submitted for review to NWDB on a case-by-case basis, in advance of the start of treatment. Submit a claim for review to admin@northwestdentalbenefits.com. If after NWDB's sole review and discretion the claim is approved, the Member may be eligible for up to a combination of coverage and out of pocket expenses so long as not exceeding any benefit limits extended

in this plan. NWDB understands that special, or unique, circumstances can happen and wishes to be part of the treatment conversation.

Schedule of Co-Payments

Blue Square 2025

Code	Description	Copay
D0120	Recare Examination	$0
D0140	Limited Oral Evaluation-Problem Focused	$0
D0145	Oral Eval Pt Under 3/Prim Caregiver	$0
D0150	Comprehensive Oral Evaluation	$0
D0160	Detailed & Extens Oral Eval-Prb Focused	$0
D0170	Re-Eval. - Limited, Problem Focused	$0
D0171	Post-Op Office Visit - Re-Evaluation	$0
D0180	Probe-Perio Eval	$0
D0190	Screening Of A Patient	$0
D0191	Assessment Of A Patient	$0
D0210	Intraoral-Complete (Incl. Bitewings)	$0
D0220	Intraoral-Periapical First Film	$0
D0230	Intraoral-Pa Additional	$0
D0240	Intraoral-Occlusal Film	$0
D0250	Extraoral - First Radiographic Image	$0
D0251	Extra-Oral Posterior Radiographic Image	$0
D0270	Bitewing-One Film	$0
D0272	Bitewings-Two Films	$0
D0273	Bitewings-Three Films	$0
D0274	Bitewings-Four Films	$0
D0277	Bw - 7 To 8 Films	$0
D0330	Panoramic Film	$30
D0340	Cephalometric Film	$40
D0350	2D Oral/Facial Photographic Image	$20
D0364	Cone Beam Ct Less Than Whole Jaw	$100
D0365	Cone Beam Ct Capture And Int-Mandible	$100
D0366	Cone Beam Ct Capture And Int-Maxilla	$100
D0367	Cone Beam Of Both Jaws	$100
D0368	Cone Beam Ct Capture And Int-Tmj Series	$100
D0380	Cone Beam Ct Image Capture-Partial Jaw	$100

D0381	Cone Beam Ct Image Capture-Mandible	$100
D0382	Cone Beam Ct Image Capture-Maxilla	$100
D0383	Cone Beam Ct Image Capture-Both Jaws	$100
D0384	Cone Beam Ct Image Capture-Tmj	$100
D0393	Xnav - Tx Simulation Using 3D Image	$250
D0460	Pulp Vitality Tests	$0
D0470	Diagnostic Casts	$40
D0601	Caries Risk Assessment&Documentation-Low	$0
D0602	Caries Risk Assessment&Documentation-Mod	$0
D0603	Caries Risk Assessment&Documentation-Hig	$0
D1110	Adult-Prophylaxis	$0
D1120	Child-Prophylaxis	$0
D1206	Therapeutic Fl Varnish	$0
D1208	Topical Ap. Of Fluoride	$0
D1330	Oral Hygiene Instructions	$0
D1351	Sealant-Per Tooth	$0
D1352	Prev Resin Restoration Mod To High Carie	$20
D1353	Sealant Repair - Per Tooth	$0
D1354	Interim Caries Arresting Medicament Appl	$20
D1510	Space Maintainer-Fixed-Unilateral	$175
D1516	Space Maintainer-Fixed-Maxillary	$225
D1517	Space Maintainer-Fixed-Mandible	$225
D1551	Re-Cmnt/Bnd Bilat Sp Mnt-Max	$25
D1553	Re-Cmnt/Bnd Unilat Sp Mnt-Quad	$25
D1558	Removal Mandibular Space Maintainer	$25
D1575	Distal Shoe Space Maintainer-Fixed-Unila	$125
D2140	Amalgam-One Surface, Permanent	$35
D2150	Amalgam-Two Surfaces, Permanent	$35
D2160	Amalgam-Three Surfaces, Permanent	$35
D2161	Amalgam-Four Or More Surfaces, Permanent	$35
D2330	Resin-One Surface, Anterior	$25
D2331	Resin-Two Surfaces, Anterior	$30
D2332	Resin-Three Surfaces, Anterior	$35
D2335	Resin-Four Or More Surfaces, Anterior	$40
D2390	Resin-Based Composite Crown, Anterior	$225
D2391	Resin-One Surface, Post-Perm	$25

D2392	Resin-Two Surfaces, Post-Perm	$30
D2393	Resin-Three Surf, Post-Perm	$35
D2394	Resin-Four Surface, Post-Perm	$40
D2740	Crown-Porcelain/Ceramic Substrate	$350
D2750	Crown-Porcelain Fused To High Noble Meta	$350
D2751	Crown-Porcelain Fused To Predom. Metal	$350
D2780	Crown - 3/4 Cast High Noble Metal	$550
D2781	Crown - 3/4 Cast Pred. Base Metal	$350
D2782	Crown - 3/4 Cast Noble Metal	$350
D2783	Crown - 3/4 Porcelain/Ceramic	$350
D2794	Crown-Titanium	$450
D2799	Provisional Crown	$175
D2910	Recement Inlay, Onlay Or Overlay	$40
D2915	Recement Post	$30
D2920	Recement Crown	$30
D2929	Prefab. Por/Ceramic Crown-Prim Tooth	$175
D2930	Prefab. Stainless Steel Crown-Primary	$75
D2931	Prefab. Stainless Steel Crown-Permanent	$75
D2932	Prefab. Resin Crown	$175
D2933	Prefab. Stainless Steel Crown With Resin	$175
D2934	Prefab Esth Stainless Steel Crown-Primar	$175
D2940	Sedative Filling	$30
D2941	Interim Therapeutic Restor. (Primary)	$25
D2950	Core Buildup, Including Any Pins	$50
D2951	Pin Retention-Per Tooth, In Add To Resto	$50
D2952	Cast Post And Core	$175
D2953	Each Add`L Ind Fab Post - Same Tooth	$120
D2954	Prefab. Post And Core In Add. To Crown	$175
D2957	Each Additional Prefab. Post-Same Tooth	$120
D2980	Crown Repair, By Report	$120
D2990	Resin Infilt Of Incep Smooth Surf Lesion	$30
D3110	Pulp Cap-Direct (Ex. Final Restoration)	$50
D3120	Pulp Cap-Indirect (Ex. Final Restoration	$50
D3220	Therapeutic Pulpotomy (Ex. Final Restor.	$70
D3221	Pulpal Debridement	$75
D3222	Partial Pulpotomy-Apexogenesis-Prm Tooth	$120

D3230	Pulpal Therapy (Resorbable Filling)-Ant	$120
D3310	Rct Anterior Tooth	$250
D3320	Rct Premolar Tooth	$300
D3330	Rct Molar Tooth	$400
D3331	Tx Of Rt Canal Obstruct Non Surgical Acc	$350
D3332	Incomplete Endo Therapy	$125
D3333	Internal Root Repair Of Perf. Defects	$175
D3346	Retreat Of Prev Rct- Anterior	$400
D3347	Retreatment Of Prev Root Canal-Bicuspid	$550
D3348	Retreatment Of Prev Root Canal-Molar	$650
D3351	Apexification/Recalc. Initial Visit	$75
D3352	Apexification/Recalc. Interim Medication	$75
D3353	Apexification/Recal. Final Visit	$125
D3355	Pulpal Regeneration (Initial Visit)	$55
D3357	Pulpal Regeneration (Complete Treatment)	$175
D3410	Apicoectomy/Periradicular Surgery-Ant.	$400
D3421	Apicoectomy/Periradicular Surg - Bicuspid	$500
D3425	Apicoectomy/Periradicular Surg - Molar (	$550
D3426	Apicoectomy/Periradicular Surg (Each Add	$175
D3428	Bone Graft/Periradicular Surgery-Tooth	$200
D3429	Bone Graft/Periradicular Surgery- Add	$200
D3430	Retrograde Filling-Per Root	$100
D3432	Tissue Regen Resorb Barrier W Peri Surge	$175
D3450	Root Amputation-Per Root	$450
D3470	Intentional Replantation	$450
D4210	Gingivectomy Or Gingivoplasty-Per Quad	$400
D4211	Gingivectomy Or Gingivoplasty-Per Tooth	$100
D4212	Gingivectomy Or Plasty Restor/Tooth	$100
D4240	Ging Flap, Incl. Root Plan, 4 Or More	$400
D4241	Ging Flap, Incl. Root Plan, 1-3 Teeth	$300
D4245	Apically Positioned Flap	$300
D4249	Clinical Crown Lengthening-Hard Tissue	$450
D4260	Osseous Surgery-Per Quad	$600
D4261	Osseus Surgery 1-3 Teeth	$500
D4263	Bone Replace Graft-First Site In Quad	$200
D4264	Bone Replace Graft-Each Add Site In Quad	$200

D4265	Biologic Material To Aid In Tissue Regen	$125
D4266	Resorbable Barrier, Per Site	$100
D4267	Membrane	$125
D4270	Pedicle Soft Tissue Graft Procedure	$500
D4273	Connective Tissue Graft	$500
D4274	Distal Or Procimal Wedge Procedure	$400
D4275	Soft Tissue Allograft	$500
D4276	Comb Connective Tissue/Double Ped Graft	$500
D4277	Free Soft Tissue Graft 1St Tooth	$500
D4278	Free Soft Tissue Graft Additional Site	$450
D4283	Auto Connective Tissue Graft/Each Add Th	$500
D4285	Non-Auto Connective Tissue Graft/Add Th	$500
D4322	Splint – Intra-Coronal; Natural Teeth Or Prosthetic Crowns	$200
D4323	Splint – Extra-Coronal; Natural Teeth Or Prosthetic Crowns	$100
D4341	Periodontal Scaling And Root Planing	$50
D4342	Perio Scaling & Root Planing 1-3 Teeth	$40
D4346	Scaling With Gingival Inflammation	$50
D4355	Full Mouth Debridement For Perio Eval	$50
D4381	Local Del Of Antimicrob Agent Into Disea	$50
D4910	Periodontal Maintenance Procedures	$30
D5110	Complete Upper	$750
D5120	Complete Lower	$750
D5130	Immediate Upper	$750
D5140	Immediate Lower	$750
D5211	Maxillary Partial Denture - Resin Base	$550
D5212	Mandibular Partial Denture - Resin Base	$550
D5213	Maxillary Partial - Cast Metal - Resin Base	$750
D5214	Mandibular Partial - Cast Metal - Resin Base	$750
D5221	Immediate Maxillary Partial - Resin Base	$750
D5222	Immediate Mandibular Partial-Resin Base	$750
D5223	Immediate Maxillary Partial-Cast Metal	$750
D5224	Immediate Mandibular Partial-Cast Metal	$750
D5225	Maxillary Partial Denture Resin Based	$750
D5226	Mandibular Partial Flexible Base	$550
D5227	Imm Max Partial Denture - Flex	$550
D5228	Imm Mand Part Denture - Flex	$550

D5410	Adjust Complete Denture-Upper	$30
D5411	Adjust Complete Denture-Lower	$30
D5421	Adjust Partial Denture-Upper	$30
D5422	Adjust Partial Denture-Lower	$30
D5511	Repair Broken Dent Base, Mandible	$120
D5512	Repair Broken Dent Base, Maxillary	$120
D5520	Replace Missing Or Broken Teeth	$115
D5640	Replace Broken Teeth-Per Tooth	$115
D5650	Add Tooth To Existing Partial Denture	$175
D5660	Add Clasp To Existing Partial Denture	$175
D5670	Replace All Tth/Acry Cast Met Frame(Max)	$550
D5671	Replace All Tth/Acry Cast Met Frame(Man)	$550
D5710	Rebase Complete Upper Denture	$350
D5711	Rebase Complete Lower Denture	$350
D5720	Rebase Upper Partial Denture	$350
D5721	Rebase Lower Partial Denture	$350
D5730	(Chair) Reline Full Upper Denture	$230
D5731	Reline Complete Lower Denture (Chair)	$230
D5740	Reline Upper Partial Denture (Chair)	$230
D5741	Reline Lower Partial Denture (Chair)	$230
D5750	(Lab)Reline Full Upper Denture	$275
D5751	(Lab) Reline Full Lower Denture	$275
D5760	Reline Upper Partial Denture (Lab)	$275
D5761	Reline Lower Partial Denture (Lab)	$275
D5810	Interim Complete Denture (Upper)	$500
D5811	Interim Complete Denture (Lower)	$500
D5820	Flipper - Partial Denture (Upper)	$300
D5821	Flipper - Partial Denture (Lower)	$300
D5863	Overdenture (Complete Maxillary)	$825
D5864	Overdenture (Partial Maxillary)	$825
D5865	Overdenture (Complete Mandibular)	$825
D5866	Overdenture (Partial Mandibular)	$825
D6010	Implant	$850
D6011	Second Stage Implant Surgery	$120
D6012	Surg Place Of Int Impl: Endosteal Impl	$875
D6013	Surgical Placement Of Mini Implant	$550

D6057	Custom Fabricated Abutment - Lab Process	$575
D6058	Abut Supported Porc/Ceramic Crown	$400
D6059	Implant Abutment Supported Pfm	$475
D6061	Abutment Supported Porcelain Crown	$475
D6065	Implant Supp. Porc./Ceramic Crown	$475
D6066	Crown Over Implant	$400
D6069	Pm Abut Over Implant	$400
D6085	Provisional Implant Crown	$325
D6092	Recement Impl/Abutment Supported Crown	$50
D6093	Recement Impl/Abut Supp Fixed Part Dent	$50
D6210	Pontic-Cast High Noble Metal	$400
D6214	Pontic-Titanium	$400
D6240	Pontic-Porcelain Fused To High Noble Met	$400
D6242	Pontic-Porcelain Fused To Noble Metal	$400
D6245	Pontic - Porcelain/Ceramic	$350
D6740	Porcelain Abutment	$400
D6750	Abutment Crown-Porc Fused To Noble Meta	$375
D6930	Recement Bridge	$60
D7111	Extract,Coronal Remnants-Deciduous Tooth	$30
D7140	Removal Simple	$35
D7210	Surgical Removal Of Erupted Tooth	$60
D7220	Removal Soft Tissue	$75
D7230	Removal Partial Bony	$100
D7240	Removal Completely Bony	$145
D7241	Comp Bony/ W Unusual Surg Complications	$175
D7250	Surgical Removal Of Residual Tooth Roots	$75
D7251	Coronectomy - Intentional Partial Ext	$125
D7261	Primary Closure Of A Sinus Perforation	$500
D7270	Tooth Reimplantation Or Stabilization	$300
D7280	Surgical Exposure Of Impacted Or Unerupt	$60
D7283	Place Ortho Bracket To Expose Tooth	$75
D7285	Biopsy Of Oral Tissue-Hard	$400
D7286	Biopsy Of Oral Tissue-Soft	$200
D7310	Alveoloplasty In Con. With Extrac./Quad	$100
D7311	Alveoloplasty In Con W/Extract 1-3/Quad	$60
D7320	Alveoloplasty Not W/Ext Per Quad	$200

D7321	Alveoloplasty Without Extract 1 To 3/Qua	$100
D7410	Excision Benign Lesion Up To 1.25Cm	$200
D7411	Excision Of Benign Lesion > 1.25 Cm	$375
D7471	Remove Tori	$450
D7472	Removal Of Torus Palatinus	$475
D7473	Removal Of Torus Mandibularis	$475
D7510	Incision & Drainage Of Abscess	$75
D7950	Ridge Augmentation Bone Graft	$475
D7951	Sinus Lift Lateral	$900
D7952	Sinus Lift Vertical	$400
D7953	Bone Replacement Graft For Ridge Preseva	$200
D7961	Buccal/Labial Frenectomy (Frenu	$250
D7962	Lingual Frenectomy	$250
D7963	Frenuloplasty	$250
D7970	Excision Of Hyperplastic Tissue-Per Arch	$75
D8010	Healthy Ltd Ortho Treat Of The Prim Dent	***
D8020	Limited Ortho Treat Of The Trans Dent	***
D8030	Limited Ortho Treat Of The Adol Dent	***
D8040	Limited Ortho Treat Of The Adult Dent	***
D8070	Comp Ortho Treat Of The Trans Dent	***
D8080	Comp Ortho Treat Of The Adol Dent	***
D8090	Comp Ortho Treat Of The Adult Dent	***
D8210	Removable Appliance Therapy	***
D8220	Fixed Appliance Therapy	***
D8660	Pre-Ortho Tx Visit	***
D8670	Ortho Recall (As Part Of Contract)	***
D8680	Ortho Retention	***
D8701	Repair Fixed Ret, Incl Reattach. Maxilla	***
D8702	Repair Fixed Ret, Incl Reattach. Mandibu	***
D8703	Retainer Replacement - Maxillary	***
D8704	Replacement Of Lost/Broken Retainer, Max	***
D9110	Palliative (Emergency) Treatment - Minor	$115
D9120	Section Bridge	$30
D9230	Analgesia	$30
D9944	Occlusal Guard Full Arch *Hard*	$350
D9946	Occlusal Guard Partial Arch	$250

D9950	Mounted Study Models	$60
D9951	Equilabration Adjustment-Limited	$75
D9952	Equilabration Adjustment-Complete	$500
S7140	Simple Extraction Supernumerary Tooth	$0
S7210	Surgical Removal Of Supernumerary Tooth	$0
S7230	Ext Of Supernumerary 3rd	$0

*** Copay and Member responsibility varies on a case-by-case basis.

DELTA DENTAL®

deltadentalid.com

March 25, 2025

Brooke Cunningham
Lakeland School District #272
15506 N Washington St
Rathdrum, ID 83858

Dear Brooke,

Thank you for your continued trust. The partnership between Delta Dental of Idaho and Lakeland School District is a valuable tool in the improvement of the oral health—and therefore the overall health—of your employees.

We've completed our renewal analysis and have determined that Lakeland School District warrants a 5% renewal increase for a one-year contract. Assuming no change in plan design, the premium rates for the contract period September 1, 2025, through August 31, 2026, will be:

	Rates
Employee Only	$36.80
Employee + Spouse	$79.71
Employee + One Child	$70.80
Employee + Two or More Children	$105.32
Employee + Spouse + Child(ren)	$141.15

Over the past 12 months, Lakeland School District has enjoyed a savings of 31.9%, or $218,646, of the total amount of claims submitted, as a result of working with Delta Dental of Idaho. To learn about your contractual savings with Delta Dental of Idaho, please review the enclosed Cost Management Savings Report.

Besides great savings, Delta Dental of Idaho members also enjoy value-added programs such as:

- HOW®

  A healthy mouth is a vital part of your overall health, and Delta Dental of Idaho cares about yours. That's why we created Health *through* Oral Wellness® (HOW®). HOW is a unique, patient-centered program that adds additional preventive benefits to your dental plan based on the individual oral health needs of your members.

DELTA DENTAL OF IDAHO
555 E. Parkcenter Boulevard
Boise, Idaho 83706

Name Jessica Grantham

Signature Signed by: Jessica Grantham 0BBC54DF0FEB437...

Date 6/20/2025 | 11:29 AM EDT

Fee Schedule
Lakeland Joint School District #272

FSA*

First Year Set Up	
Annual Renewal Fee	**$250.00**
Monthly Per Participant	**$3.50**

*Rates good through 9/1/26

HRA*

First Year Set Up	
Annual Renewal Fee	
Monthly Per Participant	

COBRA**

First Year Set Up	
Annual Renewal Fee	
Monthly Per Eligible Employee	

HSA*

First Year Set Up	
Annual Renewal Fee	**inlcuded w/ FSA**
Monthly Per Participant	**$3.50**

Mass Transit & Parking*

First Year Set Up	
Annual Renewal Fee	
Monthly Per Participant	

Debit Card

One Time Fee	**$0.00**
Replacement Card Fee	**$10.00/card**
Expedited Debit Card Requests	**$54.00/card**

**$50 monthly minimum may apply*
***$40 monthly minimum may apply (COBRA Only Clients)*

Please Note: The employer listed above is responsible for reporting the correct number of participants on the monthly invoice to Peak One Administration. Adjustments of invoices that are more than 30 days before the invoice due date are not reimbursable and/or not collectable by Peak One.

Employer Signature Signed by: Jessica Grantham 0BBC54DF0FEB437... Date 6/20/2025 | 11:29 AM EDT

PEAK ONE administration

Renewal Client Worksheet

☒ FSA ☒ Debit Card ☒ POP ☐ HRA ☒ HSA ☐ COBRA

Company Information

Company Name: Lakeland Joint School District #272	DBA:	
Mailing Address: 15506 N Washington St	Phone Number: 208-687-0431	
City: Rathdrum	State: ID	Zip Code: 83858
Tax Identification Number: 82-6000812	Company Website: https://www.sd272.org/	

Benefit Contact: *Granted access to the Employer Portal and will be the person that Peak One should contact for general questions*

First and Last Name: Brook Cunningham	Title: HR Director
Email Address: bcunningham@lakeland272.org	Phone Number: 208-687-0431

Billing Contact: *If person receiving the monthly invoice is different than the Benefit Contact listed above*

First and Last Name: Morgan Stehr	Title: Payroll Specialist
Email Address: morgan.stehr@lakeland272.org	Phone Number: 208-687-0431

Broker/Insurance Agent Contact Information: *If you do not have a broker/insurance agent, please skip this section*

First and Last Name: Sam Layson	Agency Affiliation: Acrisure
Email Address: sblayson@acrisure.com	Phone Number: 208-765-2620

Account Advocate: *The AS will be the client's direct contact at Peak One Administration*

Name: Mitch Rasmussen	Email Address: mrasmussen@peakoneadmin.com
Phone Number: 208-215-2119	Fax Number: 855-495-3669

Employer Signature: Signed by: Jessica Grantham 0BBC54DF0FEB437... _____

PEAKONE administration

FSA/HSA Plan Design

☐ **Renew As Is** ☐ **Renewing With Changes** ☐ **New Plan**

Plan Year Begin Date: 9/1
Plan Year End Date: 8/31
Plan Year Renewal Date: 9/1

Plan Selection

☒ Medical FSA ☒ Limited Purpose FSA ☒ Dependent Care FSA ☒ HSA
☐ Parking ☐ Mass Transit

Payroll Specification – *Please attach a list of all pay periods during the plan year*

How often are employees paid?	☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly	☒ Monthly	☐ Other ____
How many pay cycles occur during the plan year?	☒ 12	☐ 24	☐ 26	☐ 52	☐ Other ____
Date of First Payroll Deduction			Date of Last Payroll Deduction		

Contribution Specification

Account	Minimum	Maximum	Employer Contribution (if applicable)
Medical FSA	$100	$ ($3300 IRS Maximum as of 2025)	$0
Dependent Care FSA	$100	$2500/$5000	$0
Limited Purpose FSA	$100	$ ($3300 IRS Maximum as of 2025)	$0
Parking	$	$325/month	$
Mass Transit	$	$325/month	$
HSA	$0	$4300/$8550 (As of 1/1/2025)	$

Reimbursement Specification

☒ Debit Card ☒ Direct Deposit ☒ Check ☐ Roster Notification

Copay Specification – *Please complete the table below if debit card was selected an available reimbursement option*

Medical Copay(s)	$20	$40	$100	$200	$
Prescription Copay(s)	$250	$10	$30	$50	$
Dental Copay(s)	$15	$50	$150	$25	$1500
Vision Copay(s)	$10	$25	$	$	$

Run Out Specification

End of Plan Year Run Out Period ☐ 60 Days ☒ 90 Days ☐ Other ____	Run Out Period for Terminated Participants ☐ 60 Days ☒ 90 Days ☐ Other ____
Terminated Participant Run Out Period Begins ☒ After termination date ☐ After plan year end date	Terminated Participants Can Incur Expenses After Termination Date? ☐ Yes ☒ No
Up to $660 Rollover Allowed? ☒ Yes ☐ No	2 ½ Month Grace? ☐ Yes ☒ No
Minimum Rollover Amount: $0	Are participants required to elect in the new plan year to receive rollover? ☒ Yes ☐ No

Employer Signature: Signed by: Jessica Grantham 0BBC54DF0FEB437...

Special FSA and HRA Plan Funding Arrangements

To facilitate prompt claims payments to your FSA, HRA and HSA, Peak One Administration is offering a plan funding arrangement to accommodate your organization's needs. Once selected, funding arrangements are not changed during the plan year without special circumstances and company approval.

Custodial Bank Account (FSA and HRA)

- Uses TPA-owned bank account for funding of claim reimbursements
- Peak One signs checks and mails directly to the employee submitting the claim
- Direct Deposit is available
- Debit cards are available

Group Name: Lakeland joint School District #272

☒ **Use Peak One Administration Special Banking Reimbursement Option**

☐ Daily

☐ Weekly (Wednesday)

I will be responsible for providing appropriate funding into TPA's custodial bank account. Failure to do so will result in a delay in claims being processed or a requirement to change my banking options.

☒ **I choose to elect sending in payroll redirection to be posted appropriately to plan participant accounts and agree to provide an electronic spreadsheet in the Peak One designated format. I understand that failure to provide an electronic spreadsheet in the designated format will result in a non processing status of payroll redirections. If at any time distributions exceed the amount of contributions, I understand that I must submit a cash advance to fund claims.**

Funding method to remit payment to Peak One: ☐ ACH ☐ Check

Peak One remittance information provided below.

MAIL CHECK PAYMENTS TO:	Peak One Administration 3903 E Primrose Lane Suite 102 Post Falls, ID 83854	
SEND ACH PAYMENTS TO:	US BANK PEAK ONE CUSTODIAL ACCOUNT	
UPIC Account Number 31186980		ABA Number 021052053
SEND ELECTRONIC SPREADSHEET TO:	**benefits@peakoneadmin.com**	

Authorized signature required for banking options.

X Signed by: Jessica Grantham 0DBC54DF0FED437...	6/20/2025 | 11:29 AM EDT
Signature	Date

May 28, 2025

LAKELAND SCHOOL DISTRICT #272
15506 N WASHINGTON ST
RATHDRUM, ID 83858-8317

RE: Group Policy: GL, G2-2248A

Dear JESSICA GRANTHAM,

United Heritage would like to thank you for partnering with us to provide your employees with quality products and services to support their insurance needs. We have completed the renewal process for your policies with United Heritage.

Please review your last billing statement to ensure the information is correct, as this is the information, we used to complete your renewal.

We ask that you regularly review your policy for all eligibility and participation requirements. This practice assists us in providing the exceptional customer experience you and your organization have come to expect from us.

Please review the attached Renewal Rates.

These rates are guaranteed not to increase before the date below, subject to the provisions of the policy.	
Basic Life	**9/1/2027**
Supplemental Life	**9/1/2027**

It is a pleasure working with you. If there is anything, we can do for you or your employees, please let us know.

Sincerely,

Janna Fettinger
jfettinger@unitedheritage.com
Group Lead Renewal Specialist
(208) 475-0978 (Phone)

Renewal Rates

BASIC LIFE	CURRENT RATE	NEW RATE
Employee Life (per $1,000)	$0.000	$0.000
Dependent Life (per family)	$0.750	$0.750

SUPPLEMENTAL LIFE		
BENEFIT	**CURRENT RATE**	**NEW RATE**
Supplemental Life Employee (per $1,000)		
Under 30 yrs.	$0.050	$0.050
30 - 34 yrs.	$0.060	$0.060
35 - 39 yrs.	$0.080	$0.080
40 - 44 yrs.	$0.130	$0.130
45 - 49 yrs.	$0.230	$0.230
50 - 54 yrs.	$0.360	$0.360
55 - 59 yrs.	$0.610	$0.610
60 - 64 yrs.	$0.660	$0.660
65 yrs. or more	$1.160	$1.160
Supplemental Life Spouse (per $1,000)		
Under 30 yrs.	$0.050	$0.050
30 - 34 yrs.	$0.060	$0.060
35 - 39 yrs.	$0.080	$0.080
40 - 44 yrs.	$0.130	$0.130
45 - 49 yrs.	$0.230	$0.230
50 - 54 yrs.	$0.360	$0.360
55 - 59 yrs.	$0.610	$0.610
60 - 64 yrs.	$0.660	$0.660
65 yrs. or more	$1.160	$1.160
Child Supplemental Life (per $1,000)	$0.200	$0.200

May 28, 2025

LAKELAND SCHOOL DISTRICT #272
15506 N WASHINGTON ST
RATHDRUM, ID 83858-8317

RE: Group Policy: GL-2248

Dear JESSICA GRANTHAM,

United Heritage would like to thank you for partnering with us to provide your employees with quality products and services to support their insurance needs. We have completed the renewal process for your policies with United Heritage.

Please review your last billing statement to ensure the information is correct, as this is the information, we used to complete your renewal.

We ask that you regularly review your policy for all eligibility and participation requirements. This practice assists us in providing the exceptional customer experience you and your organization have come to expect from us.

Please review the attached Renewal Rates.

These rates are guaranteed not to increase before the date below, subject to the provisions of the policy.	
Basic Life	**9/1/2027**

It is a pleasure working with you. If there is anything, we can do for you or your employees, please let us know.

Sincerely,

Janna Fettinger
jfettinger@unitedheritage.com
Group Lead Renewal Specialist
(208) 475-0978 (Phone)

Renewal Rates

BASIC LIFE	CURRENT RATE	NEW RATE
Employee Life (per $1,000)	$0.110	$0.110
AD&D (per $1,000)	$0.020	$0.020

May 28, 2025

LAKELAND SCHOOL DISTRICT #272
15506 N WASHINGTON ST
RATHDRUM, ID 83858-8317

RE: Group Policy: GD-2248C

Dear JESSICA GRANTHAM,

United Heritage would like to thank you for partnering with us to provide your employees with quality products and services to support their insurance needs. We have completed the renewal process for your policies with United Heritage.

Please review your last billing statement to ensure the information is correct, as this is the information, we used to complete your renewal.

We ask that you regularly review your policy for all eligibility and participation requirements. This practice assists us in providing the exceptional customer experience you and your organization have come to expect from us.

Please review the attached Renewal Rates.

These rates are guaranteed not to increase before the date below, subject to the provisions of the policy.	
Long Term Disability	**9/1/2027**

It is a pleasure working with you. If there is anything, we can do for you or your employees, please let us know.

Sincerely,

Janna Fettinger
jfettinger@unitedheritage.com
Group Lead Renewal Specialist
(208) 475-0978 (Phone)

Renewal Rates

LONG TERM DISABILITY	CURRENT RATE	NEW RATE
Voluntary Long Term Disability		
Under 25 yrs.	**$0.070**	**$0.070**
25 - 29 yrs.	**$0.090**	**$0.090**
30 - 34 yrs.	**$0.110**	**$0.110**
35 - 39 yrs.	**$0.140**	**$0.140**
40 - 44 yrs.	**$0.230**	**$0.230**
45 - 49 yrs.	**$0.330**	**$0.330**
50 - 54 yrs.	**$0.450**	**$0.450**
55 - 59 yrs.	**$0.540**	**$0.540**
60 - 64 yrs.	**$0.540**	**$0.540**
65 yrs. or more	**$0.540**	**$0.540**

Active Renewal

Signature Signed by: Jessica Grantham 0BBC54DF0FEB437...

Date 6/20/2025 | 11:29 AM EDT

May 28, 2025

LAKELAND SCHOOL DISTRICT #272
15506 N WASHINGTON ST
RATHDRUM, ID 83858-8317

RE: Group Policy: GL-2248R

Dear BROOK CUNNINGHAM,

United Heritage would like to thank you for partnering with us to provide your employees with quality products and services to support their insurance needs. We have completed the renewal process for your policies with United Heritage.

Please review your last billing statement to ensure the information is correct, as this is the information, we used to complete your renewal.

We ask that you regularly review your policy for all eligibility and participation requirements. This practice assists us in providing the exceptional customer experience you and your organization have come to expect from us.

Please review the attached Renewal Rates.

These rates are guaranteed not to increase before the date below, subject to the provisions of the policy.	
Retiree Basic Life	**9/1/2027**

It is a pleasure working with you. If there is anything, we can do for you or your employees, please let us know.

Sincerely,

Janna Fettinger
jfettinger@unitedheritage.com
Group Lead Renewal Specialist
(208) 475-0978 (Phone)

Renewal Rates

BASIC LIFE	CURRENT RATE	NEW RATE
Retiree Life (per $1,000)	**$1.500**	**$1.500**
Retiree Dependent Life (per family)	**$3.000**	**$3.000**

Retiree Renewal

Signature Signed by: Jessica Grantham 0BBC54DF0FEB437...

Date 6/20/2025 | 11:29 AM EDT

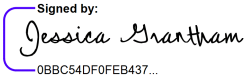
Certificate Of Completion

Envelope Id: AD4B28A0-29F2-496D-B9C7-423A63F826D7
Status: Completed
Subject: Lakeland School District - 2025 Renewal Documents
Company Name: Lakeland School District
Source Envelope:
Document Pages: 43
Signatures: 10
Certificate Pages: 5
Initials: 0
AutoNav: Enabled
EnvelopeId Stamping: Enabled
Time Zone: (UTC-05:00) Eastern Time (US & Canada)

Envelope Originator:
Katelyn Gilchrist
100 Ottawa Avenue, SW
Grand Rapids, MI 49503
KMGilchrist@acrisure.com
IP Address: 136.226.54.248

Record Tracking

Status: Original
6/19/2025 4:53:43 PM
Holder: Katelyn Gilchrist
KMGilchrist@acrisure.com
Location: DocuSign

Signer Events	Signature	Timestamp
Jessica Grantham jessica.grantham@lakeland272.org Chief Finance Officer Security Level: Email, Account Authentication (None)	Signed by:  0BBC54DF0FEB437...	Sent: 6/19/2025 5:13:30 PM Viewed: 6/20/2025 11:29:07 AM Signed: 6/20/2025 11:29:38 AM
	Signature Adoption: Pre-selected Style Using IP Address: 162.218.180.34	

Electronic Record and Signature Disclosure:
Accepted: 6/20/2025 11:29:07 AM
ID: 5c754477-25cb-48e8-9f68-cad39e9bcfa1

In Person Signer Events	Signature	Timestamp

Editor Delivery Events	Status	Timestamp

Agent Delivery Events	Status	Timestamp

Intermediary Delivery Events	Status	Timestamp

Certified Delivery Events	Status	Timestamp

Carbon Copy Events	Status	Timestamp
Sam Layson SBLayson@acrisure.com Acrisure - The Murray Group Security Level: Email, Account Authentication (None)	COPIED	Sent: 6/20/2025 11:29:43 AM

Electronic Record and Signature Disclosure:
Not Offered via Docusign

Witness Events	Signature	Timestamp

Notary Events	Signature	Timestamp

Envelope Summary Events	Status	Timestamps
Envelope Sent	Hashed/Encrypted	6/19/2025 5:13:30 PM
Certified Delivered	Security Checked	6/20/2025 11:29:07 AM
Signing Complete	Security Checked	6/20/2025 11:29:38 AM
Completed	Security Checked	6/20/2025 11:29:43 AM

Payment Events	Status	Timestamps
Electronic Record and Signature Disclosure		

ELECTRONIC RECORD AND SIGNATURE DISCLOSURE

From time to time, Acrisure, LLC (we, us or Company) may be required by law to provide to you certain written notices or disclosures. Described below are the terms and conditions for providing to you such notices and disclosures electronically through the DocuSign system. Please read the information below carefully and thoroughly, and if you can access this information electronically to your satisfaction and agree to this Electronic Record and Signature Disclosure (ERSD), please confirm your agreement by selecting the check-box next to 'I agree to use electronic records and signatures' before clicking 'CONTINUE' within the DocuSign system.

Getting paper copies

At any time, you may request from us a paper copy of any record provided or made available electronically to you by us. You will have the ability to download and print documents we send to you through the DocuSign system during and immediately after the signing session and, if you elect to create a DocuSign account, you may access the documents for a limited period of time (usually 30 days) after such documents are first sent to you. After such time, if you wish for us to send you paper copies of any such documents from our office to you, you will be charged a $0.00 per-page fee. You may request delivery of such paper copies from us by following the procedure described below.

Withdrawing your consent

If you decide to receive notices and disclosures from us electronically, you may at any time change your mind and tell us that thereafter you want to receive required notices and disclosures only in paper format. How you must inform us of your decision to receive future notices and disclosure in paper format and withdraw your consent to receive notices and disclosures electronically is described below.

Consequences of changing your mind

If you elect to receive required notices and disclosures only in paper format, it will slow the speed at which we can complete certain steps in transactions with you and delivering services to you because we will need first to send the required notices or disclosures to you in paper format, and then wait until we receive back from you your acknowledgment of your receipt of such paper notices or disclosures. Further, you will no longer be able to use the DocuSign system to receive required notices and consents electronically from us or to sign electronically documents from us.

All notices and disclosures will be sent to you electronically

Unless you tell us otherwise in accordance with the procedures described herein, we will provide electronically to you through the DocuSign system all required notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to you during the course of our relationship with you. To reduce the chance of you inadvertently not receiving any notice or disclosure, we prefer to provide all of the required notices and disclosures to you by the same method and to the same address that you have given us. Thus, you can receive all the disclosures and notices electronically or in paper format through the paper mail delivery system. If you do not agree with this process, please let us know as described below. Please also see the paragraph immediately above that describes the consequences of your electing not to receive delivery of the notices and disclosures electronically from us.

How to contact Acrisure, LLC:

You may contact us to let us know of your changes as to how we may contact you electronically, to request paper copies of certain information from us, and to withdraw your prior consent to receive notices and disclosures electronically as follows:
To contact us by email send messages to: ksmith@acrisure.com

To advise Acrisure, LLC of your new email address

To let us know of a change in your email address where we should send notices and disclosures electronically to you, you must send an email message to us at ksmith@acrisure.com and in the body of such request you must state: your previous email address, your new email address. We do not require any other information from you to change your email address.

If you created a DocuSign account, you may update it with your new email address through your account preferences.

To request paper copies from Acrisure, LLC

To request delivery from us of paper copies of the notices and disclosures previously provided by us to you electronically, you must send us an email to ksmith@acrisure.com and in the body of such request you must state your email address, full name, mailing address, and telephone number. We will bill you for any fees at that time, if any.

To withdraw your consent with Acrisure, LLC

To inform us that you no longer wish to receive future notices and disclosures in electronic format you may:

i. decline to sign a document from within your signing session, and on the subsequent page, select the check-box indicating you wish to withdraw your consent, or you may;

ii. send us an email to ksmith@acrisure.com and in the body of such request you must state your email, full name, mailing address, and telephone number. We do not need any other information from you to withdraw consent.. The consequences of your withdrawing consent for online documents will be that transactions may take a longer time to process..

Required hardware and software

The minimum system requirements for using the DocuSign system may change over time. The current system requirements are found here: https://support.docusign.com/guides/signer-guide-signing-system-requirements.

Acknowledging your access and consent to receive and sign documents electronically

To confirm to us that you can access this information electronically, which will be similar to other electronic notices and disclosures that we will provide to you, please confirm that you have read this ERSD, and (i) that you are able to print on paper or electronically save this ERSD for your future reference and access; or (ii) that you are able to email this ERSD to an email address where you will be able to print on paper or save it for your future reference and access. Further, if you consent to receiving notices and disclosures exclusively in electronic format as described herein, then select the check-box next to 'I agree to use electronic records and signatures' before clicking 'CONTINUE' within the DocuSign system.

By selecting the check-box next to 'I agree to use electronic records and signatures', you confirm that:

- You can access and read this Electronic Record and Signature Disclosure; and
- You can print on paper this Electronic Record and Signature Disclosure, or save or send this Electronic Record and Disclosure to a location where you can print it, for future reference and access; and
- Until or unless you notify Acrisure, LLC as described above, you consent to receive exclusively through electronic means all notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to you by Acrisure, LLC during the course of your relationship with Acrisure, LLC.