DENTAL PLAN DOCUMENT AND SUMMARY OF HEALTH CARE BENEFITS FOR: TRUST: IDAHO INDEPENDENT INTERGOVERNMENTAL AUTHORITY (III-A) TRUST

EFFECTIVE DATE: OCTOBER 1, 2024

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HOW TO SUBMIT CLAIMS

A Participant must submit a claim to Delta Dental of Idaho (DDI) in order to receive benefits for Covered Services. There are two ways for a Participant to submit a claim:

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

2. The Participant can send DDI the claim.

To File A Participant's Own Claim
If a Covered Provider prefers that a Participant file the claim, here is the procedure to follow:

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

2. Obtain a Dental Claim Form from the Delta Dental of Idaho website, located at www.deltadentalid.com, or from the Dental Provider and follow the instructions. Use a separate billing and Dental Claim Form for each patient.

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

   Delta Dental of Idaho
   P.O. Box 2870
   Boise, ID 83701

For assistance with claims or dental benefit information, please call Delta Dental of Idaho's Customer Service at (800)-356-7586 or (208) 489-3580.

How Delta Dental of Idaho Notifies The Participant
DDI will send the Participant an Explanation of Benefits (EOB) either electronically or by mail, as soon as the claim is processed. The EOB will show all the payments DDI made and to whom the payments were sent. It will also explain any charges DDI did not pay in full. Participants should keep this EOB for their records. If a Participant would like a paper copy of their EOB, they may request one from DDI Customer Service.

GENERAL CONTACT INFORMATION

For general information, please contact Delta Dental of Idaho:

Street Address:

Delta Dental of Idaho
555 E Parkcenter Boulevard
Boise, ID 83706

Mailing Address:
Delta Dental of Idaho
P.O. Box 2870
Boise, ID 83701

Customer Service:
(208) 489-3580 (Boise Area)
(800) 356-7586
Customerservice@deltadentalid.com

IDAHO DEPARTMENT OF INSURANCE CONTACT INFORMATION

Idaho Department of Insurance
Consumer Affairs
700 W State Street, 3rd
Floor PO Box 83720
Boise ID 83720-0043
1-800-721-3272 or www.DOI.Idaho.gov

DENTAL PLAN BENEFITS

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

I. Benefit Period and Benefit Limit For Covered Services

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

II. Covered Providers

The following are Covered Providers under this section:

- Dentist
- Denturist

III. Deductibles

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

IV. Predetermination Of Benefits

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

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

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

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

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

A Predetermination of Benefits is valid for three (3) months from the date it is issued. After three (3) months, a Dental Treatment Plan must be resubmitted for a new Predetermination of Benefits before treatment begins. All Predetermination of Benefits will be processed without taking into consideration dental benefits that may be paid under another certificate of insurance.

V. Amount Of Payment

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

{VARIABLE-
Benefits for Orthodontic Services are paid as follows:

A. DDI will pay benefits on the patient's initial banding.
B. Thereafter, DDI, on behalf of the Trust, will pay benefits up to the Orthodontic Lifetime Benefit Limit as Covered Services are performed so long as the Participant continues orthodontic treatment and remains covered under this Plan.**}**

A. Dental Services Outside Idaho

For Dental Covered Services furnished by a Dentist outside the state of Idaho, DDI will provide benefit payments according to the following:

1. If the Dentist has a PPO or Premier agreement for claims payment with the Delta Dental plan in the area where the Covered Services were rendered, DDI will base the payment on the local plan's payment arrangement and allow In-Network benefits.
2. If the Dentist does not have a PPO or Premier agreement for claims payment with the Delta Dental plan in the area where the Covered Services are rendered, DDI will base the payment on the Maximum Allowance and allow Out-of-Network benefits.

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

B. Dental Services From A Contracting Dentist

A Contracting Dentist rendering Covered Services as provided in this section shall not make an additional charge to a Participant for amounts in excess of the Maximum Allowance except for Deductible, Cost Sharing, and charges for noncovered services, if any. A Contracting Dentist is not obligated to accept DDI's Maximum Allowance for services after 200% of any Benefit Period or Lifetime Maximum Limit have been exceeded. In this instance, Participants are responsible for any difference between the amount charged by the Contracting Dentist and the Maximum Allowance.

C. Dental Services From A Noncontracting Dentist

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

VI. Closed List OF Dental Covered Services

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

Health through Oral Wellness® (HOW®) Program:

Delta Dental of Idaho's innovative Health through Oral Wellness® (HOW®) program works with existing dental benefits to help Delta Dental members achieve and maintain better oral wellness. By taking an oral health assessment with the dentist, HOW provides additional benefits at no extra cost based on specific oral health risks and needs.

As a participant in the Health through Oral Wellness® (HOW®) program, the enrollee may be eligible for additional preventive benefits, subject to the annual maximum, deductible, cost sharing and/or co-pays and other standard policy provisions. These additional preventive benefits may include more frequent prophylaxis (cleanings), fluoride treatments, sealants, periodontal maintenance (gum disease treatment), full mouth debridement, cavity susceptibility tests, oral hygiene instruction, nutritional counseling, and tobacco cessation counseling.

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

A. Type I: Preventive Dental Services

1. Oral examination—limited to two (2) per Benefit Period.
2. Emergency oral examination—covered for trauma, acute infection, or acute pain.
3. Complete mouth series or panoramic x-ray —limited to one (1) time in any five (5) consecutive Benefit Periods, unless requested by DDI for verification of treatment claimed.
4. Individual periapical x-rays—limited to the same benefit as a complete mouth series or panoramic x-ray. Individual periapical x-rays are not covered when performed during root canal therapy as an intra-operative procedure.
5. Occlusal x-rays—limited to once per Benefit Period.

6. Extraoral x-rays – limited to once per Benefit Period.
7. Bitewing x-rays—limited to once every 12 months. Limited to the same benefit as a complete mouth series or panoramic x-ray.
8. Dental prophylaxis—limited to two (2) every Benefit Period regardless of type (dental prophylaxis or periodontal maintenance).
9. Fluoride treatments—limited to two (2) applications per Benefit Period and limited to Participants who are under age nineteen (19).
10. Topical application of sealants per tooth—limited to primary and permanent posterior unrestored dentition of Participants under age nineteen (19). Also limited to one (1) time in any two (2) consecutive Benefit Periods.
11. Space maintainers—limited to Participants who are under age fourteen (14). Benefits limited to deciduous teeth. Includes all adjustments made within six (6) months of installation.

B. Type II: Basic Dental Services

1. Amalgam restorations—posterior restorations involving multiple surfaces will be combined for benefit purposes and paid according to the number of surfaces treated. Same tooth surface restoration is covered once in a two (2) year period.
2. Pin retention.
3. Resin-Composite restorations—posterior restoration involving multiple surfaces will be combined for benefit purposes and paid according to the number of surfaces treated. Same tooth surface restoration is covered once in a two (2) year period.
4. Simple extractions.
5. Surgical removal of an erupted or partially erupted tooth or mucoperiosteal flap or incision of soft tissue.
6. Impaction that requires incision of overlying soft tissue, elevation of a flap and either removal of bone and tooth or sectioning and removal of the tooth (extraction of tooth, partial bony impaction).
7. Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone, and sectioning of the tooth for removal (extraction of tooth, complete bony extraction).
8. Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone, sectioning of the tooth for removal, and/or presents unusual difficulties and circumstances (including report).
9. Root recovery.
10. Palliative treatment paid as a separate benefit only if no other treatment is rendered during the visit.
11. Excision of pericoronal tissues.
12. Tooth reimplantation.
13. Tooth transplantation—separate benefits are not payable for donor site charges.
14. Alveoloplasty and alveolectomy—not separately payable if performed on the same date as extraction.
15. Frenectomy (frenulectomy).
16. Excision of hyperplastic tissue.
17. Incision and drainage.
18. Radical excision (lesion diameter up to or greater than 1.25 cm) —not payable in addition to extraction performed in same site on same date.
19. Excision pericoronal gingiva (operculectomy).
20. Excision of benign tumor (lesion diameter up to or greater than 1.25 cm) —not payable in addition to extraction performed in same site on same date.
21. Biopsy of soft or hard oral tissue (for removal of specimen only).
22. Synthetic bone grafting procedures.
23. Removal of odontogenic cyst or tumor (diameter up to or greater than 1.25 cm) —not payable in addition to extraction performed in same site on same date.
24. Suture of small wounds.
25. General anesthesia—limited to the first thirty (30) minutes in conjunction with Oral Surgery.
26. I.V. sedation—limited to the first thirty (30) minutes in conjunction with Oral Surgery.
27. Pulpotomy.
28. Root canal therapy—multiple endodontic treatments, on the same tooth within a period of two (2) years, are subject to review and approval by DDI.
29. Apicoectomy and retrograde filling.
30. Hemisection.
31. Scaling and root planing—limited to once per quadrant of the mouth, every two (2) Benefit Periods.

32. Periodontal maintenance— limited to two (2) times every Benefit Period , providing a routine prophylaxis has not been performed in the same time period; limited to four (4) per Benefit Period if Participant has had previously treated periodontal disease.
33. Gingivectomy—one (1) such surgical procedure per quadrant, once every three (3) years.
34. Osseous Surgery—one (1) such surgical procedure per quadrant, once every three (3) years.
35. Osseous grafts—only autogenous grafts are covered. Synthetic grafting techniques are not covered.
36. Pedicle grafts.
37. Free soft tissue grafts.
38. Full Mouth Debridement—limited to once per lifetime if no cleanings within 12 months of the service date (an additional cleaning is allowed within 60 days of the full mouth debridement).
39. Recement inlays; recement crowns; recement bridges.
40. Repairs to crowns.
41. Sedative Fillings.

C. Type III: Major Dental Services

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

1. Crown build-up—covered only if Medically Necessary and are subject to DDI review.
2. Tissue conditioning—limited to repairs or adjustments performed more than twelve (12) months after the initial insertion of prosthesis.
3. Occlusal guard—covered for erosion or abrasion limited to one (1) appliance every two (2) Benefit Periods.
4. Repairs to full dentures, repairs to partial dentures, and/or repairs to bridges—limited to repairs performed more than twelve (12) months after the initial insertion of prosthesis.
5. Inlays and onlays—covered only when the teeth cannot be restored by a filling, and only if more than seven (7) years have elapsed since the last placement. If a tooth can be restored with a filling, the benefit will be limited to the allowable benefit for a composite restoration.
6. Crowns and laminate veneers—covered only when the tooth has visible destruction of tooth surface from decay and the tooth cannot be restored by a filling. Benefits will not be allowed when placement of the crown or veneer is for micro fractures, stress fractures or craze lines. Coverage is available if more than one-third (1/3) of the tooth is missing due to accident or erosion. Coverage is allowed if more than seven (7) years have elapsed since the last placement. For Participants under age twelve (12), benefits are limited to plastic/resin based or stainless steel crowns.
7. Stainless steel crowns—covered only when the tooth has visible destruction of tooth surface from decay and the tooth cannot be restored by a filling. Benefits will not be allowed when placement of the crown or veneer is for micro fractures, stress fractures or craze lines. Coverage is available if more than one-third (1/3) of the tooth is missing due to accident or erosion. Coverage is allowed if more than two (2) years have elapsed since the last placement.
8. Post and core.
9. Full dentures—includes all adjustments within six (6) months of installation. Replacement of a denture is covered only if the existing denture is more than seven (7) years old and cannot be repaired. There are no additional benefits for overdentures or customized dentures.
10. Partial dentures—includes two (2) clasps and rests, all teeth, and all adjustments within six (6) months of installation. Replacement of a partial denture with another denture or fixed bridgework is eligible for benefits only if the existing denture is more than seven (7) years old and cannot be repaired. There are no additional benefits for precision or semi-precision attachments.
11. Each additional clasp and rest (beyond two (2)).
12. Denture adjustments—one (1) adjustment per Benefit Period and only if performed more than six (6) months after the insertion of the denture.
13. Relining dentures—Relines performed twelve (12) months after initial placement and no more than once in a twenty-four (24) month period.
14. Fixed bridges—Replacement of an existing fixed bridge or partial denture is eligible only if the existing appliance is more than seven (7) years old and cannot be repaired.
15. Implant, including the implant body, implant abutment and implant crown – benefits are covered per tooth with a maximum lifetime benefit of $1,200 or the plan's benefit year maximum, whichever is less (age 19 and over).

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

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

Implant Crown – Coverage is allowed if more than seven (7) years has elapsed since the last placement of a prosthetic of any type on the tooth.

{ VARIABLE-

D. Type IV: Orthodontic Services

1. Orthodontia or Orthodontic Treatment.}

VII. Conditions

A. Right To Review Dental Work

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

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

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

C. Alternate Treatment Plan

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

ELIGIBILITY AND ENROLLMENT SECTION

I. Eligibility And Enrollment

The Employer decides which categories of its Employees and Dependents will have the opportunity to apply for coverage under this Plan in accordance with the Employer's employee handbook. The Employer will determine if there are certain probationary periods that must be satisfied before a new Eligible Employee can qualify for coverage under this Plan. Please contact your manager of employee benefits for the probationary period and any other restrictions applicable.

A. Eligible Employee

To qualify as an Eligible Employee under this Plan, a person must be and remain a full-time employee or partner of the Employer who regularly works a minimum required hours per week established by the Employer and is paid on a regular, periodic basis through the Plan Sponsor's payroll system**,** or a retiree who is under the age of sixty-five (65) years and has met the eligibility requirements for retirement as determined by the Plan Sponsor; or for an elected official who is specifically stated as eligible in the individual Agency's Personnel Policy. **Please see your employee handbook for complete eligibility requirements.**

B. Eligible Dependent

The Employer decides which categories of dependents are eligible for coverage under this Policy as described in the employee handbook. **Please see your employee handbook for complete eligibility requirements.** Notwithstanding any other provision of the Plan, if the benefits of the Plan are not available to certain dependents and certain categories of dependents are not eligible to enroll or receive benefits, references in this Plan do not apply.

If this Plan provides coverage for an Eligible Dependent Spouse and/or Eligible Dependent Child(ren) a person must be and remain one (1) of the following:

1. The Enrollee's spouse under a legally valid marriage.
2. The Enrollee's natural child, stepchild, legally adopted child, child placed with the Enrollee for adoption, or child for whom the Enrollee or the Enrollee's spouse has court-appointed guardianship or custody. The child must be:
   a) Under the age of twenty-six (26); or
   b) Medically certified as disabled due to intellectual disability or physical handicap *and* financially dependent upon the Enrollee for support, regardless of age.
3. An Enrollee must notify the Plan Sponsor within thirty (30) days when a dependent no longer qualifies as an Eligible Dependent. Coverage for the former Eligible Dependent will terminate the last day of the month in which the change in eligibility status took place.

II. Leave Of Absence

On its regular billing, the Trust shall notify Delta Dental of Idaho of the Enrollee's date of departure for the leave of absence, and shall continue its regular Contribution for the Enrollee's coverage during the leave of absence.

III. Trust Contribution

The Trust agrees it will pay one hundred percent (100%) of the amount paid in benefits for all Participants under this Plan, except as modified by the Administrative Services Agreement.

IV. Miscellaneous Eligibility And Enrollment Provisions

A. All eligible Persons will have the opportunity to apply for coverage. All applications submitted to the Trust by the Plan Sponsor now or in the future, are for Eligible Persons or Eligible Dependents only.

The Trust agrees to be responsible for and make the total required payment to DDI as provided in the Administrative Services Agreement. The Trust further agrees that no other hospital, medical or surgical group coverage will be offered to employees during the term of this Plan, unless required by State or Federal law.

B. Before the Effective Date of the change, the Plan Sponsor must submit all eligibility changes for Enrollees and Eligible Dependents to the Trust. It is the Plan Sponsor's responsibility to verify that all Participants are eligible for coverage as specified in this Plan. DDI will have the right to audit the Employer's employment, payroll, and eligibility records to verify that all Participants are eligible and properly enrolled and to ensure that the Employer meets enrollment requirements.

D. 1. For an Eligible Employee to enroll himself or herself and any Eligible Dependents for coverage (or for an Enrollee to enroll Eligible Dependents for coverage) the Eligible Employee or Enrollee must complete an III-A Trust application submit it to the Plan Sponsor.

2. The Effective Date of coverage for an Eligible Employee and Eligible Dependents listed on the Eligible Employee's application is the date indicated by the Trust.

E. 1. Except as stated otherwise in subparagraphs D.2 and 3. below, the initial enrollment period is ninety (90) 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. An Enrollee's newborn Dependent, including adopted newborn children who are placed with the adoptive Enrollee within sixty (60) days of the adopted child's date of birth, are covered under this Plan from and after the date of birth for sixty (60) days.

In order to continue coverage beyond the sixty (60) days outlined above, the Enrollee must submit an III-A Trust 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 Plan, 'child' means an individual who has not attained age twenty-six (26) years as of the date of the adoption or placement for adoption. In this Plan, "placed for adoption" means physical placement in the care of the adoptive Enrollee, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it means when the adoptive Enrollee signs an agreement for adoption of the child and signs an agreement assuming financial responsibility for the child.

3. If enrollment is requested during a Special Enrollment Period due to marriage, the Effective Date of coverage will be the first day of the month following the marriage.

F. Late Enrollee

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 Enrollee. Following the receipt and acceptance of a completed enrollment application, the Effective Date of coverage for a Late Enrollee will be the date of the Trust's next Plan Date.

G. Special Enrollment Periods/Qualifying Events

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

1. Individuals Losing Other Coverage — An Eligible Enrollee or Eligible Dependent losing other coverage may enroll for coverage under this Plan if each of the following conditions is met:
   a) The Eligible Enrollee 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 Enrollee's or Eligible Dependent's coverage described in subparagraph a):
      (1) was under a COBRA continuation provision and the coverage under such provision was exhausted; or
      (2) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.
   c) Under the terms of this Plan, the Eligible Enrollee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph b)(1) or termination of coverage or employer contribution described in subparagraph b)(2).

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

before age twenty-six (26) or placement for adoption before age twenty-six (26), 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 Enrollee 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 an Enrollee 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 Delta Dental of Idaho;

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

(3) in the case of an Eligible Dependent's adoption or placement for adoption, the date of birth for an Eligible Dependent adopted or placed for adoption within 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 under this Plan 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 under this Plan no later than sixty (60) days after the date of termination of such coverage.

V. Qualified Medical Child Support Order

A. If this Plan provides Family Coverage DDI, on behalf of the Trust, will comply with a Qualified Medical Child Support Order (QMCSO) and any other applicable federal or state laws. A medical child support order is any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that:

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

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

1. The name and the last known mailing address (if any) of the Enrollee and the name and mailing address of each child covered by the order.
2. A reasonable description of the type of coverage to be provided by this Plan to each such child, or the manner in which such type of coverage is to be determined.
3. The period to which such order applies.

C. 1. Within fifteen (15) days of receipt of a medical child support order, DDI will notify the party who sent the order and each affected child of the receipt and of the criteria DDI uses to determine if the medical child support order is a QMCSO. In addition, DDI 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 DDI. 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, DDI will determine if the medical child support order is a QMCSO and will notify the Enrollee, the party who sent the order, and each affected child of such determination.

D. DDI, 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 state Department of Health and Welfare as defined by the QMCSO.

DEFINITIONS SECTION

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

Accidental Injury—an objectively demonstrable impairment of bodily function or damage to part of the body caused by trauma from a sudden, unforeseen external force or object, occurring at a reasonably identifiable time and place, and without a Participant's foresight or expectation, which requires medical attention at the time of the accident. 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 Service Agreement—a formal agreement between DDI and the Board of Trustees 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 this Plan.

Amendment (Amend)—a formal document signed by the 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's benefits for Covered Services accumulate toward annual benefit limits, Deductible amounts and out-of-pocket Limits. For the purposes of this document, this period of time is a calendar year from January 1 through December 31.

Benefit Limit—the Benefit Limit is per Eligible Participant under this Plan and applies to all paid Dental Covered Services as they relate to Basic and Major Services. Preventive and Diagnostic Services do not count towards the Benefit Limit.

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

Board of Trustees—the Board of Trustees of the Idaho Independent Intergovernmental Authority (III-A) Trust has all discretionary authority to interpret the provisions and control the operation and administration of the Plan within the limits of the law. All decisions made by the Board of Trustees, including final determination of Medical Necessity, shall be final and binding. The Board of Trustees also reserves the right to modify eligibility clauses for new Plan participants who join the Plan as a result of a merger, acquisition or for any employee who was covered under a labor agreement plan during a previous period of employment to which the employee's Employer contributes, provided that coverage under this Plan begins within 31 days of the date coverage under the previous Plan terminates. The Idaho Independent Intergovernmental Authority (III-A) Trust may choose to hire a consultant and/or Contract Administrator to perform specified duties in relation to the Plan. The Board of Trustees also has the right to amend, modify or terminate the Plan at any time or in any manner as outlined in the Administrative Services Agreement.

The administration of the Plan document is under the supervision of the Board of Trustees. The Idaho Independent Intergovernmental Authority (III-A) Trust acts on behalf of the Board of Trustees. The Board of Trustees has agreed to indemnify each employee in the Idaho Independent Intergovernmental Authority (III-A) Trust for any liability he/she incurs as a result of acting on behalf of the Board of Trustees, except if such liability is due to his/her gross negligence or misconduct.

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

Delta Dental of Idaho, Inc. or DDI—a nonprofit dental service corporation, hired by Idaho Independent Intergovernmental Authority (III-A) Trust to act as the third party Contract Administrator to perform claims processing and other specific administrative services as outlined in the Plan and/or Administrative Service Agreement.

Congenital Anomaly—a condition existing at or from birth, which is a significant deviation from the common form or function of the body, whether caused by a hereditary or a developmental defect or Disease. In this Plan, the term significant deviation is defined to be a deviation which impairs the function of the body and includes but is not limited to the conditions of

cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be Congenital Anomalies.

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

Contracting Dentist—a Dentist who has entered into a written agreement with DDI regarding payment for Dental Covered Services rendered to a Participant under a PPO or Premier Dental Plan Option. If a Dentist has an agreement for claims payment with a Delta Dental Plans Association affiliate in the area where the Covered Services are rendered, DDI will base the payment on the local plan's payment arrangement and allow in-network benefits.

Contribution—the amount paid or payable by the Employer 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 Plan from whom a Participant must receive Covered Services in order to be eligible to receive benefits.

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

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

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

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

Dental Treatment Plan—the Dentist's report of recommended treatment on a form satisfactory to DDI that:
1. Itemizes dental procedures by American Dental Association (ADA) code and description necessary for the care of a Participant.
2. Lists the charges for each procedure.
3. Is accompanied by supporting preoperative x-rays and any other appropriate diagnostic materials reasonably required by DDI to help make a benefit decision.

Dentist—an individual licensed to practice Dentistry.

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

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

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

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

Eligible Dependent—a person eligible for enrollment under an Enrollee's coverage.

Eligible Employee—an employee, sole proprietor or partner of a Plan Sponsor, or a retiree who is under the age of sixty-five (65) years, who is entitled to apply as an Enrollee.

Employer—an Employer participating in the Trust.

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

Family Coverage—the enrollment of an Enrollee and two (2) or more Eligible Dependents under this Plan.

Health through Oral Wellness® (HOW®) Program—Delta Dental of Idaho's innovative program works with existing dental benefits to help Delta Dental members achieve and maintain better oral wellness.

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

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

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

In-Network Services—Covered Services provided by a Contracting Dentist.

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

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

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

Lifetime Benefit Limit—the greatest aggregate amount payable by DDI on behalf of a Participant for specified Covered Services during all periods in which the Participant has been continuously enrolled or covered under any agreement, certificate, contract, or on behalf of the Trust.

Maximum Allowance—for Covered Services under the terms of this Plan, Maximum Allowance is the lesser of the billed charge or the amount established by DDI as the highest level of compensation for a Covered Service. If the Covered Services are rendered outside the state of Idaho by a Noncontracting or Contracting Provider with a Delta Dental Plans Association affiliate in the location of the Covered Services, the Maximum Allowance is the lesser of the billed charge or the amount established by the affiliate as compensation.

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

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

Medically Necessary (or Medical Necessity) —the Covered Service or supply recommended by the treating Covered Provider to identify or treat a Participant's condition, Disease, Illness or Accidental Injury and which is determined by DDI 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 Dentist 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 Plan.

The term Medically Necessary as defined and used in this 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, DDI considers the dental records as well as utilizes Dental Consultants to review claims for the necessity of dental treatment. This process ensures the treatment proposed or performed is clinically appropriate.

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

Noncontracting Dentist—a Dentist who has not entered into a written agreement with DDI regarding payment for Dental Covered Services rendered to a Participant under a PPO or Premier Dental Plan Option. If the Dentist does not have an agreement for claims payment with the affiliate in the area where Covered Services are rendered, DDI will base the payment on the Maximum Allowance and allow Out-of-Network benefits.

Open Enrollment Period—A period of time scheduled annually by the Trust. The Participant may, during the Open Enrollment Period enroll as an Eligible Employee or enroll Eligible Dependents previously excluded from or denied coverage in the Dental Benefits Plan currently available to the Trust through DDI.

Orthodontic Lifetime Limit—the Orthodontic Lifetime Limit, per Eligible Participant under this Plan and applies to all Dental Covered Services related to Orthodontia.

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

Out-Of-Network Services—Covered Services that are not rendered by a Contracting Dentist.

Participant—an Enrollee or an enrolled Eligible Dependent covered under this Plan**.**

Plan(s)—a multiple employer welfare 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 Employer and Eligible Employees.

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

Plan Sponsor—a participating Employer in the Trust that performs the applicable responsibilities as outlined in this Plan on behalf of the Trust.

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

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

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

Premier Dental Option—a Premier Dental Option in which a Participant receives a level of benefits for In-Network Services.

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

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

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

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

Surgery—within the scope of a Provider's license, the performance of:
1. Generally accepted operative and cutting procedures.
2. Endoscopic examinations and other invasive procedures using specialized instruments.
3. The correction of fractures and dislocations.
4. Customary preoperative and postoperative care.

Trust—Idaho Independent Intergovernmental Authority (III-A) Trust, also the Board of Trustees.

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

EXCLUSIONS AND LIMITATIONS SECTION

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

I. General Exclusions And Limitations

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

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

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

1. For full dentures or partial dentures: on the date the final impression is taken.
2. For fixed bridges, crowns, inlays or onlays: on the date the teeth are first prepared.
3. For root canal therapy: on the later of the date the pulp chamber is opened or the date canals are explored to the apex.
4. For periodontal Surgery: on the date the Surgery is actually performed.
5. For all other services: on the date the service is performed.
6. For orthodontic services, if benefits are available under this Plan: on the date any bands or other appliances are first inserted.

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

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

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

F. A service for cosmetic purposes.

G. In excess of the Maximum Allowance.

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

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

J. Replacement of lost or stolen appliances.

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

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

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

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

O. Any service, procedure or supply for which the prognosis for success is not reasonably favorable as determined by DDI on behalf of the Trust.

P. Myofunctional therapy and biofeedback procedures.

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

R. Diagnostic casts.

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

T. Investigational in nature.

U. 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.

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

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

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

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

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

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

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

AC. 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.

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

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

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

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

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

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

AI. For acupuncture or hypnosis.

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

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

AL. Denture duplication.

AM. Occlusal adjustments.

AN. Treatment of jaw fractures.

AO. Charges for acid etching.

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

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

AR. Nutritional counseling, tobacco counseling and oral hygiene instruction are not covered benefits except for participants in Delta Dental's Health through Oral Wellness® (HOW®) program.

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

AT. Cone beam image.

GENERAL PROVISIONS SECTION

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

A. If an Enrollee ceases to be an Eligible Employee or the Employer does not remit the required contribution, the Enrollee's coverage and the coverage of any and all enrolled Eligible Dependents will terminate on the last day of the last month for which payment was made. If the Trust does not remit the required payments as required by the Administrative Services Agreement and Delta Dental of Idaho elects to terminate this Agreement, the enrollee's coverage and the coverage of any and all enrolled Eligible Dependents will terminate on the last day for which the Trust reimbursed Delta Dental of Idaho for the payment of claims and administrative fees.

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

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

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

E. The Trust may terminate or retroactively rescind a Participant's coverage under this Plan for any intentional misrepresentation, omission, or concealment of fact by, concerning, or on behalf of any Participant that was or would have been material to the 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 Plan for a child placed for adoption with an Enrollee continues as it would for a naturally born child of the Enrollee until the first of the following events occurs:

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

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

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

II. Plan Administrator—COBRA and ERISA

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

III. Contract Between DDI And The Trust—Description Of Coverage

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

IV. Applicable Law

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

V. Benefits To Which Participants Are Entitled

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

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

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

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

VI. Notice Of Claim

DDI will process claims for benefits on behalf of the Trust according to the Administrative Services Agreement between the parties. A claim for Covered Services must be submitted within one (1) year from the date of service and must include all the information necessary for DDI, on behalf of the Trust, to determine benefits.

VII. Release And Disclosure Of Medical Records And Other Information

In order to effectively apply the provisions of this Plan, DDI 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. DDI may also disclose to Providers and other entities, information obtained from the Participant's transactions such as Plan coverage, Contributions, payment history and claims data necessary to allow the processing of a claim and for other health care operations. To protect the Participant's privacy, DDI treats all information in a confidential manner. For further information regarding DDI's privacy policies and procedures, the Participant may request a copy of DDI's Notice of Privacy Practices by contacting Customer Service at the number provided in this Plan.

VIII. Exclusion Of General Damages

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

IX. Payment Of Benefits

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

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

B. Delta Dental of Idaho 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 DDI 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 DDI 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 Enrollee'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. DDI 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 and of the Participant's right to file a complaint with the Department of Insurance.

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

X. Participant/Provider Relationship

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

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

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

XI. Participating Plan

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

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

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

The Order of Benefit Determination Rules govern the order in which each Contract will pay a claim for benefits. The Contract that pays first is called the Primary Contract. The Primary Contract must pay benefits in accordance with its policy terms without regard to the possibility that another Contract may cover some expenses. The Contract that pays

after the Primary Contract is the Secondary Contract. The Secondary Contract may reduce the benefits it pays so that payments from all Contracts does not exceed one hundred percent (100%) of the total Allowable Expenses.

A. Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Order Of Benefit Determination Rules

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

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

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

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

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

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

so that the Contract covering the Participant as an employee, member, policyholder, subscriber or retiree is the Secondary Contract and the other Contract is the Primary Contract.

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

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

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

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

XIII. Incorporated By Reference

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

XIV. Inquiry And Appeals Procedures

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

A. Informal Inquiry

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

B. Formal Appeal

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

1. A written appeal must be sent to the Appeals and Grievance Coordinator within one hundred eighty (180) days after receipt of the notice of Adverse Benefit Determination. Urgent claim appeals, and

the documents in support of such appeals may be submitted by phone or facsimile. The appeal should set forth the reasons why the Participant contends DDI's decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.

2. After receipt of the appeal, all facts, including those originally used in making the initial decision and any additional information that is sent or that is otherwise relevant, will be reviewed by a DDI Dental Director, or dental consultant. For non-urgent claim appeals, DDI 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 dental exigencies of each claim.

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

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

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

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

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

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

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

D. External Review

At DDI's discretion, 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 Delta Dental of Idaho's second formal written appeal decision. External Review will be made by an impartial provider, associated with an independent review organization, who

practices in the same or a similar specialty as the one involved in the review. The Independent Review Organization will issue a determination within sixty (60) days of receipt of the request for External Review.

Submission of an appeal for External Review is voluntary and does not affect a Participant's other rights that may be available following the exhaustion of the formal appeals process, except that the time to file such action shall be tolled while the External Review is pending

XV. Reimbursement Of Benefits Paid By Mistake

If DDI mistakenly makes payment for benefits on behalf of an Enrollee or his or her Eligible Dependent(s) that the Enrollee or his or her Eligible Dependent(s) is not entitled to under this Plan, the Enrollee must reimburse the erroneous payment to DDI, on behalf of the Trust.

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

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

XVI. Subrogation and Reimbursement Rights of Delta Dental of Idaho

The benefits of this Plan will be available to a Participant when he or she is injured, suffers harm or incurs loss due to any act, omission, or defective or unreasonably hazardous product or service of another person, firm, corporation or entity (hereinafter referred to as "third party"). To the extent that such benefits for Covered Services are provided or paid for by Delta Dental of Idaho, on behalf of the Trust under this Plan or any other Delta Dental of Idaho plan, agreement, certificate, contract or plan, Delta Dental of Idaho, 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 his or her heirs, estate, and/or personal representative.

As a condition of receiving benefits for Covered Services in such an event, the Participant or his or her personal representative shall furnish Delta Dental of Idaho 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 his or her 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.

Delta Dental of Idaho, 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 his or her legal representative will transfer to Delta Dental of Idaho, on behalf of the Trust any rights he or she may have to take legal action arising from the injury, harm or loss to recover any sums paid on behalf of the Participant. Thus, Delta Dental of Idaho, 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 Delta Dental of Idaho in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm or loss and shall do nothing whatsoever to prejudice Delta Dental of Idaho's subrogation rights and efforts. Delta Dental of Idaho, 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, Delta Dental of Idaho and the Trust are not responsible for any attorney's fees or other expenses or costs incurred by the Participant without the prior written consent of Delta Dental of Idaho and, therefore, the "common fund" doctrine does not apply to any amounts recovered by any attorney the Participant hires regardless of whether amounts recovered are used to repay benefits paid by Delta Dental of Idaho, on behalf of the Trust.

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

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

Delta Dental of Idaho, 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.

Delta Dental of Idaho's subrogation and reimbursement rights shall take priority over the Participant's rights both for benefits provided and payments made by Delta Dental of Idaho, and for benefits to be provided or payments to be made by Delta Dental of Idaho in the future on account of the injury, harm or loss giving rise to Delta Dental of Idaho'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 Delta Dental of Idaho.

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 Delta Dental of Idaho's subrogation and reimbursement rights, and shall constitute a Special Credit applicable to such future benefits and payments that would otherwise be owed by this Plan, or any subsequent Plan provided by this Plan Sponsor. Thereafter, Delta Dental of Idaho, on behalf of the Trust, shall have no obligation to provide any further benefits or make any further payment until the Participant has incurred medical expenses in treatment of such injury, harm or loss equal to such Special 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 the Plan or reduce benefits unless contained in a written instrument signed by the Plan Sponsor or the enrolled person.

XVIII. Individual Benefits Management

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

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

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

XVIV. Coverage And Benefits Determination

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

XX. Dental Care Providers Outside the United States

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

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

GENERAL INFORMATION

Name and Address of the Trust

Idaho Independent Intergovernmental Authority (III-A) Trust
PO Box 190477
Boise, ID 83719
(208) 317-2814

Name and Address of the Third Party Contract Administrator

Street Address:
Delta Dental of Idaho
555 E. Parkcenter Boulevard
Boise, ID 83706

Mailing Address:
Delta Dental of Idaho
P.O. Box 2870
Boise, ID 83701

Customer Service:
(208) 489-3580 (Boise Area)
(800) 356-7586
Customerservice@deltadentalid.com

Name and Address of the Designated Agent for Service of Legal Process

Jeremy Chou
Givens Pursley LLP
601 W Bannock Street
Boise, ID 83702

Internal Revenue Service and Plan Identification Number

The corporate tax identification number assigned by the Internal Revenue Service is 45-1341997 the Plan number is 501.

Plan Year

The Plan Year is the 12-month fiscal period for the Plan beginning October 1, which is used for the purpose of IRS tax filing.

Method of Funding Benefits

Benefits are self-funded from the Trust, employee and Employer Contributions.

Payments out of the Plan to health care providers on behalf of the covered person will be based on the provisions of the Plan.