Plan Name: Idaho AGC Self-Funded Benefit Trust

Plan Sponsor: Idaho Branch Inc.,
Associated General Contractors of America, Inc.

Trust: Idaho AGC Self-Funded Benefit Trust

Administered by Delta Dental of Idaho

Core Dental Plan
Effective Date: January 1, 2025

This is a self-funded plan and is not insurance and does not participate in the Idaho Life and Health Guaranty Association

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CONTACT INFORMATION

Delta Dental of Idaho
555 East Parkcenter Blvd.
Boise, Idaho 83706

Telephone Numbers

Member Inquiries

Toll Free 1-800-356-7586

Dental Office Inquiries

Toll Free 1-800-356-7586

Welcome Using Your Program

Welcome to Delta Dental of Idaho.

This handbook describes the main features of the dental plan (the “Plan”).

The Plan itself is self-funded by the Group and Delta Dental of Idaho has been contracted to provide claims and other administrative services.

In this handbook, the terms, "you" and "your" refer to the enrolled employee. The terms "we", "us", and "our", refer to Delta Dental of Idaho, the Claims Administrator of the Plan.

Our dental plans offer access to one of the largest dental networks in Idaho and across the nation. They are easy to use and cost effective. If you choose a participating dentist from the Delta PPO or Premier Dental Directory (which is available on the Delta Dental website at www.deltadentalid.com under “Find a Dentist”), all of the paperwork takes place between our office and your dentist's office. For travelers and employees outside Idaho, Delta Dental Plans Association provides offices and/or contacts in every state.

When you need dental care you may use any dental provider. However, **there are differences in reimbursement by Delta Dental for participating dentists and non-participating dental providers.** While a Participant may choose the services of any dentist, Delta Dental does not guarantee the availability of any particular dentist.

During your first appointment, tell your dental provider that you have dental benefits through Delta Dental. You will need to provide your subscriber identification number and Delta Dental Group number to the dentist.

For expensive treatment plans, a predetermination is recommended. Your dentist may submit a predetermination request to get an estimate of what your coverage would pay. The predetermination will be processed according to your plan’s current contract and returned to your dental provider. You and your dental provider should review the information before beginning treatment.

If you have questions about your plan, contact our Customer Service Department toll-free at 1-800-356-7586.

Review your handbook carefully. It describes the benefits of your plan. It is the responsibility of the Participant to review his or her plan and to be aware of its limitations and exclusions.

Please note: This handbook is a description of your dental care benefits. All plan provisions are governed by the Group’s agreement with Delta Dental of Idaho. This handbook may not contain every plan provision.

Summary Plan Description

1. **Plan Name:**
   Idaho AGC Self-Funded Benefit Trust

2. **Plan Sponsor:**
   Idaho Branch Inc., Associated General Contractors of America, Inc.
   1649 West Shoreline Drive, Suite 100
   Boise, Idaho 83702
   208-344-9755

3. **Employer Identification Number: 82-0096396**

4. **Agent for Legal Process:** The Plan Sponsor named above.

5. **Plan Number: 502**

6. **Type of Plan:** Employee Dental Benefit Plan

7. **Plan Year:** January 1st through December 31st

8. **Plan Administrator:** The Plan Sponsor is the administrator of the Plan.

9. **Funding Medium and Type of Plan Administration:** The Plan is self-funded and the Group has contracted with Delta Dental of Idaho, hereinafter referred to as Delta Dental, to provide claims administrative services.

   The Plan is funded by employer and/or employee contributions. The amount of total contributions is determined from time to time by the use of sound actuarial and underwriting methods. The portion an employee pays toward the total contribution is determined by the employer.

10. **Named Fiduciary:** Board of Trustees for the Idaho AGC Self-Funded Benefit Trust

This information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). This Member Handbook is the Summary Plan Description.

In furnishing this information, Delta Dental is acting on behalf of your Plan Administrator, who remains responsible for complying with the ERISA reporting rules and regulations.

Definitions

For the purpose of this Plan, the following definitions shall apply:

Abutment is a tooth used to support a prosthetic device (implant crowns, bridges, partial dentures or overdentures).

Accepted fee is the maximum amount allowed for a single procedure. This amount is either the dentist's billed charge, the dentist's allowed fee with Delta Dental, or the Maximum Plan Allowance (MPA), whichever is less. If the database does not contain a fee for a particular procedure in a particular area, the claim is referred to our Dental Professional Relations department, which determines the fee based on the maximum plan allowance of a comparable service.

Alveolar structures are the upper and lower jaw bones.

Alveoloplasty is the surgical shaping of the bone of the upper or the lower jaw. It is performed most commonly in conjunction with the removal of a tooth or multiple teeth to have the gums heal smoothly for the placement of partial denture or denture.

Amalgam is a silver-colored material used in restoring teeth.

Anterior refers to teeth located at the front of the mouth. (See tooth chart)

Benefit year means a calendar year.

Benefits means those dental services which are available under the terms of this Plan.

Bicuspid is a premolar tooth, between the front and back teeth. (See tooth chart).

Bridge is also called a fixed partial denture. A bridge replaces one or more missing teeth using a pontic (false tooth or teeth) permanently attached to the adjacent teeth. Abutment crowns (crowns placed on adjacent teeth) are considered part of the bridge.

Broken A tooth is considered broken when a piece or pieces of the tooth have been completely separated from the rest of the tooth. A tooth with cracks is not considered broken.

Cast restoration includes crowns, inlays, onlays, and any other restoration to fit a specific patient's tooth that is made at a laboratory and cemented into the tooth.

Claim determination period means a calendar year (January 1 through December 31) or portion thereof.

Composite is a tooth-colored material used in restoring teeth.

Co-payment means the relative percentages to be paid by a Participant.

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 as 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.

Contribution – the amount paid or payable by the employer or Eligible Employee into the Idaho AGC Self-Funded Benefit Trust.

Covered employment means employment for which the Group has made contributions to provide dental care benefits.

Debridement is the removal of excess plaque. A periodontal 'pre-cleaning' procedure done when there is too much plaque for the dentist to perform an exam.

Deductible is the amount of covered expenses that are paid by the Participant before benefits are payable by the Plan.

Delta Dental of Idaho means the health insurer licensed in Idaho that contracts with the groups to provide dental coverage to their employees, members, or subscribers. Delta Dental is the claims administrator of this Plan. References to Delta Dental as paying claims or issuing benefits mean that Delta Dental processes a claim and the Group reimburses Delta Dental any benefit issued.

Delta Dental of Idaho means a managing general agent licensed in Idaho to administer dental plans for Delta Dental of Idaho.

Dental provider means a duly licensed dentist, certified denturist or registered hygienist, legally entitled to practice dentistry at the time and in the place services are performed; to the extent that he or she is operating within the scope of his or her license, certificate, or registration as required under law within the State of practice.

Dentally necessary means:

- Services that are established as necessary for the treatment or prevention of a dental injury or disease otherwise covered under this Plan;
- Services that are appropriate with regard to standards of good dental practice in the service area;
- Services that have a good prognosis; and/or
- Services that are the least costly of the alternative supplies or levels of service that can be safely provided to you. For example, coverage would not be allowed for a crown when a filling would be adequate to restore the tooth appropriately.

Please note:
The fact that a dentist may recommend or approve a service or supply does not, of itself, make the charge a covered expense.

Domestic Partner—the partner of an Eligible employee who is of the same or opposite gender with a relationship that demonstrates the following:
1. Partners have executed an Affidavit of Domestic Partnership;
2. Cohabitation in an exclusive mutual commitment similar to that of marriage and have been involved in the domestic partnership for a period of not less than six consecutive months;
3. Neither partner is legally married to any other person nor has another Domestic Partner;
4. Partners are both of the age of consent and are not related by marriage or blood in a way that would otherwise prohibit marriage in the state of their residence;

Eligibility date means the date an employee's or dependent's eligibility for benefits becomes effective under the terms of this Plan.

Eligible dependent means any of the dependents of an employee who are eligible for benefits in accordance with the conditions of eligibility outlined in this Plan.

Eligible employee means any employee who meets the conditions of eligibility outlined in this Plan.

Eligible person means any employee or dependent who meets the conditions of eligibility outlined in this Plan. For the purposes of this Plan, an eligible person includes an individual who has made contribution payments to continue coverage under the Plan.

Participant means an employee, dependent of the employee or an individual otherwise eligible for this Plan who has enrolled for coverage under the terms of this Plan.

Group eligibility waiting period means the period of employment or membership with the group that a prospective Participant must complete before coverage begins.

Group health plan means any plan, fund or program established and maintained by the Idaho AGC Self-Funded Benefit Trust, for the purpose of providing healthcare for its participants or beneficiaries through health plan benefits, reimbursement or otherwise. This dental plan is a group health plan.
Group means Idaho AGC Self-Funded Benefit Trust whose members or employees dental benefits are being provided.

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.

Maximum Payment Limit means the amount payable by the Plan for covered services received each calendar year, or portion thereof, for each Participant.

Maximum Plan Allowance (MPA) is the allowable fee per procedure by product and network status. The non-participating dentist has the right to bill the difference between the Accepted Fee and the actual charge. This difference will be a patient responsibility.

Mental Incapacity, for the purposes of this Plan, means an unmarried child of any age who is medically certified as disabled and financially dependent upon the parent.

Nonparticipating Dentist means a licensed dentist who is not participating in the Delta Dental network. Payment for services provided by a Nonparticipating Dentist is based on actual charges, or the Nonparticipating Dentist allowance in Idaho, whichever is less. The Participant is responsible for any remaining balance.

Palliative treatment is treatment performed only to control pain, swelling, or bleeding in or around the teeth and gums. Palliative treatment does not include follow-up care or definitive restorations such as, but not limited to, crowns, extractions, or root canal treatment.

Participant – a participating employee or an enrolled eligible dependent covered under this plan.

Participating Dentist – PPO or Premier - have agreed upon acceptable fees with Delta Dental. If the dentist is a Participating Dentist with Delta Dental, the plan pays the accepted fee, or the appropriate copayment of the allowed amount for each covered dental procedure.

Periodic exam is a routine exam (check-up), commonly performed every six months.

Periodontal maintenance is a periodontal procedure for patients who have previously been treated for periodontal disease. In addition to cleaning the visible surfaces of the teeth (as in prophylaxis) surfaces below the gum-line are also cleaned. This is a more comprehensive service than a regular cleaning (prophylaxis).

Physical Incapacity, for the purposes of this Plan, means an unmarried child of any age who is medically certified as disabled and financially dependent upon the parent.

Plan Sponsor is Idaho Branch Inc., Associated General Contractors of America, Inc., who has contracted with Delta Dental of Idaho to provide claims and other administrative services.

Plan means the dental coverage funded by the Group and administered by Delta Dental**.**

Pontic is an artificial tooth that replaces a missing tooth, and is part of a bridge.

Posterior refers to teeth located toward the back of the mouth. (See tooth chart)

Prophylaxis is cleaning and polishing of all teeth.

Restoration is the treatment that repairs a broken or decayed tooth. Restorations include, but are not limited to, fillings and crowns.

Veneer (chair side and laboratory) is a layer of tooth-colored material attached to the surface of an anterior tooth to repair chips or cracks, fix gaps and change the shape and size of teeth. A chair side veneer is a restoration created in the dentist's office. A laboratory veneer is a restoration that is created (cast) at a laboratory. Chair side and laboratory veneers may be paid at different benefit levels.

ViziLite is a non-excisional soft tissue screening to detect oral cellular abnormalities.

Waiting period means the period that must pass before the individual is eligible to enroll for benefits under the terms of the Plan.

Eligibility

This section describes who is eligible to enroll in the Plan. Please be aware that the date you become eligible may be different than the date coverage begins. See "When Coverage Begins" for more specific information.

EMPLOYEES

You are eligible for coverage under the Plan if you are in a classification of employment designated as eligible by your employer and you satisfy a probationary period established by your employer and you satisfy one of the following hour requirements:

1. If you became enrolled in the plan prior to June 1, 1996, your customary employment excluding overtime must be at least 80 hours per month to have continuing coverage under the plan.
2. If you became enrolled after May 31, 1996, your customary employment excluding overtime must be at least 120 hours per month to have continuing coverage under the plan.
3. If you work on State and Federal funded projects subject to the Davis-Bacon Act or the State equivalent Act, your employer may cover you as an Hour Bank employee. As an Hour Bank employee, you must complete 140 hours of service with your employer and receive credit for 140 hours in your Hour Bank under the plan to be eligible for coverage under the Plan. For additional details see the special rules for Hour Bank employees section below.

DEPENDENTS

All employees will have the opportunity to apply for coverage under this Plan. All applications submitted to Delta Dental by the group now or in the future, will be for Eligible employees or Eligible dependents only. To qualify as an Eligible dependent, a person must be and remain one (1) of the following:

1) Your spouse under a legally valid marriage.
2) Your Domestic partner under a valid Affidavit of Domestic Partnership.
3) You, your spouse's or your domestic partner's natural child; stepchild, legally adopted child, a child placed with you for adoption, or child for which you, your spouse's or domestic partner's employer has court-appointed guardianship or custody. The child must be:
    a. Under the age of twenty-six (26); or
    b. Medically certified as disabled and financially dependent upon the parent. The disabled dependent may remain on the parent's or parents' plan. You must provide us with a written physician's statement or certification that confirms the condition. Documentation of the child's medical condition must be reviewed and approved by our medical consultant. Periodic review by the medical consultant will also be required on an ongoing basis.
4) You must notify your employer within thirty (30) days when a dependent no longer qualifies as an eligible dependent. Coverage for a former eligible dependent will terminate the last day of the month in which the change in eligibility occurred.

Dependents in military service are not eligible.

SPECIAL RULES FOR HOUR BANK EMPLOYEES

Hours credited to the Eligible Employee's Hour Bank account will be used to purchase health benefits coverage for the month immediately following. The charge to the Eligible Employee's Hour Bank account will be 140 hours for one month's coverage. Once the Eligible Employee becomes eligible, if the Hour Bank account has less than 140 hours, they will be notified by the Administration Office that coverage will cease and they will have the opportunity to self-pay the difference between the number of hours in the account and 140 hours so that health benefits coverage can be continued for that month. The amount required to be paid will be the amount determined by multiplying the Plan's then current Hour Bank withdrawal rate times the number of hours that the Eligible Employee's account is less than 140. The Hour Bank withdrawal rate is a dollar amount per hour established each year by the Plan for the payment of the monthly health benefits contribution from an

Hour Bank account. If the employer is covered by COBRA, the Eligible Employee also will be notified of the right to elect COBRA continuation coverage following termination of active coverage. The Eligible Employee's remaining Hour Bank Coverage and COBRA coverage will run concurrently. If they do not elect to self-pay the difference in the 140 hours and, if eligible for COBRA, if they do not elect COBRA, the Eligible Employee's coverage will cease as of the end of the last month for which a full charge of 140 hours was made. If the Eligible Employee is eligible for COBRA, COBRA will commence immediately following the last month for which they have Hour Bank coverage. Generally, self-pay coverage and COBRA coverage must be continuous and immediately following any prior active coverage and the Eligible Employee may not have a break in coverage in one or more months and then elect self-pay or COBRA coverage for one or more months that are not continuous with prior active coverage.

There is an eighteen (18) month cap on the amount of coverage that the Eligible Employee can accumulate in the Hour Bank account. If they accumulate or have accumulated more than eighteen (18) months coverage in the Hour Bank account, any excess will be paid out to the Eligible Employee within a reasonable period of time following March 31 of each year. If the Eligible Employee (a) terminates employment with the employer, or (b) changes jobs with the employer to a different job classification that is not Hour Bank employment, the Eligible Employee's health benefits coverage under the Plan will continue so long as there is a sufficient balance in the Hour Bank account to provide such coverage. If the Eligible Employee changes jobs with the employer to a different job classification that is not Hour Bank employment, but is covered under this Plan, the Hour Bank account will be held for use at a future time when the Eligible Employee is either no longer employed, not covered under this Plan, or has returned to Hour Bank employment. Once the balance falls below 140 hours, the Eligible Employee will be notified by the Administration Office and will be given the opportunity to self-pay any difference between the amount in the Hour Bank account and 140 hours, and, if eligible for COBRA, to elect COBRA continuation coverage as described above. Self-pay coverage and COBRA continuation coverage for former employees must be continuous and immediately following any prior active coverage. Any Hour Bank account balance of less than 140 hours that is not used within four (4) months of the last date of coverage will be forfeited to the Trust. If the Eligible Employee has an Hour Bank account balance of less than 140 hours and returns to Hour Bank employment and the Eligible Employee either self pays or is credited with sufficient hours to have at least 140 hours in their Hour Bank account within four (4) months of the last date of coverage, they will receive health benefits coverage under the Trust for the next following month. If the employer ceases to participate in the Trust as a participating employer, health benefits coverage under the Trust will not continue, and the Eligible Employee will not be eligible to continue coverage under the Trust through self-payment under COBRA or through purchasing coverage by exhausting his or her Hour Bank. If the employer ceases to participate in the Trust as a participating employer, any balance remaining in an Eligible Employee's Hour Bank will be paid out to the Eligible Employee on the employer's termination.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

This Plan will cover individuals deemed to be alternative recipients under a qualified medical child support order (QMCSO). A QMCSO is a court judgment, decree, or order, or a state administrative order that has the force and effect of law, and that is typically issued as part of a divorce or as part of a state child support order proceeding and requires health plan coverage for an alternative recipient. An alternative recipient is a child of a participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant.

The effective date of coverage for a child added to the Plan under a QMCSO is the date specified in the court order, or if none, the date of the court order.

The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. You may obtain a copy of such procedures from the Plan Administrator without charge.

Enrollment

This section explains how to enroll in the Plan.

WHEN YOU FIRST BECOME ELIGIBLE

You must file a complete and signed application for yourself and any dependents you want covered when you become eligible to apply for coverage. Employees become eligible to apply on the day you are hired or the end of any required waiting period. File the application with the Group.

You must notify the Group and Delta Dental whenever you change your address.

ENROLLING NEW DEPENDENTS

You may obtain coverage for newly acquired or newly eligible dependents by submitting a complete and signed application within 30 days of their eligibility, except for newborn and newly adopted dependents. (See "Newborn and Newly Adopted Dependents". If you marry while covered under the Plan your spouse and his or her children are eligible to enroll. A completed and signed application must be submitted to your employer within 30 days following the date of the marriage. (See "When Coverage Begins") All dependents must meet the eligibility requirements.

You must notify your employer if family members are added or dropped from coverage, even if it does not affect your contribution.

NEWBORN AND NEWLY ADOPTED DEPENDENTS

If you add a newborn Dependent, including an adopted newborn child who has been placed with you within sixty (60) days of the adopted child's date of birth, the child is covered under this Plan from and after the date of birth for 60 days. In order to continue coverage beyond the sixty (60) days outlined above, the Participant must complete a signed enrollment application listing the new child as a dependent and submit the required contribution within thirty-one (31) days of the date the monthly billing is received by the Group and a notice of contribution is provided to the Participant by the Group. Proof of legal guardianship will be required for coverage of a grandchild.

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 the adoption or the date of placement for adoption. To extend coverage beyond the first sixty (60) days, the enrolled employee must submit a complete and signed application listing the child as a dependent.

Placement for adoption means you have assumed and retained a legal obligation for full or partial support of the child in anticipation of adoption.

WHEN COVERAGE BEGINS

Coverage begins for you and any enrolled dependents on the first day of the month after the waiting period has been satisfied.

When a new dependent is due to marriage, coverage begins the first day of the month if the marriage date is the first day of the month. If the marriage did not occur on the first day of the month, coverage begins the first day of the month following the date of marriage.

When the new dependent is due to the birth of a newborn, coverage is effective on the date of the newborn's birth. When the dependent is due to an adoption or placement for adoption, coverage is effective on the date of adoption or placement. Court ordered coverage is effective on the date specified by the court order.

The necessary contributions for your coverage must also be paid for coverage to become effective.

Late Enrollee

Any employee and/or their dependent(s) who did not enroll on the dental plan following completion of the employee's eligibility period, as defined above, will be considered a late enrollee and will have a 24 month waiting period for Major Services (Class III).

WHEN COVERAGE ENDS

A. Termination by Enrolled Employee
You may terminate your coverage, or coverage for any enrolled dependent, by giving us written notice through the Group. Coverage will end on the last day of the month through which contributions are paid. If you terminate your own coverage, coverage for your dependents also ends at the same time.

B. Death

If you die, coverage for your enrolled dependents ends on the last day of the month in which your death occurs. Note that your enrolled dependents may extend their coverage for up to 3 years if the requirements for continuation of coverage are met. The Group must notify us of any continuation of coverage. Should the dependent(s) elect to continue coverage, the dependent(s) will be enrolled into a new policy. The group contributions will be discontinued whereby the dependents will be fully responsible for submitting the required monthly payment to the Plan.

C. Loss of Eligibility
If your employment terminates, your coverage will end for you and all enrolled dependents on the last day of the month in which termination occurs, unless you choose to continue coverage.

D. Loss of Eligibility by Dependent
An enrolled child will lose eligibility when he or she no longer qualifies as an eligible dependent. Coverage will end on the last day of the month in which the child's eligibility ends, unless the child continues coverage as provided under this Plan.

Coverage ends for an enrolled spouse on the last day of the month in which a decree of divorce or annulment is entered (regardless of any appeal), unless the divorced spouse continues coverage as provided under this Plan.

Important Note: The following sections on Family and Medical Leave, Leave of Absence, and Uniformed Services Employment and Reemployment Rights Act (USERRA) may apply to you. Please check with the Group to find out whether you qualify for this coverage.

E. Family and Medical Leave
If the group grants you a leave of absence under the Family and Medical Leave Act of 1993 (FMLA), the following rules will apply:

- You and your enrolled dependents will remain eligible for coverage during your FMLA leave. If you and/or your enrolled dependents elect not to remain enrolled during FMLA leave, you (and/or your enrolled dependents) will be eligible to reenroll under the Plan on the date you return from leave. To reenroll, you must submit a complete and signed application within 60 days of your return to work. All of the terms and conditions of the contract will resume at the time of reenrollment as if there had been no lapse in coverage. You will not have to re-serve any group eligibility-waiting period under the Plan.

- Your rights under FMLA will be governed by that statute and its regulations.
- If you and/or your enrolled dependents elect to continue benefits during FMLA leave, you should consult your plan administrator about the payment of your share of contributions for coverage as there are certain timelines and other requirements for payment to the employee share of contributions.

F. Uniformed Services Employment and Reemployment Rights Act (USERRA)

Coverage will terminate if you are called to active duty by any of the armed forces of the United States of America. Coverage can be continued for up to 24 months or the period of uniformed service leave plus time allowed for re-employment, whichever is shortest, if you pay any required contributions toward the cost of the coverage during the leave. If the leave is 30 days or less, the contribution rate will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage.

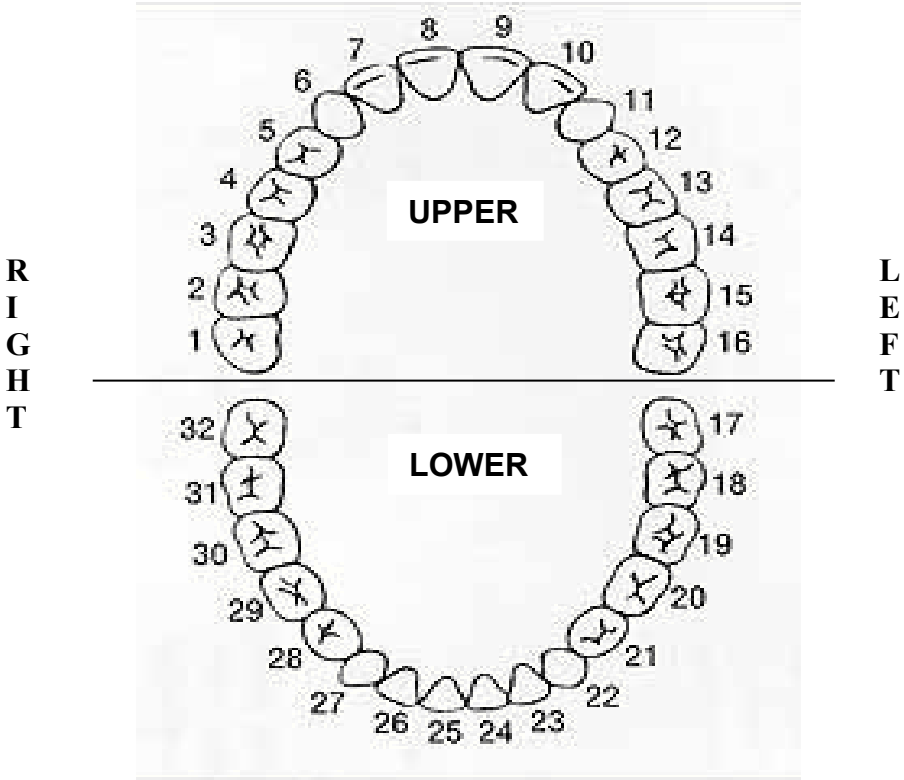
If you do not elect continuation coverage under the Uniformed Services Employment and Reemployment Rights Act or if continuation coverage is terminated or exhausted, coverage will be reinstated on the first day you return to active employment with the Group if you are released under honorable conditions, but only if you return to active employment:

- On the first full business day following completion of your military service and expiration of eight (8) hours after a period allowing for safe transportation of the person from the place of service to the person's residence for a leave of 30 days or less;
- Within 14 days of completing your military service for a leave of 31 to 180 days; or
- Within 90 days of completing your military service for a leave of more than 180 days.

Regardless of the length of the leave, a reasonable amount of travel time or recovery time for an illness or injury determined by the Veteran's Administration (VA) to be service connected will be allowed.

When coverage under this Plan is reinstated, all provisions and limitations of this Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous under this Plan. There will be no additional eligibility waiting period and the pre-existing condition limitation will be credited as if you had been continuously covered under this Plan from your original effective date. (This waiver of limitations does not provide coverage or waiver of any eligibility waiting period for any illness or injury caused or aggravated by your military service, as determined by the VA. For complete information regarding your rights under the Uniformed Services Employment and Reemployment Rights Act, contact the Group).

Tooth Chart – The Permanent Arch



The Permanent Arch		
Tooth #		Description of Tooth
Upper	Lower	
1	17	3rd Molar (wisdom tooth)
2	18	2nd Molar (12-yr molar)
3	19	1st Molar (6-yr molar)
4	20	2nd Bicuspid (2nd premolar)
5	21	1st Bicuspid (1st premolar)
6	22	Cuspid (canine/eye tooth)
7	23	Lateral Incisor
8	24	Central Incisor
9	25	Central Incisor
10	26	Lateral Incisor
11	27	Cuspid (canine/eye tooth)
12	28	1st Bicuspid (1st premolar)
13	29	2nd Bicuspid (2nd premolar)
14	30	1st Molar (6-yr molar)
15	31	2nd Molar (12-yr molar)
16	32	3rd Molar (wisdom tooth)

Dental Benefits

Below is a general list of services your dental care program covers when performed by a dental provider (licensed dentist, certified denturist or registered hygienist). These services are covered only when determined to be necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury (accidental injury coverage is secondary to medical). A panel of dentists shall determine these standards.

Covered dental services are outlined in three "classes" that start with preventive care and advance into specialized dental procedures. Covered dental services include coverage for dentally necessary care and treatment of a Congenital Anomaly for newborn and newly adopted children.

Deductible:
Before a Participant shall qualify for the benefits, each Participant must have incurred, subsequent to the Effective Date of coverage, the deductible amount of $50 each *Plan Year*. Each family member must meet the deductible; however, no family shall be obligated to meet more than three (3) separate deductibles each *Plan Year*.

Percentage of Fees Paid:
Participating PPO Dentist fees will be paid at one hundred percent (100%) of the accepted fee for Class I services, eighty percent (80%) of the accepted fee for Class II services, and fifty percent (50%) of the accepted fee for Class III services.

Participating Premier Dentist fees will be paid at eighty percent (80%) of the accepted fee for Class I services, eighty percent (80%) of the accepted fee for Class II services, and fifty percent (50%) of the accepted fee for Class III services.

Services of a Nonparticipating Dentist: In the event covered services are provided by a Nonparticipating Dentist, the enrollee will be reimbursed at the appropriate percentage (outlined above) of the accepted fee for services listed below. The member is responsible for payment of any fees greater than the accepted fee for the covered service.

Maximum Payment:
Benefits provided shall not exceed $1,000 per enrollee each *Plan Year*.

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.

Class I (not subject to the deductible or annual maximum) – Preventive services consisting of:

1) Oral examination (limited to once in a six [6] month period).
2) Full mouth x-rays or panorex x-ray (limited to once every five [5] years).
3) Dental x-rays (bitewing x-rays limited to once each twelve [12] months).
4) Prophylaxis, including periodontal prophylaxis (limited to once in a six [6] month period).

5) Topical application of fluoride for enrollees under nineteen (19) years of age (limited to once each twelve [12] consecutive calendar months).
6) Space maintainers, including adjustments made within six (6) months of installation (limited to enrollees age eighteen [18] and under).
7) Topical application of sealants for enrollees up to nineteen (19) years of age (limited to once in any three [3] year period).
8) Topical application of sealants for adults allowed twice within 12 months after periodontal surgery to protect roots from caries.

Class II - Basic services consisting of:

1) Palliative emergency treatment and emergency oral examinations. See Class I for examination benefits.
2) Biopsies of the oral tissue.
3) Pulp vitality tests.
4) If the enrollee elects to have another more costly restorative material, covered dental services shall be limited to the cost of the filling *composite*. A restoration shall be considered a covered dental service once in a two (2) year period on the same surface of a tooth.
5) Endodontics, including pulpotomy, root canal treatment, apicoectomy and hemisection.
6) Oral Surgical services limited to:
    a) Simple extractions.
    b) Surgical removal of teeth and maxillary or mandibular intrabony cysts, procedures performed for the preparation of the mouth for dentures. The allowance for an oral surgery includes a treatment plan, local anesthesia and postoperative care.
    c) General anesthesia and I.V. sedation when it is necessary for multiple partial, or complete bony extractions or for complex oral surgery due to the existence of a concurrent condition.
    d) Mucogingivoplastic Surgery.
    e) Management of acute periodontal infection and oral lesions. Prophylaxis for periodontal maintenance shall be provided once each six (6) months, subject to review for document guidelines.
7) Complex periodontal services, including gingival curettage, gingivectomy, osseous surgery, flap entry and closure, and mucogingivoplastic surgery. Periodontal surgery includes the treatment plan, local anesthesia, pre-operative and post-operative care for a period of three (3) months. Periodontal surgical services are covered once, per quadrant, with pockets of 5 mm or more, in any three (3) year period.
8) Benefits for inlays provided at the same total benefit as a composite filling for posterior (back) teeth and as composite filling for anterior (front) and bicuspid teeth, once every 24 months.

Class III - Major services consisting of:

1) Initial installation of dentures or bridgework to replace one or more natural teeth which have been extracted.
2) Replacement of existing dentures or bridgework, provided that the existing denture or bridgework was installed at least seven (7) years prior to its replacement and cannot be made serviceable.
3) Repairs to existing dentures or bridgework (limited to once each twenty-four (24) consecutive calendar months).
4) Denture services limited to:
    a. The making, fitting, construction, altering, reproducing, or repairing of a full upper or lower removable prosthetic denture, the repairing of a removable partial upper or lower prosthetic denture, the furnishing or supplying of such a denture directly to a person or advising the use of any such denture.
    b. The taking or making, or the giving of advice, assistance or facilities respecting the taking or making of any impression, bite, cast or design preparatory to, or for the purpose of making, constructing, fitting, furnishing, supplying, altering,, repairing or reproducing any such full upper or lower removable prosthetics denture.
    c. Within the context of this provision, all work except cast frame work must be performed on the denturist's premise.
5) Fixed bridge repairs, repair of removable dentures, re-cementing of crowns, and/or bridges.

6) Denture re-lining (limited to once each two [2] years).
7) Crowns, limited to once each seven [7] years. Repair of crowns are limited to once every 24 months.
8) Veneer to replace a tooth structure that cannot be replaced by another restoration in those situations which would qualify for placement of a full crown, subject to Delta Dental's approval.
9) Onlays according to the same pricing and necessity guidelines that apply to crowns, subject to Delta Dental's approval.
10) Repair to existing dentures, removable dentures, bridgework, inlays and/or onlays.

Value –Added Orthodontic Discount Program

Delta Dental of Idaho Participants and their eligible dependents can receive a discounted fee for adult and child orthodontic treatment if they obtain services from a Delta Dental Discount Program orthodontist in Idaho. Please see your employer for additional information. **This value-added service is not insurance.**

Dental Exclusions and Limitations

No benefits shall be provided in connection with the following:

1) Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes, except for newborn and adopted children.
2) Nitrous oxide.
3) Dental services for which the enrollee would have no legal obligation to pay in the absence of this or any similar coverage.
4) Dental care or treatment not specifically listed as eligible.
5) Charges for replacement of lost or stolen items.
6) Hospitalization in connection with covered dental services.
7) Dental work covered under the Workers' Compensation Law.
8) Charges which exceed the accepted fee as determined by Delta Dental.
9) Orthodontic treatment, including correction of malocclusion.
10) Diagnostic photographs, diagnostic casts, and study models.
11) Duplicate x-rays.
12) Oral hygiene instruction.
13) Recontouring restorations.
14) Replacements of space maintainers.
15) Temporary dentures.
16) Replacement of crowns and gold cast restorations, (including inlays and onlays) less than seven (7) years old.
17) Any condition, disease, ailment, Injury, or diagnostic service to the extent that benefits are provided under Medicare.
18) Charges for which benefits or services are provided for a member under any group, or other insurance or prepayment plan arranged through an employer, union, trustee or association.
19) Occlusal equilibration and/or treatment for temporomandibular joint (TMJ) disorders.
20) Experimental dental procedures.
21) Payment for dental services incurred prior to the date the enrollee became eligible for such services under the plan. An expense is incurred when:
    a) the impression is taken - in the case of dentures, or fixed bridgework;
    b) preparation of the tooth is begun - in the case of crown work; or
    c) work on the tooth is begun - in the case of root canal therapy.
22) In the event an enrollee transfers from the care of one dentist to that of another dentist during the course of treatment, or if more than one dentist renders services for a dental procedure, Delta Dental shall be liable for not more than the amount it would have been liable for had but one dentist rendered the service. In all cases in which there are optional techniques of treatment carrying different fees, Delta Dental shall be liable hereunder only for the treatment carrying the lesser fee.
23) Nutritional counseling, tobacco counseling and oral hygiene instruction are not covered benefits except for participants in Delta Dental's HOW® program.

CLAIMS AND PAYMENT FOR SERVICES

1) Submission of Claim: After the last day on which services are rendered, a report of services rendered shall be submitted to Delta Dental.

2) Payment for Eligible Services:

    a) Benefits for covered services provided by a Participating Dentist shall be made by Delta Dental directly to such Participating Dentist.
    b) Benefits for covered services provided by a Nonparticipating Dentist may be made by Delta Dental directly to the enrollee.

Late Claims

No payment will be made on any claims submitted to Delta Dental more than twelve (12) months after the last day on which the services were rendered, unless it shall be shown to the satisfaction of Delta Dental that there was unusual and justifiable cause of such late submission.

Coordination of Benefits

Coordination of Benefits (COB) occurs when you have healthcare coverage under more than one plan.

DEFINITIONS

For purposes of this section on Coordination of Benefits, the following definitions apply:

Plan means plan coverage's, which provide benefit payments or services to a Participant for dental care.

This Plan is the part of this group dental plan that provides benefits for dental expenses.

Primary Plan is the plan that pays a claim for benefits first.

Secondary Plan is the plan that pays after the Primary Plan.

Allowable Expense means any amount which is covered by this Plan during a Claim Period.

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

1. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate Plan is used to provide coordinated coverage for members of a group, the separate plan is considered parts of the same Plan and there is no COB among those separate Plans.
   a) Plan includes: group and non-group insurance plans, health maintenance organization (HMO) plans, 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) A Plan 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 Plan for coverage under a) or b) is a separate plan. If a Plan 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 plan.

2. This Plan means, in a COB provision, the part of the plan providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the plan providing health care benefits is separate from This Plan. A Plan 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 Plan is a Primary Plan or Secondary Plan when the Participant has health care coverage under more than one (1) Plan. When This Plan is primary, it determines payment for its benefits first before those of any

other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all plan benefits do not exceed one hundred percent (100%) of the total Allowable Expense.

4. Allowable Expense is a healthcare expense, including deductibles, cost-sharing and copayments, that is covered at least in part by any Plan covering the Participant. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan 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 plans provides coverage for private hospital room expenses.

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

   d) If a Participant is covered by one (1) Plan 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 Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

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

5. Closed panel plan is a Plan 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.

ORDER OF BENEFITS DETERMINATION RULES

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

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

   a) Except as provided in Paragraph 2.b) below, a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan 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 plan provided by the Plan holder. Examples of these types of situations are 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 plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other Plan.

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

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

   b) **Dependent Child Covered Under More Than One plan.** Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan 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 Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
   (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 plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan year commencing after the Plan 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 healthcare expenses or healthcare 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 Plan covering the Custodial Parent;
2. The Plan covering the spouse of the Custodial Parent;
3. The Plan covering the non-Custodial Parent; and then
4. The Plan covering the spouse of the non-Custodial Parent.

For a dependent child covered under more than one Plan 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 Plan that covers a Participant as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The plan covering that same Participant as a retired or laid-off employee is the Secondary Plan. 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 Plan does not have this rule, and as a result, the Plans 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 Plan, the Plan 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 Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans 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 Plan that covered the Participant as an employee, member, policyholder, subscriber, or retiree longer is the Primary Plan and the Plan that covered the Participant the shorter period of time is the Secondary Plan.

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

EFFECT ON THE BENEFITS OF THIS PLAN

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

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

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, This Plan 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 Plan. This Plan 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.

RIGHT OF RECOVERY

If the amount of the payments made by This Plan 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 Participants 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.

THE PLAN'S RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

In order to receive benefits, the claimant must give the Plan any information that is needed to coordinate benefits. With the claimant's consent, the Plan may release to or collect from any person or organization any needed information about the claimant.

CONTINUATION COVERAGE (COBRA)

EXPLANATION OF BENEFIT

IMPORTANT NOTICE

The following section on Continuation Coverage (COBRA) may apply to you. Please check with the Plan Administrator to find out whether you qualify for this coverage. Both you and your spouse should read this notice carefully.

INTRODUCTION

The Plan will provide benefits only to those qualified beneficiaries who elect coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), subject to the following limitations: (i) the Plan will offer no greater COBRA rights than the COBRA statute requires; (ii) the Plan will not be responsible for COBRA coverage if the enrolled employee or other qualified beneficiary does not comply with any of the notice, election or other requirements outlined below; and (iii) Delta Dental will not be responsible for COBRA coverage if the Plan Administrator has not distributed election notices and COBRA election forms within the required time periods, or if the Plan Administrator otherwise fails to comply with any of the requirements outlined below.

On the Group's behalf, the following summary of your rights and obligations, and the obligations of the Plan Administrator, with respect to COBRA coverage are set forth. Note: the Plan Administrator will typically be the employer.

COBRA is a federal law requiring most employer-sponsored group health plans to offer qualified beneficiaries the opportunity to elect a temporary extension of health coverage if coverage is lost due to a qualifying event (see below). A qualified beneficiary is someone who is covered under the Plan the day before a qualifying event, and can include the enrolled employee (or retired employee), the enrolled employee's spouse, and the dependent children of the enrolled employee.

An enrolled employee or the spouse may elect continuation coverage for eligible family members. However, each family member has an independent right to elect COBRA coverage. This means that a spouse or child may elect continuation coverage even if the employee does not.

If you are eligible for continuation coverage, you do not have to show that you are insurable. However, under the law, you are responsible for all contributions for continuation coverage. Your first payment for continuation coverage is due within 45 days after you provide notice of electing coverage (this is the date your election notice is postmarked, if mailed, or the date your election notice is received by the Plan Administrator, if hand-delivered). This payment must include the amount necessary to cover all months that have ended between the date regular coverage ended and the payment date. Subsequent payments are due on the first day of the month; however, you will have a grace period of 30 days to pay the contribution. The Plan will not bill you for any payments due. If you do not pay the applicable contribution, in good funds, when due, your continuation coverage will end and may not be reinstated. The contribution rate may include a 2% add-on to cover administrative expenses.

QUALIFYING EVENTS

A. Employee

As an employee covered by this Plan, you may elect continuation coverage if you lose coverage for any one of the following three qualifying events:

(1) Termination of employment (other than termination for gross misconduct on your part);
(2) A reduction in hours; or
(3) If you are a retiree, the Group files for reorganization under Chapter 11 of the bankruptcy code.

B. Spouse

If you are the spouse of an employee (or of a retiree for reason 5 below) covered by the Plan, you have the right to choose continuation coverage for yourself if you lose coverage for **any** of the following five qualifying events:

(1) The death of your spouse;
(2) The termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with the Group;
(3) Divorce or legal separation from your spouse;
(4) Your spouse becomes entitled to Medicare; or
(5) Your spouse's employer files for Chapter 11 reorganization.

(Also, if an employee eliminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan Administrator within 60 days of the later divorce or legal separation and can establish that the coverage was eliminated earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.)

C. Children

A dependent child of an employee (or of a retiree for reason 6 below) covered by the Plan, has the right to continuation coverage if coverage is lost for any of the following six qualifying events:

(1) The death of the employee parent;
(2) The termination of the employee parent's employment (for reasons other than gross misconduct) or reduction in an employee parent's hours of employment with the Group;
(3) Parents' divorce or legal separation;
(4) Employee parent becomes entitled (that is, covered) under Medicare;
(5) The dependent ceases to be a "dependent child" under the Plan; or
(6) The employee parent's employer files for Chapter 11 reorganization.

OTHER COVERAGE

The right to elect continuation coverage shall be available to individuals who are entitled to Medicare at the time of the election or are covered under another group health plan at the time of the election.

NOTICE REQUIREMENTS

Qualifying Event Notice. The Plan provides that your family member's coverage terminates as of the last day of the month in which a divorce or legal separation occurs (spouse's coverage is lost) or a child loses dependent status under the Plan (child loses coverage). Under COBRA, the employee or a family member has the responsibility to notify the Plan Administrator if one of these events occurs by mailing or hand-delivering a written notice to the Plan Administrator. The notice must include the following: 1) the name of the employer for the Plan; 2) the name and social security number of the Participant(s); 3) the affected beneficiary(ies); 4) the event (e.g. divorce); and 5) the date the event occurred. Notice must be given no later than 60 days after the loss

of coverage under the Plan. When the Plan Administrator receives timely notice, you, your spouse, and/or dependent child will be notified of your right to continuation coverage within 14 days after the Plan Administrator receives the notice. If notice of the event is not timely given, continuation coverage will not be available.

Election Notice. You, your spouse and dependent children will be notified by the Plan Administrator of the right to elect COBRA continuation coverage within 44 days of any of the following events that result in a loss of coverage: the employee's termination of employment (other than for gross misconduct), reduction in hours, death of the employee, or the employee's becoming entitled to Medicare.

Election. You or your family member must elect continuation coverage within 60 days after Plan coverage ends, or, if later, 60 days after the Plan Administrator sends you or your family member notice of the right to elect continuation coverage. If continuation coverage (discussed below) is not elected, you, your spouse's and your dependent's group health coverage will end.

LENGTH OF CONTINUATION COVERAGE

If you choose continuation coverage, the Group will provide the same coverage as is available to similarly situated employees or dependents under the Plan.

18-Month Continuation Period. In the case of a loss of coverage due to end of employment (other than for gross misconduct) or a reduction of hours of employment, coverage generally may be continued only for up to a total of 18 months.

36-Month Continuation Period. In the case of losses of coverage due to an employee's death, divorce or legal separation, a dependent child ceasing to be a dependent under the terms of the Plan, or the bankruptcy of the Group (applies to retiree plans only), coverage under the Plan may be continued for up to a total of 36 months. When the qualifying event is the end of employment (other than for gross misconduct) or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage under the Plan for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last up to 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the enrolled employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

EXTENDING THE LENGTH OF COBRA COVERAGE

If you elect COBRA, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Plan Administrator of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage.

Disability. If any of the qualified beneficiaries is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from an enrolled employee's termination of employment or reduction of hours may be extended to a total of up to 29 months. The disability must have started at some time before the 61st day after the enrolled employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months). Each qualified beneficiary who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies. The disability extension is available only if you notify the Plan Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the enrolled employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the enrolled employee's termination or reduction of hours.

You must provide the Plan Administrator a copy of the Social Security Administration's determination within the 18-month period and not later than 60 days after the Social Security Administration's determination was made. If the notice is not provided to the Plan Administrator during the 60-day notice period and within 18 months after the enrolled employee's termination of employment or reduction of hours, then there will be no disability extension of COBRA coverage. The contribution for COBRA coverage may increase after the 18th month of coverage to 150% of the contribution.

If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Plan Administrator of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Event: An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the enrolled employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the date of the first qualifying event. Such second qualifying events may include the death of an enrolled employee, divorce or legal separation from the enrolled employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when an enrolled employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.).

This extension due to a second qualifying event is available only if you notify the Plan Administrator in writing of the second qualifying event within 60 days after the date of the second qualifying event. If this notice is not provided to the Plan Administrator during the 60-day notice period, then there will be no extension of COBRA coverage due to a second qualifying event.

NEWBORN OR ADOPTED CHILD

If, during continuation coverage, a child is born to or placed for adoption with the enrolled employee, the child is considered a qualified beneficiary. The employee may elect continuation coverage for the child provided the child satisfies the otherwise applicable Plan eligibility requirements (for example, age). The employee or a family member must notify the Group within 60 days of the birth or placement to obtain continuation coverage. If the employee or family member fails to notify the Group in a timely fashion, the child will not be eligible for continuation coverage.

SPECIAL ENROLLMENT

Under continuation coverage, qualified beneficiaries have the same rights afforded similarly situated plan participants who are not enrolled in COBRA. A qualified beneficiary may add newborns, new spouses, and adopted children (or children placed for adoption) as enrolled dependents in accordance with the Plan's eligibility and enrollment rules, including HIPAA special enrollment.

WHEN CONTINUATION COVERAGE ENDS

This notice shows the maximum period of COBRA coverage available to the qualified beneficiaries. COBRA coverage will automatically terminate before the end of the maximum period if:

- any required contribution is not paid in full on time;
- a qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied);

- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA;
- the Group ceases to provide any group health plan for its employees; or
- during a disability extension period (the disability extension is explained above), the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate).

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

If you have any questions about COBRA, please contact the Plan Administrator. Please notify the Plan Administrator if you or your spouse have changed addresses.

TRADE ACT OF 2002

This COBRA provision applies only to employees who have lost their jobs or had a reduction in hours as a result of import competition or shifts of production to other countries.

A. Second Election Period for Certain Trade-Displaced Individuals

Certain enrolled employees who did not elect COBRA coverage are entitled to elect COBRA coverage during a special second election period. Enrolled employees who are eligible to make a COBRA election during this special second election period (Trade Adjustment Assistance (TAA) Eligible Employees) must satisfy each of the following requirements:

- They must be receiving a trade readjustment allowance under the Trade Act of 1974 (or be eligible for such an allowance once unemployment compensation is exhausted) or receiving alternative trade adjustment assistance under the Trade Act of 1974;
- They must have lost group health plan coverage due to a termination of employment or reduction of hours that resulted in eligibility for a trade readjustment allowance or alternative trade adjustment assistance; and
- They did not elect COBRA during the regular COBRA election period available to them as a result of their termination of employment or reduction of hours.

The special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which a TAA Eligible Employee began receiving a trade readjustment allowance (or would have become eligible for such an allowance but for the requirement to exhaust unemployment compensation) or began receiving alternative trade adjustment assistance, but only if the election is made within six months after the initial loss of group health plan coverage that occurred in connection with the TAA Eligible Employee's termination of employment.

B. Duration of COBRA Coverage Elected During the Special Second Election Period

COBRA coverage elected during the special second election period is not retroactive. Coverage commences on the day that the special second election period began, and the maximum COBRA coverage period will terminate on the same day that it would have terminated if COBRA coverage had been elected during the regular 60-day election period.

C. COBRA Tax Credit

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of contributions paid for qualified health coverage, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.cfm.

D. If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

E. You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Plan Contact identified below:

F. Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

G. Plan Contact Information

Idaho AGC Self-Funded Benefit Trust
1649 West Shoreline Drive, Suite 100
Boise, Idaho 83702
208-344-9755

Claims Administration and Payment

The following section explains how claims are administered.

SUBMISSION AND PAYMENT OF CLAIMS

A. Claim Submission
A claim must be submitted to Delta Dental within 90 days after the date the expense was incurred. Failure to furnish a claim within the time required shall not invalidate or reduce any claim if it was not reasonably possible to submit the claim within 90 days, provided it is submitted as soon as reasonably possible. In no event, except absence of legal capacity, is a claim valid if submitted later than one year from the date submission is otherwise required.

A claim for which additional information is received will not be reprocessed after the Plan's claim submission period, as described in the previous paragraph.

B. Explanation of Benefits (EOB)
Soon after you make a claim, Delta Dental will report to you on the action taken by sending you a document called an Explanation of Benefits (EOB). The Explanation of Benefits (EOB) will indicate if a claim has been paid, denied, or accumulated toward satisfying the deductible. If all or part of a claim is denied, the reason for the action will be stated in the Explanation of Benefits.

If you do not receive an Explanation of Benefits within a few weeks of the date of service, this may indicate that Delta Dental has not received the claim. To be eligible for reimbursement, claims must be received within the claim submission period explained under Submission and Payment of Claims.

C. Claim Inquiries
If you have any questions about how to file a claim, the status of a pending claim, or any action taken on a claim, please call us toll-free at 1-800-356-7586, write to our Dental Customer Service Department, or email via the Delta Dental website at www.deltadentalid.com. We will respond to your inquiry within 30 days of receipt.

D. Plan Time Frames for Processing Claims
If your claim is denied, we will send an EOB to you with an explanation of the denial within 30 days after we receive your claim. If we need additional time to process your claim for reasons beyond our control, we will send a notice of delay to you explaining those reasons within 30 days after we receive your claim. We will then complete our processing and send an EOB to you within 45 days after we receive your claim. If we need additional information to complete our processing of your claim, our notice of delay will describe the information needed, and the party responsible for providing the additional information will have at least 45 days to submit the additional information.

Once we receive the additional information, we will complete our processing of the claim within 15 days. Submission of information necessary to process a claim is subject to the Plan's claim submission period explained under Submission and Payment of Claims.

If the delay notice we send requests coordination of benefits information, we will issue an EOB within 44 days after receiving the claim.

APPEALS

A. Definitions

For purposes of this section, the following definitions apply:

Adverse Benefit Determination means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or accidental injury.

An adverse determination is a written notice from the Plan, in the form of a letter or an Explanation of Benefits (EOB), which has set forth the following:

- the specific reason or reasons for the benefit denial,
- reference to the specific plan provision on which the denial was based,
- a description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary, and
- appropriate information as to the steps to be taken if you wish to appeal the Plan Administrator's determination, including your right to submit written comments and have them considered, your right to review (on request and at no charge) relevant documents and other information, and your right to file suit under ERISA with respect to any adverse determination after appeal of your claim.

Appeal is a request by a Participant or his/her representative for Delta Dental to review a Delta Dental adverse benefit determination.

Appointed or Authorized Representative is an individual appointed or authorized to represent a Participant in filing an appeal or complaint. A Participant may appoint any individual (relative, friend, advocate, attorney, and/or physician). A surrogate may be authorized by the court or act in accordance with state law on behalf of the Participant (court-appointed guardian, one with Durable Power of Attorney, healthcare proxy, person designated under a healthcare consent statute).

Complaint means an expression of dissatisfaction to Delta Dental about any matter not involving an Appeal or Adverse Benefit Determination. Complaints may involve access to providers, waiting times, demeanor of dental care personnel, adequacy of facilities and quality of dental care.

A **"claim involving urgent care"** means any claim for dental care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

a) Could seriously jeopardize the life or health of the Participant or the ability of the Participant to regain maximum function, or,

b) In the opinion of a dentist with knowledge of the Participant's dental condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

B. Time Limit for Submitting Appeals and Complaints
You have 180 days from the date of an adverse benefit determination to submit a written appeal regarding an adverse determination. You have 60 days from the date of the event to submit a written complaint. If a written appeal or complaint is not submitted within the appropriate timeframes as outlined in this section, you will lose your rights to the appeal and complaint process. If you do not submit your written appeal on time, you may lose your right to file suit in court, as you will have failed to exhaust your internal administrative appeal rights, which is generally a prerequisite to bringing suit.

C. The Review Process
You have the right to request that Delta Dental review an adverse benefit determination (an appeal) or a complaint. For an appeal, you must exhaust the Delta Dental internal review process before you can exercise your right to file a lawsuit in court under ERISA Section 502(a).

Your appeal or complaint must be in writing. If you need assistance filing an appeal or complaint, contact our Customer Service Department toll-free at 1-800-356-7586. For an adverse benefit determination (appeal), it may be possible to resolve your situation with a phone call. Delta Dental will acknowledge receipt of your written appeal or complaint within seven days of receipt. You may submit written comments, documents, records, and other information relating to the claim for benefits or to the complaint. Upon request, and free of charge, you may have reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. Delta Dental's response time to your appeal or complaint is based on the nature of the claim. The appeal or complaint will receive a full investigation by persons who were not involved in the initial determination or situation.

Note:
The timelines addressed in the paragraphs below do not apply when:

- The time period is too long to accommodate the clinical urgency of the situation;
- The Participant does not reasonably cooperate; or
- Circumstances beyond the control of either party prevents that party from complying with the standards set, but only if the party who is unable to comply gives notice of the specific circumstances to the other party when the circumstances arise.

An appeal related to an **urgent care claim** will be entitled to expedited review upon request. The request may be made orally or in writing. An appeal related to an **urgent care claim** will be responded to not later than 72 hours after receipt of the appeal by the Plan, unless the Participant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, we shall notify the Participant as soon as possible, but no later than 24 hours after receipt of the appeal by the Plan, of the specific information necessary to complete the claim. The Participant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. We shall notify the Participant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (a) the Plan's receipt of the specified information, or (b) the end of the period afforded the Participant to provide the specified additional information.

The investigation of a **complaint** will be completed within 30 days of receipt of the complaint.

When an investigation has been completed, you will receive a written notice of the disposition of your appeal or complaint, including the basis for the decision. The written notice for an appeal will include information on your right to file suit under ERISA 502(a).

BENEFITS AVAILABLE FROM OTHER SOURCES

Situations may arise in which your healthcare expenses may be the responsibility of someone other than this Plan. Here are descriptions of the situations that may arise.

A. Coordination of Benefits (COB)

This provision applies to this Plan when you or your enrolled dependent have healthcare coverage under more than one plan. For a complete explanation of COB see the section titled "Coordination of Benefits."

B. Third-Party Liability

An individual covered by the Plan may have a legal right to recover benefit or healthcare costs from another person, organization or entity, or an insurer, as a result of an illness or injury for which benefits or healthcare costs were paid by the Plan. For example, an individual who is injured may be able to recover the benefits or healthcare costs from an individual or entity responsible for the injury or from an insurer, including different forms of liability insurance, or uninsured motorist coverage or under-insured motorist coverage. As another example, an individual may become sick or be injured in the course of employment, in which case the employer or a workers' compensation insurer may be responsible for healthcare expenses connected with the illness or injury. Should the Plan make an advance payment of Benefits, as described below, it is entitled to be reimbursed for any benefits paid by the Plan that are associated with any illness or injury that are or may be recoverable from a Third Party or other source. Amounts received by the Plan through these recoveries help reduce the cost of contributions and providing benefits.

Because recovery from a Third Party may be difficult and take a long time, and payment of benefits where a Third Party may be legally liable is excluded under the terms of this Plan, as a service to you, the Plan will pay a Covered Individuals' expenses based on the understanding and agreement that the Covered Individual is required to honor the Plan's rights of subrogation as discussed below, and, if requested by us, to reimburse the Plan in full from any recovery the Covered Individual may receive, no matter how the recovery is characterized.

Upon claiming or accepting Benefits, or the provision of Benefits, under the terms of this Plan, the member agrees that the Plan shall have the remedies and rights as stated in this Section. We may elect to seek recovery under one or more of the procedures outlined in this Section. The Covered Individual agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, the Plan's right of reimbursement or subrogation as discussed in this Section. We have the sole discretion to interpret and construe these reimbursement and subrogation provisions.

Definitions:

For purposes of this Section relating to Third Party Liability, the following definitions apply:

1. "Covered Individual" means an individual covered by the Plan, including a dependent of a Member/Employee. "Covered Individual" also includes the estate, heirs, guardian or conservator of the individual for whom benefits have been paid or may be paid by the Plan, and includes any trust established for the purpose of receiving "Recovery Funds" and paying for the future income, care or dental/medical expenses of such individual.
2. "Benefits" means any amount paid by the Plan, or submitted to Delta Dental for payment to or on behalf of the Covered Individual. Bills, statements or invoices submitted to us by a provider of services, supplies or facilities to or on behalf of a Covered Individual are considered requests for payment of "Benefits" by the Covered Individual.
3. "Third Party Claim" means any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action against a Third Party (or any right to assert the foregoing) by or on behalf of a Covered Individual, regardless of the characterization of the claims or damages of the Covered Individual, and regardless of the characterization of the Recovery Funds. (For example, a Covered Individual who has received payment of dental/medical expenses from the Plan may file a Third Party

claim against the party responsible for the Covered Individual's injuries, but only seek the recovery of non-economic damages. In that case, the Plan is still entitled to recover Benefits as described herein.)

4. "Third Party" means any individual or entity responsible for the injury or illness, or the aggravation of an injury or illness, of the Covered Individual. "Third Party" includes any insurer of such individual or entity, including different forms of liability insurance, or any other form of insurance that may pay money to or on behalf of the Covered Individual including uninsured motorist coverage, under-insured motorist coverage, premises med-pay coverage, PIP coverage, and workers' compensation insurance.
5. "Recovery Funds" means any amount recovered from a Third Party.

Subrogation
Upon payment by the Plan, it shall be subrogated to all of the Covered Individual's rights of recoveries therefore, and the Covered Individual shall do whatever is necessary to secure such rights and do nothing to prejudice them.

Under this sub-section, we may pursue the Third Party in the Plan's name, or in the name of the member. The Plan is entitled to all subrogation rights and remedies under the common and statutory law, as well as under this Plan.

Right of Recovery
In addition to the Plan's subrogation rights, we may, at our option, ask that the Covered Individual, and his or her attorney, if any, protect the Plan's reimbursement rights. If we elect to proceed under this sub-section, the following rules apply:

1. The Covered Individual holds any rights of recovery against the Third Party in trust for the Plan, but only for the amount of Benefits the Plan paid for that illness or injury.

2. The Plan is entitled to receive the amount of Benefits it has paid for that illness or injury out of any settlement or judgment which results from exercising the right of recovery against the Third Party. This is so regardless of whether the Third Party admits liability or asserts that the Covered Individual is also at fault. In addition, the Plan is entitled to receive the amount of Benefits it has paid whether the health care expenses are itemized or expressly excluded in the Third Party recovery.

3. If, and only if, we ask the Covered Individual, and his or her attorney, to protect the Plan's reimbursement rights under this sub-section, then the Covered Individual may subtract from the money to be paid back to the Plan, as an expense for collecting from the other party, a proportionate share of reasonable attorney fees.

4. We may ask the Covered Individual to sign an agreement to abide by the terms of this Right of Recovery sub-section. If we elect to proceed under this sub-section the Plan will not be required to pay benefits for the illness or injury until the agreement is properly signed and returned.

5. This right of recovery includes the full amount of the Benefits paid, or pending payment by the Plan, out of any recovery made by the Covered Individual from the Third Party, including, without limitation, any and all amounts from the first dollars paid or payable to the Covered Individual (including his or her legal representatives, estate or heirs, or any trust established for the purpose of paying for the future income, care or medical expenses of the Covered Individual), regardless of the characterization of the recovery, whether or not the Covered Individual is made whole, or whether or not any amounts are paid or payable directly by the Third Party, an insurer or another source. The Plan's recovery rights will not be reduced due to the Covered Individual's own negligence.

6. If it is reasonable to expect that the Covered Individual will incur future expenses for which Benefits might be paid by the Plan, the Covered Individual shall seek recovery of such future expenses in any Third Party Claim.

Motor Vehicle Accidents
Any expense for injury or illness which results from a motor vehicle accident, and which is payable under a motor vehicle insurance policy is not a covered Benefit under this Plan and will not be paid by the Plan.

If a claim for dental care expenses arising out of a motor vehicle accident is filed with the Plan, and if motor vehicle insurance has not yet paid, then the Plan may advance Benefits, subject to the rights and remedies outlined in the Subrogation and Right of Recovery sub-sections stated above.

Additional Third Party Liability Section Provisions
In connection with the Plan's rights to obtain reimbursement, or to exercise its right of subrogation, or direct recovery in motor vehicle accidents, as discussed in the above sub-sections, Covered Individuals shall do one or more of the following, and agree that we may do one or more of the following, at our option:

a. If the Covered Individual seeks payment by the Plan of any Benefits for which there may be a Third Party Claim, the Covered Individual shall notify us of the potential Third Party Claim. The Covered Individual has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to the Plan by a Provider to the Covered Individual.

b. Upon request from us, the Covered Individual shall provide to us all information available to the Covered Individual, or any representative, or attorney representing the Covered Individual, relating to the potential Third Party Claim. The Covered Individual and his or her representatives shall have the obligation to notify us in advance of any claim (written or oral) and/or any lawsuit made against a Third Party seeking recovery of any damages from the Third Party, whether or not the Covered Individual is seeking recovery of Benefits paid by the Plan from the Third Party.

c. In order to receive an advance payment of Benefits pursuant to this Section, the Plan requires that any Covered Individual seeking payment of Benefits by the Plan, and if the Covered Individual is a minor or legally incapable of contracting, then the Covered Person's parent or guardian, must fill out, sign and return to our office a Third-Party Questionnaire and Agreement that includes a questionnaire about the accident and the potential Third-Party claim. If the Covered Individual has retained an attorney to represent the Covered Individual with respect to a Third-Party Claim, then the attorney must sign the Third-Party Recovery Agreement, acknowledging the obligations described in that Agreement.

d. The Covered Individual shall cooperate with us to protect the Plan's recovery rights under this Section, and in addition, but not by way of limitation, shall:"

   i. Sign and deliver such documents as we reasonably require to protect the Plan's rights;
   ii. Provide any information to us relevant to the application of the provisions of this Section, including dental/medical information (including doctors' reports, chart notes, diagnostic test results, etc.), settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments; and
   iii. Take such actions as we may reasonably request to assist us in enforcing the Plan's rights to be reimbursed from Third Party recoveries.

e. By accepting the payment of benefits by the Plan, the Covered Individual agrees that we have the right to intervene in any lawsuit or arbitration filed by or on behalf of a Covered Individual seeking damages from a Third Party.

f. The Covered Individual agrees that we may notify any Third Party, or Third Party's representatives or insurers of the Plan's recovery rights set forth herein.

g. Even without your written authorization, we may release to, or obtain from, any other insurer, organization or person, any information we need to carry out the provisions of this Section.

h. This Section applies to any Covered Individual for whom advance payment of Benefits is made by the Plan whether or not the event giving rise to the Covered Individual's injuries occurred before the individual became covered by the Plan.

i. If the Covered Individual continues to receive dental/medical treatment for an illness or injury after obtaining a settlement or recovery from a Third Party, the Plan will provide Benefits for the continuing treatment of that illness or injury only to the extent that the Covered Individual can establish that any sums that may have been recovered from the Third Party have been exhausted.

j. If the Covered Individual or the Covered Individual's representatives fail to do any of the foregoing acts at our request, then the Plan has the right to not advance payment of Benefits or to suspend payment of any Benefits for or on behalf of the Covered Individual related to any sickness, illness, injury or dental/medical condition arising out of the event giving rise to, or the allegations in, the Third Party Claim. In exercising this right, we may notify dental/medical providers seeking authorization or pre-authorization of payment of Benefits that all payments have been suspended, and may not be paid.

k. Coordination of Benefits (where the Covered Individual has dental/medical coverage under more than one Plan or dental/medical insurance policy) is not considered a Third Party Claim.

l. If any term, provision, agreement or condition of this Section is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired or invalidated.

General Plan Information

The following describes other procedures and policies in effect when processing your claims.

REQUEST FOR INFORMATION

When necessary to process claims, we may require that you submit information concerning benefits to which you or your dependent is entitled. We may also require that you authorize your provider to provide us with information about a condition for which you claim benefits.

DISCLOSURE OF BENEFIT REDUCTION

The Plan will provide notification of material reductions in covered services or benefits to the Group no later than 60 days after the adoption of the change.

CONFIDENTIALITY OF MEMBER INFORMATION

The confidentiality of your protected health information is of extreme importance to the plan sponsor and to Delta Dental. Your protected health information includes, but is not limited to enrollment, claims, and medical and dental information. Your information is used for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. For more complete detail about how your plan sponsor uses your information, please refer to the Notice of Privacy Practices. Delta Dental as the third party administrator is required to adhere to these same practices. If you have additional questions about the privacy of your information beyond that provided in the Notice of Privacy Practices, please contact your plan sponsor.

TRANSFER OF BENEFITS

Only you and your enrolled dependents are entitled to benefits under this Plan. These benefits are not assignable or transferable to anyone else. Any attempted assignment or transfer will not be binding on the Plan.

RECOVERY OF BENEFITS PAID BY MISTAKE

If the Plan makes a payment for you or an enrolled dependent to which you are not entitled, or if the Plan pays a person who is not eligible for payments at all, it has the right to recover the payment from the person the Plan paid or anyone else who benefited from it, including a physician or provider of services. The Plan's right to recovery includes the right to deduct the amount paid from future benefits the Plan would provide for you or any enrolled dependent even if the payment was not made on that person's behalf.

CONTRACT PROVISIONS

The employer contract with Delta Dental and this member handbook plus any endorsements or amendments are the entire contract between the parties. No promises, terms, conditions or obligations exist other than those contained herein. This contract plus such endorsements or amendments, if any, shall supersede all other communications, representations or agreements, either verbal or written between the parties.

WARRANTIES

All statements made by the Group or a Participant, unless fraudulent, will be considered as representations and not warranties. No statement made for the purpose of effecting coverage will avoid the coverage or reduce benefits unless contained in a written form and signed by the Group or the Participant, a copy of which has been given to the Group or to the Participant or the beneficiary of the Participant.

LIMITATION OF LIABILITY

Delta Dental shall incur no liability whatsoever to any Participant concerning the selection of dentists to render services hereunder. In performing or contracting to perform dental service, such dentists shall be solely responsible and, in no case, shall Delta Dental be liable for the negligence of any dentist rendering such services. Nothing contained in this handbook shall be construed as obligating Delta Dental to render dental services.

PROVIDER REIMBURSEMENTS

Providers contracting with Delta Dental to provide services to covered individuals agree to look only to Delta Dental for payment of the part of the expense which is covered by the Plan and may not bill the Participant in the event Delta Dental fails to pay the provider for whatever reason. The provider may bill the Participant for applicable co-payments and deductibles or non-covered expenses except as may be restricted in the provider contract.

INDEPENDENT CONTRACTOR DISCLAIMER

Delta Dental and Participating Dentists are independent contractors. Delta Dental and Participating Dentists do NOT have a relationship of employer and employee nor of principal and agent. No relationship other than that of independent parties contracting with each other solely for the purpose of a Participating Dentist's provision of dental care to Delta Dental Participants may be deemed to exist or be construed to exist between Delta Dental and Participating Dentists. A Participating Dentist is solely responsible for the dental care provided to any patient, and Delta Dental does not control the detail, manner or methods by which a Participating Dentist provides care.

NO WAIVER

Any waiver of any provision of this Plan, or any performance under this Plan, must be in writing and signed by the waiving party. Any such waiver shall not operate as, or be deemed to be, a waiver of any prior or future performance or enforcement of that provision or any other provision. No delay or omission on the part of Delta Dental in exercising any right, power or remedy provided in this Plan, including, without limitation, our delay or omission in denying a claim under the Plan, shall operate as a waiver thereof.

GOVERNING LAW

To the extent this Plan is governed by state law, it shall be governed by and construed in accordance with the laws of the State of Idaho.

WHERE ANY LEGAL ACTION MUST BE FILED

Any legal action arising out of this Plan must be filed in either a state or federal court in the state of Idaho.

TIME LIMITS FOR FILING A LAWSUIT

Any legal action arising out of, or related to, this Plan and filed against the Plan by you, any of your dependents, any Participant or any third party, must be filed in court within three years of the time the claim arose. For example, a claim that benefits were not authorized or provided, and any and all damages relating thereto, would arise when the last level of administrative appeal under the Plan has ended.

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA").

INFORMATION ABOUT YOUR PLAN AND BENEFITS

You may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, collective bargaining agreements (if applicable), updated summary plan description, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (if any). This information can be obtained by written request. The Plan Administrator may make a reasonable charge for the copies. You are entitled to receive a summary of the Plan's annual financial report, if any is required by ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUATION OF GROUP HEALTH PLAN COVERAGE

You are entitled to continue healthcare coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this handbook and the documents governing the Plan on the rules governing your COBRA continuation coverage rights (if applicable to your plan).

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan.

The people who operate this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants.

No one, including the Group or any other person, may fire you or discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

CONTRACT TERMINATION

Either Idaho AGC Self-Funded Benefit Trust or Delta Dental may terminate this Agreement for its own convenience and without cause by written notice to the other party specifying the effective date of termination, which notice shall be delivered in accordance with the terms of this Agreement not less than 60 days before the effective date of termination. This Agreement may be terminated immediately: (a**)** by either party in the event of another party's bankruptcy, insolvency, making of an assignment for the benefit of creditors, or the administration of that party's assets in any creditor's proceedings, voluntary or involuntary; or (b) by either party upon the material breach of this Agreement by a party and that party's failure to cure such breach following thirty days prior written notice to the other parties by the terminating party; or (c) by Delta dental upon termination, for any reason, of the Dental Plan.

ENFORCE YOUR RIGHTS

If your claim for a benefit is denied or no action is taken, in whole or in part, you have a right to receive an explanation, to obtain without charge copies of documents relating to the decision, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan Administrator and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or no action is taken, in whole or in part, you may file suit in state or Federal court (see Grievance and

Appeals for additional information). In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from U.S. Department of Labor, or you may file suit in Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, (e.g., if it finds your claim is frivolous).

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact one of the following:

Employee Benefits Security Administration
US Department of Labor
1111 Third Avenue, Room 860
Seattle, Washington 98101
(206) 553-4244

Office of Participant Assistance
Employee Benefits Security Administration
US Department of Labor
200 Constitution Avenue N.W.
Washington D.C., 20210

You may also obtain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DISCRIMINATION IS AGAINST THE LAW

Delta Dental of Idaho complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Delta Dental of Idaho does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Delta Dental of Idaho provides free aids and services to people with disabilities to communicate effectively with us, such as free language services to people whose primary language is not English by qualified interpreters and some information written in Spanish. If you need these services, contact our Customer Service at (800) 356-7586 (TTY: 711) or by email at customerservice@deltadentalid.com.

If you believe that Delta Dental of Idaho has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Operations Manager, 555 E Parkcenter Blvd, Boise, Idaho 83701
customerservice@deltadentalid.com.
Toll-free (866) 912-7997, Fax (208) 344-4649.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Operations Manager is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

LANGUAGE ASSISTANCE

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-(800) 356-7586.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-(800) 356-7586.

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-(800) 356-7586

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 번으로 전화해 주십시오. 1-(800) 356-7586.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-(800) 356-7586

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-(800) 356-7586 (رقم

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-(800) 356-7586

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-(800) 356-7586

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-(800) 356-7586

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-(800) 356-7586

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-(800) 356-7586

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-(800) 356-7586

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-(800) 356-7586

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-(800) 356-7586

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان برای شم

7586-356) 800(-1. تماس بگیرید