



Blue Dental

LIMITED BENEFIT CONTRACT



Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and is incorporated as Louisiana Health Service & Indemnity Company.

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Thank you for choosing us!

It is my pleasure to welcome you to your new plan. If you are renewing your plan, welcome back! We are honored you chose the Cross and Shield for your health insurance needs. Please read this booklet for important information about your plan and how it works. If you have questions, we are here to help. Simply call the number on your ID card and we'll do our best to assist you.

My best to you,

I. Steven Udvarhelyi, M. D.
President and Chief Executive Officer

GROUP DENTAL BENEFIT PLAN

THIS IS A LIMITED BENEFIT PLAN – READ CAREFULLY

provided by



P.O. Box 98029 • Baton Rouge, Louisiana • 70898-9029

www.bcbsla.com

NOTICES

We base Our payment of Benefits for the Member's covered services on an amount known as the Allowable Charge. The Allowable Charge depends on the specific Provider from whom a Member receives covered services.

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ARTICLE I. UNDERSTANDING THE BASICS OF YOUR COVERAGE

The Schedule of Dental Benefits controls in regards to which specific dental Benefits are covered and the cost sharing (deductibles, coinsurance) applicable to each Benefit. The Benefits offered under this Benefit Plan are limited as stated in the Benefits section.

UNITED CONCORDIA DENTAL

United Concordia Companies, Inc. d/b/a United Concordia Dental (hereinafter “United Concordia Dental” or “Claims Administrator”) is the Blue Cross and Blue Shield of Louisiana’s network and claims administrator for the dental Benefits provided in this Contract, and is in charge of managing the dental networks, handling and paying claims, and providing customer services to the Members eligible to receive these benefits and their legal representatives.

United Concordia Dental has more than one network. Only one specific network will be made available to Members under this Benefit Plan (hereinafter the “Network”). The specific Network will be disclosed on the Schedule of Dental Benefits. The Network consists of a select group of Providers who have contracted with United Concordia Dental to render services to Members for specified fees and under specific terms. **All other Providers are considered Non-Participating.** Non-Participating Providers may bill you more for their services than Participating Providers.

In order to receive the full benefits under this Benefit Plan, the Member should verify that a Provider participates in the specific Network before any service is rendered. To locate a Participating Provider and verify their continued participation in the Network, or to ask any questions related to Benefits or claims, please visit the website at www.bcbsla.com or contact a customer service representative at (866) 445-5338.

We”, “Us” and “Our” in this Benefit Plan means the Company or United Concordia Dental when it acts on behalf of Blue Cross and Blue Shield of Louisiana in performing its services under the dental coverage provided for in this Contract. Capitalized words are defined terms as described below.

SERVICES RENDERED BY NON-PARTICIPATING PROVIDERS

You should know that care received from a Non-Participating Provider could mean a higher cost to you. This amount you could be subject to pay could be significant. We recommend that you ask the Non-Participating Provider about their billed charges before you receive care.

Reimbursements for services rendered by a Non-Participating Provider will be based on Our Allowable Charge and will be paid under the same limits, rules and policies that We would have applied to claims for services rendered by a Participating Provider.

ARTICLE II. DEFINITIONS

Adverse Benefit Determination – Means denial or partial denial of a Benefit, in whole or in part, based on:

- A. Medical Necessity, appropriateness, health care setting, level of care, effectiveness or treatment determined to be experimental or investigational;
- B. the Member's eligibility to participate in the Benefit Plan; or
- C. any prospective or retrospective review determination.

Allowable Charge – The lesser of the billed charge or the amount established by Claims Administrator as the greatest amount this Benefit Plan will allow for a specific service covered under the terms of this Benefit Plan.

Appeal – A written request from a Member or authorized representative to change an Adverse Benefit Determination made by the Company.

Amalgam – A durable metal alloy comprised of silver, copper, tin and mercury, used in dental restorations.

Annual Deductible – The dollar amount that each Member must pay out of their own pocket for Covered Services within each Benefit Period before any Benefits are paid under this Benefit Plan. The Annual Deductible will be shown in the Schedule of Dental Benefits, which may be waived for certain services.

Authorization (Authorized) – A determination by Claims Administrator regarding a dental health care service or supply which, based on the information provided, satisfies the clinical review criteria requirement for Medical Necessity, appropriateness of the health care setting, or level of care and effectiveness. An Authorization is not a guarantee of payment. Additionally, an Authorization is not a determination about the Member's choice of Provider.

Beneficiary – A person designated by a participant, or by the terms of a health insurance Benefit Plan, who is or may become entitled to a Benefit under the plan.

Benefit(s) – Coverage for dental services, treatments or procedures provided under this Benefit Plan. Benefits are based on the Allowable Charge for Covered Services and the Schedules of Dental Benefits.

Benefit Plan – Means this Group Dental Benefits Contract.

Benefit Period – Means a natural calendar year, from January 1st to December 31st of each year.

Claim – A Claim is written or electronic proof, in a form acceptable to the Claims Administrator, of charges for Covered Services that have been incurred by a Member during the time period the Member was insured under this Benefit Plan. The provisions in effect at the time the service or treatment is received shall govern the processing of any Claim expense actually incurred as a result of the service or treatment rendered.

Claims Administrator – United Concordia Companies, Inc. is Blue Cross and Blue Shield of Louisiana's claims administrator for this Benefit Plan.

COBRA – Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and its regulations.

Coinsurance – The sharing of Allowable Charges for Covered Services. The sharing is expressed as a percentage. Once the Member has met any applicable Deductible, Claims Administrator's percentage will be applied to the Allowable Charge for Covered Services to determine the Benefits provided.

Company – Means Blue Cross and Blue Shield of Louisiana, or United Concordia Dental when it acts on Blue Cross and Blue Shield of Louisiana's behalf.

Complaint – An oral expression of dissatisfaction with the dental plan or Provider services.

Cosmetic Surgery/Treatment – Any procedure or any portion of a procedure performed primarily to improve physical appearance. A procedure, treatment or service will not be considered Cosmetic Surgery or treatment if that procedure, treatment or service restores bodily function or corrects deformity of a part of the body that has been altered as a result of Accidental Injury, disease or disorder, or covered surgery.

Covered Service – A service or supply specified in this Benefit Plan for which Benefits are available when rendered by a Provider.

Crown – A tooth-shaped cap that is placed over a tooth to cover it and restore its shape and size, strength, and improve its appearance. When a crown is cemented into place, it fully encases the entire visible portion of a tooth that lies at and above the gum line.

Dental Care and Treatment – All procedures, treatment, and surgery considered to be within the scope of the practice of dentistry, which is defined as that practice in which a person:

- D. represents himself/herself as being able to diagnose, treat, correct, operate, or prescribe for any disease, pain, injury, deficiency, deformity, or physical condition of the human teeth, alveolar process, gums, or jaws or associated parts and offers or undertakes by certain means to diagnose, treat, correct, operate, or prescribe for any disease, pain, injury, deficiency, deformity, or physical condition of the same;
- E. takes impressions of the human teeth or jaws or performs any phase of any operation incident to the replacement of a tooth or part of a tooth or associated tissues by means of a filling, crown, denture, or other appliance; or
- F. furnishes, supplies, constructs, reproduces, or repairs or offers to furnish, supply, construct, reproduce, or repair prosthetic dentures, bridges, or other substitute for natural teeth to the user or prospective user.

Dental Implants – An artificial device that replaces the tooth root and may anchor an artificial tooth, bridge or denture.

Dental Necessity or Dentally Necessary – A dental service or procedure that is determined by Claims Administrator to either establish or maintain a patient's dental health based on professional diagnostic judgment and the prevailing standards of care in the professional community. The determination will be made by a Dentist in accordance with guidelines established by Claims Administrator.

Dentist – A person licensed to practice dentistry in the state in which dental services are provided. Dentist will include other duly licensed dental practitioner under the scope of the individual's license when state law requires independent reimbursement of such practitioners.

Dependent – A person, other than the Subscriber, who has been accepted for coverage as specified in and determined by the Schedule of Eligibility.

Effective Date – The date when the Member's coverage begins under this Benefit Plan as determined by the Schedule of Eligibility. Benefits will begin at 12:01 a.m. on this date.

Eligible Employee – An employee of the Group that has been determined by the Company as eligible to enroll in this Benefit Plan

Eligible Person – A person entitled to apply to be a Subscriber or Dependent as specified in the Schedule of Eligibility.

Endodontic (Pulpal) Therapy – A dental procedure that is performed when the decay in a child's tooth reaches into the pulp (nerve) tissue. The infected part of the nerve tissue within the crown portion of the tooth is removed to prevent further inflammation and spread of disease (caries). During this treatment, the diseased

pulp tissue is partially or completely removed from both the crown and the roots of the tooth. The canals are cleansed, disinfected, and filled with a special material.

Enrollment Date – The first day of coverage under this Benefit Plan or, if there is an Eligibility Waiting Period, the first day of the Eligibility Waiting Period.

Expedited Appeal – A request for immediate review of an Adverse Benefit Determination involving an Admission, availability of care, continued Hospital stay, or health care service for which a Member has received Emergency services, but has not been discharged from a facility, which involves any of the following:

- G. A medical condition for which the time frame for completion of a standard Appeal would seriously jeopardize the life or health of the Member or jeopardize the Member's ability to regain maximum function, or a decision not to Authorize continued services for Members currently in the emergency room, under observation, or receiving Inpatient care.
- H. A denial of coverage based on a determination the recommended or requested health care service or treatment is experimental or Investigational and the treating Physician certifies that any delay may pose an imminent threat to the Member's health, including severe pain, potential loss of life, limb or major bodily function.

Family Deductible – It will only apply when, besides the Subscriber, there are two or more Dependents covered under this Benefit Plan (a "Family" for deductible purposes). It is the dollar amount shown in the Schedule of Dental Benefits that a Family must pay out of their own pocket for Covered Services within each Benefit Period before any Benefits are paid under this Benefit Plan.

Filling – A dental restorative material used to restore the function, integrity and form of missing tooth structure, which may result from caries or external trauma.

Fluoride Treatment – Fluoride is a chemical substance that helps prevent tooth decay by making the tooth more resistant to acid attacks from plaque bacteria and sugars in the mouth. It also reverses early decay. Fluoride treatment refers to the direct application of a substance containing this substance to the tooth enamel.

Gingivectomy – Surgical removal of gum tissue.

Gingivoplasty – A surgical procedure to reshape or repair the gums.

Grievance – A written expression of dissatisfaction with the Company or with Provider services.

Group – Any company, partnership, association, corporation or other legal entity which has made application for coverage herein and has agreed to comply with all the terms and requirements of this Contract. For purposes of this Contract, the Group is the policyholder.

Inlay – A custom-made solid substance that is fitted into a cavity in a tooth between the cusps, which is cemented into place to restore its biting surface.

Member – A Subscriber or an enrolled Dependent.

Network – Refers to the Providers which participate in the specific United Concordia Dental network that is made available to Members under this Benefit Plan. United Concordia Dental has more than one network. Members have access to only one network which is disclosed in the Schedule of Dental Benefits.

Onlay – A custom-made solid substance that works like an Inlay but covers one or more cusps or the entire biting surface of the tooth. It is usually used when the tooth is too damaged to support an Inlay, but not damaged enough to require a Crown.

Orthodontics – A dental specialty that treats misalignment of teeth.

Open Enrollment Period – A period of time each year designated by the Group during which a Subscriber and his eligible Dependents may enroll for coverage under this Benefit Plan.

Periodontal Scaling and Root Planing – The process of removing or eliminating etiologic agents (dental plaque, its products, and calculus) which cause inflammation, and help to maintain disease-free the tissues that surround and support the teeth.

Policy Year – The period of time which starts on the Effective Date of this Contract, as stated in the Schedule of Dental Benefits, and ends at 11:59 PM (CDT) of the day before 12 months from the Effective Date. For Members enrolling in this Benefit Plan upon being hired by the Policyholder or during a Special Enrollment Period, the Policy Year may be less than 12 months, starting from the date of enrollment until the following date of renewal.

Prefabricated Stainless Steel Crown – A Crown made of stainless steel that is premanufactured in a variety of sizes and are intended to be fitted upon a child's primary tooth which is damaged, to simulate its original form, decrease the risk of future cavities, save the proper amount of space for the eruption of the permanent tooth, and restore the child's ability to bite and chew.

Prosthetic Dentures – Prosthetic devices constructed to replace missing teeth, and which are supported by surrounding soft and hard tissues of the oral cavity. Conventional dentures are removable, however there are many different denture designs, some which rely on bonding or clasping onto teeth or dental implants.

Provider – A physician or Dentist, or Allied Health Professional, licensed where required, performing within the scope of license, and approved by Claims Administrator. If a Provider is not subject to state or federal licensure, We have the right to define all criteria under which a Provider's services may be offered to Our Members in order for Benefits to apply to a Provider's Claims. Claims submitted by Providers who fail to meet these criteria will be denied.

I. Participating Provider – A Provider that has a Provider Agreement with United Concordia Dental pertaining to payment for Covered Services rendered to a Member.

J. Non-Participating Provider – A Provider that does not have a Provider Agreement with United Concordia Dental pertaining to payment for Covered Services rendered to a Member.

Provider Agreement – An agreement for payment contracted by Claims Administrator with Participating Providers. These agreements establish the actual payments which will be made to the Participating Provider. The payments may reflect a discount or payment formula that has been contracted between Claims Administrator and the Participating Provider.

Sealant – Plastic material usually applied to the chewing surfaces of the back teeth (premolars and molars) where decay occurs most often, so that they act as a barrier to prevent cavities.

Space Maintainer – Besides being useful for chewing, baby teeth also act as a guide for the eruption of the permanent teeth that replaces them. If a baby's tooth is lost too early, the permanent tooth that comes after it loses its guide, so it could drift or erupt into the wrong position in the mouth. Neighboring teeth also can move or tilt into the space, reducing the space available for the permanent tooth to come out. Space maintainers are appliances used when a baby tooth is lost too early to help make room for the permanent tooth it was intended to guide.

Special Enrollment Period – The sixty (60) day period of time during which a Subscriber and eligible Dependents may enroll or disenroll from coverage under this Benefit Plan outside of the Open Enrollment Period.

Spouse – The Subscriber's legal Spouse.

Subscriber – An Eligible Person who has satisfied the specifications of this Contract's Schedule of Eligibility and has enrolled for coverage, and to whom the Company has issued a copy of this Contract.

Temporomandibular/Craniomandibular Joint Disorder – Disorders resulting in pain and/or dysfunction of the temporomandibular/craniomandibular joint which arise out of rheumatic disease, dental occlusive disorders, internal or external joint stress, or other causes.

Waiting Period – A period of time a Member must be enrolled under this Benefit Plan before benefits will be paid for certain Covered Services as shown on the Schedule of Dental Benefits.

ARTICLE III. SCHEDULE OF ELIGIBILITY

THE COMPANY WILL ESTABLISH AN ENROLLMENT PROCESS AND DETERMINE ELIGIBILITY FOR GROUP AND ITS ELIGIBLE MEMBERS. COMPANY'S ENROLLMENT PROCESSES ARE DESCRIBED BELOW. ANY ELIGIBILITY REQUIREMENT LISTED IN THIS BENEFIT PLAN, WHICH IS NOT MANDATED BY STATE OR FEDERAL LAW, MAY BE DELETED OR REVISED ON THE SCHEDULE OF BENEFITS.

A. Eligibility

1. Subscriber. To be eligible to enroll as a Subscriber, an individual must be:
 - a. an Eligible Employee of Group who has satisfied any criteria designated by Company to subscribe to this policy, has satisfied any Eligibility Waiting Period required by the Group, and who is working the number of hours required by the Company to enroll in this coverage.
 - b. a retiree who satisfies any criteria designated by Us, and if shown as covered in this Group's Benefit Plan Schedule of Dental Benefits.
 - c. an elected official who satisfies any criteria designated by Us, and if shown as covered in this Group's Benefit Plan Schedule of Dental Benefits.
2. Dependent. To be eligible to apply as a Dependent, an individual must meet the following criteria at the time of enrollment. To be eligible to maintain Dependent coverage, an individual must continue to meet the criteria. Failure to continually meet the criteria thereafter may result in a determination by the Company that the Dependent is no longer eligible for coverage and Dependent Benefits may be terminated in the manner described in this Benefit Plan:
 - a. Spouse.
 - b. CHILDREN: A child under age twenty-six (26) who is one of the following:
 - (1) born of the Subscriber; or
 - (2) legally placed for adoption with the Subscriber; or
 - (3) legally adopted by the Subscriber; or
 - (4) a child for whom the Subscriber or his Spouse has been granted legal custody or provisional custody by mandate, or a child for whom the Subscriber or his Spouse is a court appointed tutor/tutrix; or
 - (5) a child supported by the Subscriber pursuant to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN); or
 - (6) a stepchild of the Subscriber; or
 - (7) a grandchild residing with the Subscriber, provided the Subscriber has been granted legal custody or provisional custody by mandate of the grandchild; or
 - (8) the Subscriber's child after attaining age twenty-six (26), or grandchild who was in the legal custody of and residing with the Subscriber prior to attaining age twenty-six (26), who is incapable of self-sustaining employment by reason of being mentally or physically disabled prior to attaining age twenty-six (26). The Subscriber must furnish Us with periodic proof of continuing incapacity and dependency within thirty-one (31) days of the child's twenty-sixth (26th) birthday. We may require subsequent proof once a year after the initial two-year period following the child's twenty-sixth (26th) birthday.

B. Application for Coverage

Applications, changes and terminations must be made to Company. Company will determine and verify eligibility to enroll in this Benefit Plan and establish an Effective Date for coverage. Application for enrollment must be made to Company during the Group's annual Open Enrollment Period each year. After the initial Open Enrollment Period, qualified persons generally may enroll in or change coverage only during subsequent Open Enrollment Periods or if an individual becomes eligible outside the annual Open Enrollment Period, he may apply for coverage beginning on the date he becomes eligible. A qualified individual may also enroll in coverage during a Special Enrollment Period available after certain trigger events occur.

1. Every Eligible Person may enroll for coverage under this Benefit Plan and may include any Eligible Dependents on such enrollment form.
2. The Group will submit any such enrollment forms to the Company as a prerequisite to coverage under this Benefit Plan.
3. No person will be covered under this Benefit Plan unless the Company has accepted the enrollment form and has been issued an identification card or other written notice of acceptance. Payment of premiums to the Company for any person will not effectuate coverage unless and until the Company's identification card or other written acceptance has been issued, and in the absence of such issuance, the Company's liability will be limited to refund of the amount of premiums paid.
4. This Group Dental Benefit Plan and coverage under it will not be issued or renewed unless the percentage of Eligible Persons specified in the Application for Group Coverage is enrolled.

C. Available Classes of Coverage as Selected by the Group

The classes of coverage defined below are available subject to the selection of class or classes of coverage by the Group as shown on the Application for Group Coverage. The Group has the right to change the classes of coverage selected when needed.

1. Subscriber Only coverage means coverage for the Subscriber only.
2. Subscriber and Spouse coverage means coverage for the Subscriber and his Spouse.
3. Subscriber and Family coverage means coverage for the Subscriber, his Spouse, and one or more Dependent children.
4. Subscriber and Child(ren) coverage means coverage for the Subscriber and one or more Dependent children.
5. Subscriber and Dependent coverage means coverage for the Subscriber and one Dependent.

D. Effective Date

When an enrollment form has been accepted and any premiums for coverage have been paid, coverage will begin on the following applicable Effective Date, subject to any Eligibility Waiting Period:

1. If a person is an Eligible Person on the Group's Benefit Plan Date and enrolls for coverage for self or for self and any eligible Dependent(s) on or before such date, this Group's Benefit Plan Date will be the Effective Date of coverage.
2. If a person becomes an Eligible Person after this Group's Benefit Plan Date, and enrolls for coverage for self or for self and any eligible Dependent(s) and the enrollment form is received by the

Company within thirty (30) days of the eligibility date, the Effective Date of coverage will be the eligibility date.

3. If an Eligible Person's application for coverage for self or for self and any eligible Dependent(s) is not received by Us within thirty (30) days of the eligibility date or Special Enrollment Period as described below, the request for enrollment will be denied. The Eligible Person shall be eligible to enroll for coverage during the next Open Enrollment Period. If the Eligible Person timely enrolls during the next Open Enrollment Period, the Eligible Person shall be considered a Late Enrollee.
4. If a child is born to a Subscriber holding coverage which includes Dependent children (Subscriber and Family coverage or Subscriber and Child(ren) coverage), and the enrollment form is received by the Company within one hundred eighty (180) days of the date of birth, the Effective Date of coverage will be the date of birth.

E. Court Ordered Determination

If a court ordered determination is made to cover an eligible Dependent under an employee's Contract, the employee must enroll himself, if not already enrolled, and enroll the eligible Dependent by completing an enrollment form and submitting the enrollment form to Our home office within thirty (30) days after the court ordered determination. If timely enrolled, coverage for the eligible Dependent will be effective on the date of the court ordered determination.

F. Special Enrollment

Special Enrollment Periods exist outside of the Open Enrollment Period when the Eligible Person experiences a specific Special Enrollment event as described under this section. During these periods, application may be made to Company (for Off-Exchange coverage) or to SHOP (for On-Exchange coverage) to enroll or drop coverage or to enroll or disenroll Dependents. Individuals who lose other coverage because they did not pay their premiums or required contributions timely, or lose other coverage for cause (such as filing fraudulent Claims or an intentional misrepresentation of a material fact in connection with the plan), are not Special Enrollees and have no special enrollment rights.

An Eligible Person who is not enrolled under this Benefit Plan may be permitted to enroll as a Special Enrollee if each of the following conditions is met:

1. The Eligible Person must be eligible for coverage under the terms of this Benefit Plan; and
2. If the Eligible Person was offered coverage under this Benefit Plan on a previous Open Enrollment, he must have declined enrollment in writing in a form established by Company for that purpose.

Examples of Special Enrollment events are:

3. Enrollment or non-enrollment in this Benefit Plan was due to an error, misrepresentation or inaction of an officer, employee or agent of the SHOP or the United States Department of Health and Human Services, or their instrumentalities.
4. Company's substantial violation of a material provision of this Benefit Plan.
5. Gaining access to new Qualified Health Plans because of a permanent move.
6. Being an Indian, as defined in Section 4 of the Indian Health Care Improvement Act.
7. Meeting other exceptional circumstances as determined by the SHOP.
8. The Subscriber gaining a Dependent or gaining dependent status under another health plan through marriage, birth, adoption, placement for adoption or mandate granting legal or provisional custody.

Premiums may be adjusted for the additional coverage if adding the new Dependent changes the class of coverage under the Benefit Plan.

When the Subscriber gains dependent status under another plan, he may disenroll from this Benefit Plan outside of the Open Enrollment Period. When the Subscriber gains a Dependent and because of that wishes to enroll himself, or enroll a Dependent in this Benefit Plan, the following rules apply:

- a. If not already participating, Eligible Employee may enroll with the Dependent if he has served any applicable Eligibility Waiting Period but has not enrolled during a previous enrollment period. In the case of the birth, adoption, or placement for adoption of a child, the Spouse of the employee may be enrolled as a Dependent if the Spouse is otherwise eligible for coverage.
 - b. If the Group offers multiple health plan options, another option may be chosen by the Eligible Employee for himself and Dependents when special enrollee status applies.
 - c. There may be a thirty (30) day period of automatic coverage for Newly-Born Infants (natural born or adopted), as described below. Any period of automatic coverage runs concurrently with the Special Enrollment Period for adding these infants to this Benefit Plan.
 - d. The Special Enrollment Period described in this subparagraph is a period of no less than thirty (30) days and shall begin on the later of the date Dependent coverage is made available or the date of the marriage, birth, adoption, or placement for adoption. If the request for enrollment is not made timely, the request will be denied and any period of automatic coverage for Newly-Born Infants will end.
 - e. In the case of a birth, adoption, or placement for adoption, a current employee may enroll himself, his Spouse and/or the newborn/adopted child and other eligible Dependent children, the enrollment must be requested no later than thirty (30) days after the birth, adoption, or placement for adoption. If the enrollment form is received by a Blue Cross and Blue Shield of Louisiana office or the SHOP no later than thirty (30) days of the birth, adoption, or placement for adoption, coverage will become effective on the date of birth for a natural Newly Born Infant, and upon the date of adoption, or placement for adoption for an adopted Newly Born Infant. The SHOP will assign the Effective Date of coverage if special enrollment is made through the SHOP. A Subscriber may enroll an unborn natural child prior to birth; however, coverage will not be effective until the date of birth. Adopted children will not be effective on the date of birth. If the request for enrollment is not made and received by Us or the SHOP within thirty (30) days of birth, adoption or placement for adoption, the request for Special Enrollment will be denied and any automatic coverage period will end.
 - f. In the case of marriage, a current Eligible Employee may enroll himself and the new Dependents acquired because of the marriage. The enrollment must be requested within thirty (30) days of the marriage. The Special Enrollment will be denied if the enrollment is not requested within thirty (30) days of the marriage.
9. Loss of "minimum essential coverage" during the Plan Year as that term is defined under Internal Revenue Code Section 5000A, such as:
- a. Medicare.
 - b. Medicaid or the Children's Health Insurance Program (CHIP), if either:
 - (1) The Eligible Employee or Dependent is covered under Medicaid or Children's Health Insurance Program ("CHIP"), and lose that coverage because of loss of eligibility; or
 - (2) the Eligible Employee or Dependent becomes eligible for premium assistance under the CHIP program.

To qualify, Eligible Employee must request coverage in this Benefit Plan no later than sixty (60) days after either the date of coverage termination under Medicaid or CHIP or the date Eligible Employee or Dependent is determined to be eligible for such premium assistance. Request for special enrollment under this section must be received by a Blue Cross and Blue Shield of Louisiana office or the SHOP within the sixty (60) day period following loss of coverage or the date Eligible Employee or Dependent is determined to be eligible for premium assistance.

When special enrollment under this section is made timely and received by Company timely, coverage will become effective on the date of the loss of coverage under Medicaid or CHIP or the date employee or Dependent is eligible for premium assistance.

The Eligible Employee may disenroll a child Dependent from this Benefit Plan and enroll the child in CHIP coverage effective on the first day of any month for which the child is eligible for such CHIP coverage. Employee must promptly notify Company or the SHOP in writing of the child's disenrollment to avoid continued coverage under this Plan.

- c. Health coverage provided by the United States Armed Forces under Chapter 55 of Title 10 of the United States Code, including Tricare.
- d. Health coverage program provided by the United States Secretary of Veterans Affairs in coordination with the United States Secretary of Health and Human Services under Chapters 17 and 18 of Title 38 of the United States Code.
- e. The health plan for Peace Corps volunteers under Section 2504(e) of Title 22 of the United States Code.
- f. The Non-appropriated Fund Health Benefits Program of the United States Department of Defense, established under Section 349 of the National Defense Authorization Act for Fiscal Year 1995.
- g. Health plans purchased in the individual health insurance market within a State of the United States.
- h. Coverage under the health benefits risk pool of a State of the United States.
- i. Any other plan recognized as "minimum essential coverage" by the United States Secretary of Health and Human Services in coordination with the United States Secretary of the Treasury for purposes of Internal Revenue Code Section 5000A.
- j. Another employer-sponsored plan.

In the case of another employer-sponsored plan, such loss of "minimum essential coverage" must be due to loss of eligibility for coverage as a result of:

- (1) Termination of employment (except for gross misconduct),
- (2) Reduction of work hours,
- (3) Death,
- (4) Divorce,
- (5) Loss of dependent status,
- (6) Termination of employer contributions towards a person's coverage,

- (7) The plan stops offering benefits to a certain class of similarly situated individuals,
- (8) Changing residence to an area not served by the plan, or
- (9) Exhaustion of COBRA continuation coverage because of:
 - (a) the full COBRA continuation period was exhausted;
 - (b) the employer or other responsible entity failed to remit required premiums on a timely basis;
 - (c) the individual whose coverage is through a Health Maintenance Organization (HMO), no longer lives, resides or works in the service area the HMO services, whether or not the choice of the individual in the service area, and there is no other COBRA coverage available;
 - (d) the individual incurs a Claim that would meet or exceed a lifetime limit on all Benefits and there is no other COBRA continuation coverage available to the individual;

A Special Enrollee due to loss of eligibility for coverage under another employer-sponsored plan must request enrollment for coverage under this Benefit Plan within thirty (30) days after other coverage ends (or after the employer stops contributing toward the other coverage). If such enrollment for On-Exchange coverage is received by the SHOP timely, coverage will become effective on the date established by the SHOP. If such enrollment for Off-Exchange coverage is received by a Blue Cross and Blue Shield of Louisiana office within thirty (30) days after loss of other coverage, coverage will become effective on the date other coverage is lost. If the enrollment is not received within thirty (30) days of the loss of other coverage, coverage under this Benefit Plan will be denied and must be requested during the next Open Enrollment Period.

ARTICLE IV. BENEFITS

This Benefit Plan will have an Annual Deductible per Member and a Family Deductible. Benefits will be paid after the corresponding Annual Deductible and Family Deductible are met. The Annual Deductible per Member and Family Deductible **will not** apply to the Diagnostic and Preventive Services section below.

This Benefit Plan has an “Annual Maximum Benefit per Member.” Once this Benefit Plan pays Benefits in that amount for a Member, no more Benefits will be covered for the remaining of the Benefit Period for that Member.

Preventive Care is a feature that could be included in your Benefit Plan. Preventive Care means that payments of this Benefit Plan for any of the Diagnostic and Preventive Services covered below **will not** count toward the Annual Maximum Benefit per Member. Please see your Schedule of Dental Benefits to determine if this feature is included in your plan.

Each Benefit will have a Coinsurance amount assigned in the Schedule of Dental Benefits. The Coinsurance represents the percentage of the Allowable Charge that this Benefit Plan will pay for each covered Benefit. Any percentage not covered will be the responsibility of the Member.

All applicable Annual Deductible per Member, Family Deductible, the Annual Maximum Benefit per Member, and Coinsurance for each Benefit will be disclosed in the Schedule of Dental Benefits.

Subject to the above, this Benefit Plan will cover the following Benefits:

A. Diagnostic and Preventive Services

1. Routine Oral Exams and Consultations
 - a. Comprehensive and periodic evaluations are limited to two (2) every twelve (12) months
 - (1) Once a comprehensive evaluation is paid, the Member is not eligible to undergo the same service with the same Provider, unless there is a significant change in health condition or the Member is absent from the Provider for 3 or more years.
 - b. Detailed problem-focused evaluations are limited to one (1) every 12 months per eligible diagnosis.
 - c. Limited problem-focused evaluations are limited to one (1) every 12 months.
 - d. Consultations are diagnostic services provided by a dentist or physician other than the practitioner providing the dental treatment, limited to one (1) every 12 months.
2. Oral Radiographs (x-rays)
 - a. Complete series intraoral x-rays or panoramic film x-rays, limited to one (1) film every five (5) years.
 - b. Bitewing x-rays, limited to one (1) set every twelve (12) months for Members under age 19, and one (1) set every eighteen (18) months for Members ages 19 and older.
 - c. Periapical intraoral films limited to four (4) every twelve (12) months per Provider if not performed in conjunction with definitive procedures.
 - d. Occlusal intraoral films limited for Members under age 8, and limited to two (2) every twenty-four (24) months.
3. Oral Cleanings (Prophylaxis)

- a. Limited to two (2) every twelve (12) months.
 - b. One additional cleaning during the Policy Year will be allowed for Members that are under the care of a medical professional during pregnancy
4. Fluoride Treatment
- a. Limited to Members under age 14, and
 - b. Limited to one (1) every twelve (12) months.
5. Sealants
- a. Limited to children under 16 years old, and only for permanent first and secondary molars, and
 - b. Limited to one per tooth every 3 years.
6. Emergency (Palliative) Treatment
- a. Limited to two (2) per 12 months, in combination with pulpal debridement
7. Application of Medicine to stop Cavities
- a. Two (2) treatments per twelve (12) months for members between ages 1 and 6
 - b. One (1) treatment per twelve (12) months for members between ages 7 and 12
8. Space Maintainers
- a. Limited to Members under age 14.
 - b. Covered when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars or deciduous molars and permanent first molars that have not, or will not, develop.
 - c. Limited to one (1) every five (5) years.

B. Basic Services

1. Basic Restorations (amalgam and posterior resin)
- a. Replacement of restorative services only covered when they are not and cannot be made serviceable.
 - b. Basic restorations will not be covered if replaced within 24 months of previous placement of any basic restoration.
 - c. Prefabricated stainless steel crowns are included under this coverage, limited to Members under age fourteen (14), and limited to one (1) for each tooth per lifetime.
2. Endodontic (Pulpal) Therapy
- a. Eligible teeth limited to primary anterior teeth when there is no permanent tooth to replace it.
 - b. Limited to one per eligible tooth per lifetime.
3. Root Canal

- a. Limited to one (1) per tooth per lifetime.
4. Non-Surgical Periodontics
- a. Periodontal scaling and root planing limited to one (1) every thirty-six (36) months for each area of the mouth.
 - b. Periodontal maintenance following active periodontal therapy limited to two (2) every twelve (12) months in addition to routine Prophylaxis.
5. Surgical Periodontics
- a. Surgical periodontal procedures limited to one (1) every thirty-six (36) months for each area of the mouth.
 - b. Guided tissue regeneration limited to one (1) for each tooth per lifetime.
 - c. Full mouth debridement limited to one (1) per lifetime.
 - d. Gingivectomy or gingivoplasty, limited to one every 36 months;
 - e. Gingival flap procedure limited to one every 36 months;
 - f. Clinical crown lengthening, limited to one (1) for each tooth per lifetime;
 - g. Osseous surgery, limited to one every 36 months;
 - h. Pedicle soft tissue graft, limited to one every 36 months;
 - i. Free soft tissue graft, limited to one every 36 months;
 - j. Subepithelial connective tissue graft, limited to one every 36 months.
6. Simple Extractions
7. Surgical Extractions
- a. Surgical removal of erupted tooth with elevation of mucoperiosteal flap and removal of bone and/or section of tooth.
8. Oral Surgery
- a. Removal of impacted tooth;
 - b. Surgical removal of residual tooth roots;
 - c. Coronectomy-intentional partial tooth removal;
 - d. Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth;
 - e. Surgical access to an unerupted tooth;
 - f. Alveoloplasty in conjunction with extraction;
 - g. Removal of exostosis;
 - h. Excision of pericoronal gingiva.

9. General Anesthesia/Sedation

- a. If used in conjunction with certain eligible oral surgery services.
- b. Limited to sixty (60) minutes per session.

10. Crown Repairs

- a. Recementation, restoration and pin retention
 - (1) Limited to one (1) every three (3) years.
 - (2) During the first twelve (12) months following insertion of any preventive, restorative or prosthodontics service by the same Provider, this benefit is considered included in the preventive, restorative or prosthodontics service benefit.

11. Adjustments and Repairs of Prosthetics

C. Major Services

1. Prosthetic Dentures and Bridges

- a. Complete, Fixed or Removable Partial Dentures
 - (1) Limited to one (1) every five (5) years.
- b. Other Prosthetic Services
 - (1) Denture relining, rebasing or adjustments are considered part of the denture charges if provided within six (6) months of insertion by the same Provider. Subsequent denture relining or rebasing are limited to one (1) every three (3) years thereafter.
 - (2) Recementation or repair of fixed partial denture.
 - (a) Limited to one (1) every three (3) years.
 - (b) Recementation during the first twelve (12) months following insertion of any preventive, restorative or prosthodontics service by the same Provider will be considered part of the corresponding preventive, restorative or prosthodontics Benefit, and will not be covered under this Other Prosthetic Services section.
 - (3) Replacement of natural tooth/teeth in an arch will not be covered within five (5) years of a fixed partial denture, full denture or partial removable denture.

2. Inlays, Onlays and Crowns

- a. Crowns, inlays, onlays, core buildup including pins, and prefabricated post and core.
- b. All limited to one (1) per tooth every five (5) years.
- c. Single crowns, inlays and onlays, and buildups, post and cores, will not be covered within five (5) years of previous placement of any of the procedures in this category.

3. Dental Implants

If shown as included in the Schedule of Dental Benefits, Dental Implant services are limited to Members age eighteen (18) and older, and to one (1) service per tooth or tooth area per lifetime. Coverage includes:

- a. Surgical placement of endosteal, eposteal and transosteal implants.
- b. Implant removal.
- c. Debridement of periimplant defects and osseous contouring surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure.
- d. Bone graft.
- e. Supporting structures:
 - (1) Connecting bar,
 - (2) Prefabricated abutment,
 - (3) Custom fabricated abutment.
- f. Abutment supported removable dentures.
- g. Abutment supported fixed dentures.
- h. Abutment supported single crowns.
- i. Implant supported single crowns.
- j. Abutment supported fixed partial dentures.
- k. Autogenous or nonautogenous osseous, osteoperioesteal or cartilage graft of the mandible or maxilla.
- l. Sinus augmentation with bone or bone substitutes via lateral open approach or vertical approach.
- m. Bone replacement graft for ridge preservation.

4. Orthodontic Services

If shown as included in the Schedule of Dental Benefits, this Benefit Plan will cover Orthodontic Services. Orthodontic Services may be limited to Members under age 19 only, if so established in the Schedule of Dental Benefits. Orthodontic Services will be subject to the Lifetime Maximum Orthodontic Benefit stated in the Schedule of Dental Benefits. Once this Benefit Plan has paid Benefits up to such Lifetime Maximum for a Member, no more Orthodontic Services Benefits will be payable for the life of that Member. The Orthodontic Services Benefits will not count towards the Annual Maximum Benefit.

Pre-authorization is required for Orthodontic Services to be covered. An explanation of the plan of treatment must be submitted to Claims Administrator. Upon review of the information, Claims Administrator will notify You and Your Provider of the reimbursement schedule, frequency of payment over the course of the treatment, and Your share of the cost.

Benefits include services for limited, interceptive and comprehensive Orthodontic treatment of the primary, transitional and adolescent dentition in addition to removable and fixed appliance

therapy. Treatment visits are provided for pre-orthodontic, periodic orthodontic and orthodontic retention. Payments are made quarterly.

Payment for Orthodontic Services will cease at the end of the month of the termination of this Benefit Plan.

ARTICLE V. EXCLUSIONS

Only American Dental Association procedure codes are covered under this Benefit Plan. Except as specifically provided in this Benefit Plan and the Schedule of Dental Benefits, no coverage will be covered for services, supplies or charges that are:

1. Started prior to the Member's Effective Date or after the Termination Date of coverage under this Benefit Plan, including, but not limited to multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures.
2. For house or hospital calls for dental services and for hospitalization costs (e.g. facility-use fees).
3. The responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile-related injury in which the Member is entitled to payment under an automobile insurance policy. Our Benefits would be in excess to the third-party benefits and therefore, We would have right of recovery for any benefits paid in excess. Our right of Subrogation is secondary to the right of the covered insured to be fully compensated for his damages.
4. For prescription and non-prescription drugs, vitamins or dietary supplements.
5. Cosmetic in nature as determined by Claims Administrator (for example but not limited to, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).
6. Elective procedures (for example but not limited to, the prophylactic extraction of third molars).
7. For congenital mouth malformations or skeletal imbalances (for example, but not limited to, treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment).
8. Dental Implant services will be excluded, even if otherwise covered if such services replace one (1) or more teeth missing prior to Member's eligibility under this Benefit Plan.
9. For diagnostic services and treatment of jaw joint problems by any method. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.
10. For treatment of fractures and dislocations of the jaw.
11. For treatment of malignancies or neoplasms.
12. For services and/or appliances that alter the vertical dimension (for example but not limited to, full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.
13. For replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
14. For preventative restorations.

15. For periodontal splinting of teeth by any method.
16. For duplicate dentures, prosthetic devices or any other duplicative device.
17. For which in the absence of insurance the Member would incur no charge.
18. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.
19. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.
20. For treatment and appliances for bruxism (night grinding of teeth).
21. For any claims submitted to Claims Administrator by the Member or on behalf of the Member in excess of twelve (12) months after the date of service.
22. For incomplete treatment (for example but not limited to, patient does not return to complete treatment) and temporary services (for example but not limited to, temporary restorations).
23. For procedures that are:
 - part of a service but are reported as separate services; or
 - reported in a treatment sequence that is not appropriate; or
 - misreported or that represent a procedure other than the one reported.
24. For specialized procedures and techniques (for example but not limited to, precision attachments, copings and intentional root canal treatment).
25. Fees for broken appointments.
26. Services for treatment of any Member detained in a correctional facility and who has been adjudicated or convicted of the criminal offense causing the detention.

Not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of Claims Administrator will apply.

ARTICLE VI. PRE-DETERMINATIONS

Predetermination of dental benefits is a service available through Claims Administrator. This benefit review in advance of treatment enables you and your Dentist to see what services are covered by the plan and what your cost sharing and other out of pocket costs would be.

Predetermination should not be requested unless total charges for a proposed treatment plan exceed \$200. You may ask your Dentist to submit a predetermination request. Claims Administrator will then provide a summary of covered expenses and payable amounts.

Please note that Pre-Determinations are not designed to be used for Emergency Treatments or routine preventive services such as exams, x-rays or cleanings.

A Pre-Determination is not an Authorization. When a Covered Benefit needs to be Authorized, a formal Authorization request prior to service will have to be submitted.

ARTICLE VII. ALTERNATE BENEFITS

If Claims Administrator determines that a less costly covered service other than the covered service the Dentist performed could have been performed to treat a dental condition, we will pay benefits based upon the less costly service if such service would produce a professionally acceptable result under generally accepted dental standards. If the Member and the Dentist choose the more expensive treatment, the Member will be responsible for the additional charges, beyond those allowed under this clause. This limitation does not apply to covered implantology services.

Alternate benefits applicable to your treatment plan will be determined during Authorization. However, should the services billed differ from those Authorized, Claims Administrator reserves the right to determine if an Alternate Benefit is applicable to the actual services rendered.

ARTICLE VIII. COORDINATION OF THIS BENEFIT PLAN WITH OTHER DENTAL COVERAGE OF WHICH THIS BENEFIT PLAN FORMS A PART

If a Member has other coverage for dental benefits, and this Benefit Plan is offered in conjunction with or as a supplement to that other dental coverage, the dental benefits under this stand-alone coverage will be determined first. We reserve the right to make any coordination of benefits necessary so that no more than the full amount of the Allowable Charge for the same claim or service is ever paid under all the dental benefits the Member may have.

ARTICLE IX. BENEFIT EXTENSION PERIOD AFTER TERMINATION OF COVERAGE

A. The dental coverage under this Benefit Plan will be extended after the date the coverage for the Member terminates only if:

1. A Covered Benefit for such service was incurred while coverage was in effect; and
2. Such Covered Benefit is completed within thirty one (31) days after coverage terminates.

B. A Covered Benefit expense will be deemed incurred as follows:

1. For appliances or changes to appliances – on the date the appliance or prosthesis is permanently placed;
2. For Crowns, dentures or bridgework – on the date the impression is taken;

3. For Root Canal therapy -- on the date the pulp chamber is opened; or
4. For all other dental expenses -- on the date the service is rendered or the supply is furnished.

ARTICLE X. CONTINUATION OF COVERAGE RIGHTS

A. Surviving Spouse Continuation

If eligibility for Group coverage ceases upon the death of the Subscriber, a surviving Spouse covered as a Dependent who is fifty (50) years of age or older, has ninety (90) days from the date of the Subscriber's death to notify Company of his election to continue the same coverage for himself, and if already covered, for his Dependent children.

- Coverage is automatic during the ninety (90) day election period. Premium is owed for this coverage. If continuation is not chosen, or if premium is not received for the ninety (90) days of automatic coverage, the ninety (90) days of automatic coverage is terminated retroactive to the end of the billing cycle in which the death occurred.
- If the continuation coverage is chosen within the ninety (90) day period, coverage will continue without interruption. Premium is owed from the last date for which premium has been paid. No physical exams are required. Premium for continuing coverage will not exceed the premium assessed for each Subscriber by class of coverage under the Group Benefit Plan.

The Group will be responsible for notifying the Spouse of the right to continue and for billing and collection of premium. However, if We have been furnished with the home address of the surviving Spouse at the time of death and have been notified by the Group in a manner acceptable to Us of the death of the Subscriber, We will notify the surviving Spouse of the right to continue.

Coverage continues on a premium-paying basis until the earliest of:

- the date premium is due and is not paid on a timely basis; or
- the date the surviving Spouse or a Dependent child becomes eligible for Medicare; or
- the date the surviving Spouse or a Dependent child becomes eligible to participate in another Group health plan; or
- the date the surviving Spouse remarries or dies; or
- the date this Group Benefit Plan ends; or
- the date a Dependent child is no longer eligible.

B. State Continuation

This section (State Continuation) is available only if the Group is not subject to Continuation of Coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 and any amendments thereto.

A Subscriber or covered Dependent whose coverage under this Benefit Plan ends because of: 1) Subscriber's death; or 2) Subscriber's termination of active employment; or 3) because of the divorce of the Subscriber or a covered Member, may be entitled to continue the coverage under this Benefit Plan. The Subscriber or Dependent requesting continuation must have been continuously covered under this Benefit Plan (or another group policy that this Benefit Plan replaced) for the three (3) consecutive months immediately preceding the date this coverage would otherwise have ended.

Continuation of coverage for a Subscriber or his Dependents is **not** available if:

- the Covered Person, within thirty-one (31) days of termination of coverage, is or could have been covered by other Group coverage or a government sponsored health plan such as Medicare or Medicaid, or Group; or
- the Subscriber's or Member's coverage under this Benefit Plan terminated due to fraud or failure to pay his required contribution to premium; or
- the Covered Person is eligible for continuation of coverage under COBRA.

To elect continuation of coverage under this section, the Subscriber or Member must notify the Group in writing of his election to continue this Group health coverage and must pay any required contribution to the Group in advance. The initial contribution must be paid no later than the end of the month following the month in which the event occurred which made the Subscriber or Member eligible. (If the Dependent is eligible due to divorce, the event shall be deemed to have occurred on the date of the judgment of divorce.) A form to continue coverage is available from the Group.

Continuation of insurance under the Group policy for any Covered Person shall terminate on the earliest of the following dates:

- twelve (12) calendar months from the date coverage would have otherwise ended; or
- the date ending the period for which the Subscriber or Dependent makes his last required premium contribution for the coverage; or
- the date the Subscriber or Member becomes or is eligible to become covered for similar benefits under any arrangement of coverage for individuals in a Group, whether insured or uninsured, including Medicare or Medicaid; or
- the date on which the Group policy is terminated; or
- the date on which an enrolled Member of a health maintenance organization legally resides outside the service area of the Company.

C. COBRA Continuation

The following provisions are applicable only if the Group is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any amendments thereto. Please refer to the Group Human Resources Manager or Benefits Manager for details about COBRA, or the applicability of COBRA to this Benefit Plan.

What is COBRA continuation coverage?

In accordance with COBRA law, the employees and eligible dependents of certain employers may have the opportunity to continue their employer-sponsored healthcare coverage for a limited time, when there is a life event (also known as a "qualifying event") that would otherwise result in the loss of coverage under the employer's plan. When a qualifying event causes such loss of coverage, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." The Subscriber, the Subscriber's Spouse and the Subscriber's dependent children are listed under the law as the qualified beneficiaries. COBRA continuation coverage offers the same coverage that the Plan gives to other participants or beneficiaries who are not receiving continuation coverage. The qualified beneficiary may be required to pay the full cost of the continuation coverage for its entire duration.

Do I have other alternatives to COBRA continuation coverage?

COBRA continuation coverage is not the only alternative Members may have when they lose coverage under this Benefit Plan. There may be other coverage options for You and Your family.

For example, You could qualify to buy individual coverage through the Health Insurance Marketplace. Losing coverage under this Benefit Plan gives You a special enrollment opportunity in the Marketplace, even when it happens outside of the Marketplace's open enrollment period. You have sixty (60) days from when You lose coverage under this Benefit Plan to apply for special enrollment through the Marketplace. In the Marketplace, You could be eligible for a new kind of tax credit that lowers Your monthly premiums right away, and You can see what Your premium, deductibles, and out-of-pocket costs will be before You make a decision to enroll. Being eligible for COBRA does not limit Your eligibility for coverage or for a tax credit through the Marketplace. However, it is important that You know that if You or any of Your Dependents choose COBRA continuation coverage instead of Marketplace coverage, You will lose the special enrollment opportunity for the Marketplace, and You will not be able to enroll until the Marketplace's normal enrollment period opens or Your COBRA continuation coverage is exhausted.

Additionally, You may qualify for a special enrollment opportunity for another group health plan for which You are eligible (such as a Spouse's plan), even if the plan generally does not accept late enrollees, if You request enrollment within thirty (30) days from losing coverage under this Benefit Plan.

Therefore, We invite You to consider all Your options so You choose the one that better fits Your needs and budget.

What if I choose to get COBRA continuation coverage?

If You and Your Dependents are qualified beneficiaries and choose to get COBRA continuation coverage, You must follow all notice and time period requirements described below or You will lose Your rights. If the Group requires shorter time periods than those stated herein, the shorter time periods of the Group apply.

What are the "qualifying events"?

A "qualifying event" is any of the following events:

- termination of employment of a covered employee for reasons other than gross misconduct;
- loss of eligibility by a covered employee due to a reduction in the number of work hours of the employee;
- death of a covered Subscriber;
- divorce or legal separation between a covered Subscriber and his/her Spouse;
- the covered Subscriber becomes entitled to Medicare Benefits resulting in the loss of coverage for Dependents;
- a Dependent child ceases to be an Eligible Dependent under the terms of this Benefit Plan; or
- the employer files for a Chapter 11 bankruptcy proceeding, but only with respect to covered former employees who retired from the employer at any time.

NOTE: Special rules apply for certain retirees and their Dependents who lose coverage because of an employer's Chapter 11 bankruptcy. In this event, certain retirees may elect lifetime COBRA coverage. Eligible Dependents of retirees may continue coverage until the retiree's death. When the retiree dies, Dependents may elect an additional thirty-six (36) months of coverage from the date of the retiree's death. In all cases, these qualified beneficiaries must pay for the coverage elected. COBRA coverage under these circumstances will terminate early for a number of reasons including but not limited to: the employer ceases to provide any group health plan to any employees or the qualified beneficiaries fail to pay the required

premiums or become covered under another employer's group health plan that does not exclude or limit Benefits for a qualified beneficiary's Pre-Existing Conditions. COBRA continuation coverage rights under Chapter 11 bankruptcy proceedings will be determined by the bankruptcy court, and the coverage eligible beneficiaries could receive may not be the same as the ones they had under the retiree plan before the employer filed for Chapter 11 bankruptcy.

Do I have to provide notification of any qualifying event?

The qualified beneficiary must give notice of the following qualifying events to the Group within 60 days of the event:

- divorce or legal separation,
- becoming entitled to Medicare, or
- a Dependent losing eligibility for coverage as a dependent child.

The Group will advise a qualified beneficiary of his rights under COBRA upon the occurrence of any qualifying event or following the timely notice of a qualifying event when such notice is required to be given by the qualified beneficiary.

What do I have to do to get COBRA continuation coverage?

To elect continuation coverage, the qualified beneficiary must complete a COBRA election form and furnish it to the Group timely. The option to elect continuation coverage will be offered during a period which:

- begins no later than the date on which a Member otherwise would lose coverage under the Group health plan (the "coverage end date"); and
- ends sixty (60) days after the coverage end date or sixty (60) days after the Member is notified of their right to continue coverage, whichever is the latest.

Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's Spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several or for all Dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of the Dependent children. The employee or the employee's Spouse can elect continuation coverage on behalf of all the qualified beneficiaries.

How much will I have to pay for COBRA continuation coverage?

A Member may be required to pay the entire cost of continuation coverage (including both employer and employee contributions) plus an amount to cover administrative expenses. If continuation of coverage is elected, the qualified beneficiary must make his first payment for continuation coverage within forty-five (45) days after the date of the election. If the qualifying beneficiary does not make the correct first payment in full within the forty-five (45) day period, all COBRA continuation coverage rights are lost. Timely monthly payments are required thereafter to keep coverage. Member may not receive notice of payments due.

When will COBRA continuation coverage begin and how long will it last?

Once elected, COBRA continuation of coverage will begin on the coverage end date and will terminate on the earliest of the following events:

- eighteen (18) months after the qualifying event in the case of termination of employment or reduction in work hours. When the employee became entitled to Medicare benefits less than eighteen (18) months before the termination of employment or reduction of work hours, continuation coverage for qualified

beneficiaries other than the employee will last the longer of thirty-six (36) months from the date of Medicare entitlement or eighteen (18) months from the qualifying event; or

- thirty-six (36) months after the qualifying event when such event is other than termination of employment or reduction of work hours; or
- the date the employer ceases to maintain any Group health plan for its employees; or
- the date coverage ceases because of nonpayment of required premiums when due; or
- the date the qualified beneficiary first becomes covered under another group health plan and benefits under that other plan are not excluded or limited with respect to a Pre-Existing Condition (NOTE: There are limitations on plans imposing Pre-Existing Condition exclusions and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act).; or
- the date the qualified beneficiary becomes entitled to Medicare (under Part A, Part B, or both).

Can I extend my COBRA continuation coverage?

A qualified beneficiary's right to COBRA continuation coverage will never last longer than thirty-six (36) months from the qualifying event. This maximum duration period cannot be extended, disregarding the circumstances.

Those that are receiving eighteen (18) months of continuation coverage can extend their period, as explained below, if they undergo a second qualifying event during that original eighteen (18) month period, or are declared disabled by the Social Security Administration.

If a qualified beneficiary experiences a second qualifying event other than the termination of employment or reduction of work hours while receiving eighteen (18) months of COBRA continuation of coverage, the Dependents who were qualified beneficiaries at the time of the first qualifying event, and elected COBRA continuation coverage, may qualify for up to eighteen (18) additional months of continuation of coverage, for a maximum of thirty-six (36) months.

This extension may be available to Dependents receiving continuation of coverage if:

- the employee or former employee dies;
- the employee or former employee becomes entitled to Medicare (under Part A, Part B, or both);
- the employee or former employee and Dependent Spouse divorce;
- the Dependent child is no longer eligible under the Benefit Plan as a Dependent.

The second qualifying event is applicable only if the event would have caused the Dependent to lose coverage under the plan had the first qualifying event not occurred. Qualified beneficiaries must notify the Group within sixty (60) days after a second qualifying event to extend the COBRA continuation coverage.

The eighteen (18) months of continuation coverage may also be extended to a maximum of twenty-nine (29) months if a qualified beneficiary is determined to be disabled (as determined under Title II, or XVI of the Social Security Act) by the Social Security Administration before the first day of COBRA coverage, or is declared disabled during the first sixty (60) days of COBRA coverage.

This eleven (11) month extension is available to all eligible individuals who are qualified beneficiaries and elected COBRA continuation coverage for the original eighteen (18) months. The qualified beneficiary must notify the Group of the disability determination before the end of the initial eighteen (18) month COBRA period and within sixty (60) days from:

- the date of the notice from the Social Security Administration of the determination of disability; or
- the date of the qualifying event.

The qualified beneficiary must also notify the Group within thirty (30) days of any final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. In this case, coverage will end the earliest of twenty-nine (29) months after the date of the qualifying event or the first day of the month that begins more than thirty (30) days after a final determination that the qualified beneficiary is no longer disabled, subject to the original eighteen (18) months of COBRA coverage.

Keep Your Plan Informed of Address Changes

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

D. Employee Rights Under the Uniformed Services Employment and Reemployment Rights Act (USERRA)

Employees going on a military leave of absence to perform "service in the United States uniformed services" (as that term is defined under USERRA) may elect to continue coverage under this Benefit Plan for up to 24 months from the date that the employee leaves for service. Only a covered employee may elect continuation coverage under USERRA for himself/herself and for those eligible Dependents that were covered under the Plan immediately before him/her leaving for military service. Dependents do not have any independent right to elect USERRA continuation coverage.

To claim USERRA continuation coverage, the employee must properly notify the employer that he/she is leaving to perform "service in the uniformed services" and apply for continuation coverage as required by the employer.

An employee who elects USERRA continuation coverage may be required to pay a premium. If the leave of absence lasts thirty (30) days or less, the person may be required to pay the employee's required contribution for coverage. However, if the military leave of absence lasts more than thirty (30) days, the person may be required to pay up to 102% of the full contribution under the Plan (including both, the employer's and the employee's contribution for coverage).

USERRA continuation coverage may be terminated before the maximum 24 month period if:

1. The employee fails to pay the required premiums timely, or
2. The day after the date on which the employee is required under the law to apply for or return to a position of employment and fails to do so.

Employers subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) may choose to provide USERRA continuation coverage rights concurrently with COBRA continuation coverage, as allowed by law. Each employer acts independently in choosing how to apply this provision and is not reflective of any guidelines issued from BCBSLA. In all cases, the employer should be consulted on how this provision applies to their employer group sponsored plan.

Please contact your employer to ask for more details on how USERRA and other continuation coverage rights apply to You.

ARTICLE XI. GENERAL PROVISIONS – GROUP/POLICYHOLDER AND MEMBERS

The Group enters into this Benefit Plan on behalf of the eligible individuals enrolling under this Benefit Plan. Acceptance of this Benefit Plan by the Group is acceptance by and binding upon those who enroll as Subscribers and Dependents.

A. The Benefit Plan

1. This Benefit Plan, including the Group's acceptance of the Company's proposal, Application, Enrollment Forms, benefit change forms and renewal forms and documentation, expressing the entire money and other consideration for coverage, the Schedule of Benefits, and any amendments or endorsements, constitutes the entire contract between the parties.
2. Except as specifically provided herein, this Benefit Plan will not make the Company liable or responsible for any duty or obligation imposed on the employer by federal or state law or regulations. To the extent that this Benefit Plan may be an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, the Group will be the administrator of such employee welfare benefit plan and will be solely responsible for meeting any obligations imposed by law or regulation on the administrator of the plan, except those specifically undertaken by the Company herein. To the extent this Benefit Plan is subject to COBRA, the Group, or its contracted designee, will be the administrator for the purposes of COBRA. The Group is responsible for establishing and following all required COBRA procedures that may be applicable to the Group. The Group will indemnify and hold the Company harmless in the event the Company incurs any liability as a result of the Group's failure to do so.
3. The Company will not be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance or malpractice on the part of any Provider or his agent or employee or other person participating in or having to do with the care or treatment of a Member.
4. The Company will have full discretionary authority to determine eligibility for Benefits and/or construe the terms of this Benefit Plan.
5. The Company shall have the right to enter into any contractual agreements with subcontractors, Providers or other third parties relative to this Benefit Plan. Any of the functions to be performed by the Company under this Benefit Plan may be performed by Us or any of Our subsidiaries, affiliates, subcontractors, or designees.

B. Section 1557 Grievance Procedure

Blue Cross and Blue Shield of Louisiana does not to discriminate on the basis of race, color, national origin, sex, age or disability. Blue Cross and Blue Shield of Louisiana has adopted an internal grievance procedure providing for prompt resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of the Section 1557 Coordinator, who has been designated to coordinate the efforts of Blue Cross and Blue Shield of Louisiana to comply with Section 1557 at the following address:

Section 1557 Coordinator
P. O. Box 98012
Baton Rouge, LA 70898-9012
225-298-7238
800-711-5519 (TTY 711)
Fax: 225-298-7240
Email: Section1557Coordinator@bcbsla.com

If You believe You have been subjected to discrimination on the basis of race, color, national origin, sex, age or disability, You may file a grievance under this procedure. It is against the law for Blue Cross and Blue

Shield of Louisiana to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

- Grievances must be submitted to the Section 1557 Coordinator within 60 days of the date You become aware of the alleged discriminatory action.
- A complaint must be in writing, containing Your name and address. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator will investigate the complaint. This investigation may be informal, but it will be thorough. You are encouraged to submit evidence related to Your complaint. The Section 1557 Coordinator will maintain the files and records of Blue Cross and Blue Shield of Louisiana relating to such grievances. To the extent possible, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the grievance no later than 30 days after it is received.
- You may appeal the decision of the Section 1557 Coordinator by writing to the Section 1557 Grievance Administrator within 15 days of receiving the Section 1557 Coordinator's decision. The Section 1557 Grievance Administrator shall issue a written decision in response to the appeal no later than 30 days after it is received.

The availability and use of this grievance procedure does not prevent You from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the United States Department of Health and Human Services, Office for Civil Rights. You can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

United States Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at: <http://www.hhs.gov/ocr/office/file/index.html>. Such complaints must be filed within 180 days of the date of the alleged discrimination.

Blue Cross and Blue Shield of Louisiana will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

C. Benefit Plan Changes

The Company reserves the right to modify the terms of this Benefit Plan. Changes will be effective upon renewal of the Benefit Plan and preceded by not less than sixty (60) day notice to the Group. No change or waiver of any Benefit Plan provision will be effective until approved by the Company's chief executive officer or other person authorized to make changes.

D. Identification Cards and Benefit Plans

We will prepare an identification card for each Subscriber. We will issue a Benefit Plan to the Group and print a sufficient number of copies of the Benefit Plan for Group's Subscribers. At the direction of Group,

We will either deliver all materials to the Group for Group's distribution to the Subscribers, or We will deliver the Subscriber materials directly to each Subscriber. The Subscriber's copy of the Benefit Plan shall serve as his certificate of coverage. Unless otherwise agreed between the Group and Us, the Group has the sole responsibility for distributing all such documents to Subscribers.

E. Payment of Premiums

1. Our premiums for the Benefit Plan may increase after the Group's first twelve (12) months of coverage and every six (6) months thereafter, except when premiums may increase more frequently as described in the following paragraph. Except as provided in the following paragraph, the Company will give forty-five (45) days written notice to the Group at the last address shown in the Company's records regarding any change in rates. Such increase in premiums will become effective on the date specified in the notice and continued payment of premiums will constitute acceptance of the change.

We reserve the right to increase the premiums more often than stated above due to the Group's addition of a newly covered person or entity not previously considered in the rate determination process at any time during the life of the Benefit Plan. Additionally, the Company reserves the right to increase the premium amount because of: (1) any change in age or geographic location of any individual insured or policyholder; (2) a change in the extent or nature of the risk of the Group; or (3) any change in the Benefit level from that which was in force at the time of the last rate determination. Such increase of premiums will become effective on the next billing date following the effective date of the change. Continued payment of premiums will constitute acceptance of the change.

2. Premiums are due and payable beginning with the Effective Date of this Benefit Plan and on the same date each month thereafter. The Group is considered delinquent if premiums are not paid as of the due date.
3. If the Group does not make payment to the Company home office within thirty (30) days of the due date, this Benefit Plan will be cancelled effective midnight of the last day for which premiums have been paid. The Company will not be liable for any Benefits for services rendered following the date of cancellation.

F. Benefits to Which Members are Entitled

1. The liability of the Company is limited to the Benefits specified in this Benefit Plan.
2. Benefits for Covered Services specified in this Benefit Plan will be provided only for services and supplies rendered on and after the Member's Effective Date by a Provider specified in this Benefit Plan and regularly included in such Provider's charges.

G. Notice of Member Eligibility - Group's Personnel Data

1. The Group is solely responsible for furnishing the information that is required by the Company for purposes of enrolling Members of the Group under this Benefit Plan, processing terminations, and effecting changes in family and membership status. Acceptance of payments for persons no longer eligible for coverage will not obligate the Company to provide Benefits under this Benefit Plan.
2. All notification of membership or coverage changes must be on forms approved by the Company and include all information required by Company to effect changes.
3. The Group must notify the Company's Membership & Billing Department of a Member's termination of coverage by completing a cancellation form (or such other form of notification acceptable to Us) and submitting it to Our offices no later than within the next billing cycle immediately following the billing cycle in which the Member or any of the Member's Dependents is terminated from the Group or eligibility for coverage ends (or any other period described in the Schedule of Dental Benefits). The Group will also submit to the Company's Membership & Billing Department evidence of a

Member's or his Dependent's election of any applicable COBRA coverage following such termination within three (3) business days of Group's receipt of signed COBRA forms. Company is under no obligation to refund any premium paid by Group or any Member, if payment was made to Company due to Group's failure to timely notify Company of a Member's or his Dependent's termination of coverage.

4. Requests for termination of coverage that are submitted after the period provided above will only be honored prospectively after the date of receipt and the Group will be responsible to pay all corresponding premiums until the effective date of termination. All requests for termination of coverage, whether timely or not, will be subject to any other terms, conditions and legal requirements that may apply.

Whenever the Group submits a request to Company to terminate a Member's coverage or that of any of Member's Dependents, the Group will be deemed to be making a representation that neither the Member nor his Dependent has made payments towards the cost of premiums for any coverage period beyond the date on which the Group desires the coverage to be terminated, and that no information was given or representation was made to the Member or his Dependent that would create an expectation that the individual would continue coverage beyond that date, except for legally required disclosures regarding any rights to COBRA or other mandated continuation coverage. In the event that the individual should have a right to continue coverage under COBRA or any similar mandate, the Group will be required to timely request the individual's termination of coverage under the regular process created by Company for such purpose, and to submit any election from the individual to continuation coverage in a separate process.

5. The Group warrants the accuracy of the information it transmits to the Company and understands that the Company will rely on this information. The Group agrees to supply or allow inspection of personnel records to verify eligibility as requested by the Company.
6. The Group further agrees to indemnify the Company for all expenses the Company incurs, if any, as a result of the Group's failure to transmit the information, failure to transmit it in the time period required by the Company, and/or failure to transmit correct information. Indemnification includes, but is not limited to, Claims payments made on behalf of individuals that are not eligible for Benefits. Alternatively, the Company may, at its sole option, hold the Group responsible for all premium payments for Members who are not timely cancelled from coverage due to the Group's failure to timely notify the Company of terminations or changes in eligibility.

H. Termination of a Member's Coverage

1. The Company may choose to rescind coverage or terminate a Member's coverage if a Member performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the terms of this Benefit Plan. The issuance of this coverage is conditioned on the representations and statements contained at application and enrollment. All representations made are material to the issuance of this coverage. Any information provided on the application or enrollment form or intentionally omitted therefrom, as to any proposed Subscriber or covered Member, shall constitute an intentional misrepresentation of material fact. A Member's coverage may be rescinded retroactively to the Effective Date of coverage or terminated within three (3) years of the Member's Effective Date, for fraud or intentional misrepresentation of material fact. Company will give the Member sixty (60) days advance written notice prior to rescinding or terminating coverage under this section. If Members are enrolled that are not eligible for coverage, it will be considered an act of fraud or intentional misrepresentation of material fact.
2. Unless COBRA or other type of continuation of coverage is available and selected as provided in this Benefit Plan, a Member's coverage terminates as provided below:
 - a. The Subscriber's coverage and that of all his Dependents automatically, and without notice, terminates at the end of the period in which the Subscriber ceases to be eligible.

- b. The coverage of the Subscriber's Spouse will terminate automatically, and without notice, at the end of the period for which premiums have been paid at the time of the entry of a final decree of divorce or other legal termination of marriage.
 - c. The coverage of a Dependent will terminate automatically, and without notice, at the end of the billing cycle in which the Dependent reaches the maximum age for coverage or otherwise ceases to be an eligible Dependent, if premiums have been paid through that period.
 - d. Upon the death of a Subscriber, the coverage of all of his surviving Dependents will terminate automatically and without notice at the end of the month that death occurred if premiums have been paid through that month. However, a surviving Spouse or Dependent may be able to elect COBRA or other type of continuation of coverage as described elsewhere in this Benefit Plan.
3. In the event the Group cancels this Benefit Plan or Company terminates this Benefit Plan for nonpayment of the appropriate payment when due or because the for the Group fails to perform any obligation required by this Benefit Plan, such cancellation or termination alone will operate to end all rights of the Member to Benefits under this Benefit Plan as of the Effective Date of such cancellation or termination. The Group shall have the obligation to notify its Members, participants, and beneficiaries of such cancellation or termination. Company has no such obligation to notify at the Member level.
 4. Except as otherwise provided in this Benefit Plan, no Benefits are available to a Member for Covered Services rendered after the date of cancellation or termination of a Member's coverage.
 5. When Members on the policy change, Company reserves the right to change Subscriber's class of coverage and bill appropriate premium to reflect the Members covered.
 6. Cancellation or termination will be effective at midnight on the last day of the billing cycle.
 7. When the Group's coverage ends because the plan ceases to exist or COBRA is exhausted, Members may apply for individual coverage to Company or to the Exchange.

I. Filing of Claims

You must file all Claims within ninety (90) days from the date services were rendered, unless it is not reasonably possible to do so. In no event may any Claim be filed later than fifteen (15) months from the date services were rendered.

J. Time Limit for Legal Action

1. No lawsuit related to a Claim may be filed any later than twelve (12) months after the Claims are required to be filed.
2. Any and all lawsuits, other than those related to Claims as stated above, must be brought within one (1) year of the end of the Benefit Period.

K. Release of Information

We may request that the Member or the Provider furnish **certain information relating to the Member's Claim for Benefits. We will hold such information, records, or copies** of records as confidential except where in the Company's discretion the same should be disclosed.

L. Assignment

A Member's rights and Benefits under this Benefit Plan are personal to the Member and may not be assigned in whole or in part by the Member. We will not recognize assignments or attempted assignments

of benefits. Nothing contained in this written description of dental coverage shall be construed to make the Group or Us liable to any third party to whom a Member may be liable for the cost of dental care, treatment or services.

M. Member/Provider Relationship.0

1. The choice of a Provider is solely the Member's.
2. The Company and all Participating Providers are to each other independent contractors, and will not be considered to be agents, representatives, or employees of each other for any purpose whatsoever. Blue Cross and Blue Shield of Louisiana does not render Covered Services, but only makes payment for Covered Services that the Member receives. The Company will not be held liable for any act or omission of any Provider, or any Claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Member while receiving care from any Provider. The Company has no responsibility for a Provider's failure or refusal to render Covered Services to a Member.
3. The use or non-use of an adjective such as Participating and Non-Participating in referring to any Provider is not a statement as to the ability of the Provider.

N. Applicable Law

This Benefit Plan will be governed and construed in accordance with the laws and regulations of the State of Louisiana, except when preempted by federal law. This Benefit Plan is not subject to regulations by any state other than the State of Louisiana.

If any provision of this Benefit Plan is in conflict with any applicable statutes of the State of Louisiana or the United States of America, the provision is automatically amended to meet the minimum requirements of the law. Any legal action filed against the Plan must be filed in the appropriate court in the State of Louisiana.

O. Notice

Any notice required under this Benefit Plan must be in writing. Notice given to the Group will be sent to the Group's address stated in the application for Group coverage. Notice given to the Company will be sent to the Company's address stated in the application for Group coverage.

Any notice required to be given will be considered delivered when deposited in the United States Mail, postage prepaid, addressed to the Member at his address as the same appears on the records of the Company, or to the Group at the address as the same appears on the records of the Company. The Group, the Company, or a Member, by written notice, may indicate a new address for giving notice.

P. Job-Related Injury or Illness

The Group must report to the appropriate governmental agency any job-related injury or illness of a Subscriber where so required under the provisions of any legislation of any governmental unit. This Benefit Plan, with certain described exceptions, excludes Benefits for any services covered in whole or in part by Workers' Compensation laws and/or rendered as a result of occupational disease or injury, subject to the provisions of L.R.S. 23:1205 (C). In the event Benefits are initially extended by the Company and a compensation carrier or employer makes any type of settlement with the Subscriber, with any person entitled to receive settlement where the Subscriber dies, or if the Subscriber's injury or illness is found to be compensable under law, the Group or Subscriber must reimburse the Company for Benefits extended or direct the compensation carrier to make such reimbursement. The Company will be entitled to such reimbursement even if the settlement does not mention or excludes payment for dental Benefits expenses.

Q. Subrogation

1. To the extent that Benefits for Covered Services are provided or paid under this Benefit Plan, the Company will be subrogated and will succeed to the right of the Member for the recovery of the amount paid under this Benefit Plan against any person, organization or other carrier, even where such carrier provides Benefits directly to a Member who is its insured. The acceptance of such Benefits hereunder will constitute such subrogation. Our right to recover shall be subordinate to the Member's right to be "made whole." The Company will be responsible for its proportionate share of the reasonable attorney fees and costs actually incurred by the Member in pursuing recovery.
2. The Member will reimburse the Company all amounts recovered by suit, settlement, or otherwise from any person, organization or other carrier, even where such carrier provides Benefits directly to a Member who is its insured, to the extent of the Benefits provided or paid under this Benefit Plan. The Company's right to reimbursement shall be subordinate to the Member's right to be "made whole." The Company agrees that it will be responsible for its proportionate share of the reasonable attorney fees and costs actually paid by a Member in pursuing recovery.
3. The Member will take such action, furnish such information and assistance, and execute such papers as the Company may be required to facilitate enforcement of its rights, and will take no action prejudicing the rights and interest of the Company under this Benefit Plan. Nothing contained in this provision will be deemed to change, modify or vary the terms of the Coordination of Benefits section of this Benefit Plan.
4. The Member is required to notify the Company of any Accidental Injury.

R. Right of Recovery

When payment for Covered Services has been made by the Company in an amount that exceeds the maximum Benefits available for such services under this Benefit Plan, or when payment exceeds the Allowable Charge or has been made in error by the Company or for non-Covered Services, the Company will have the right to recover such payment from the Member or, if applicable, the Provider.

As an alternative, the Company reserves the right to deduct from any pending Claim for payment under this Benefit Plan any amounts the Member or Provider owes the Company.

S. Coverage in a Department of Veterans Affairs or Military Hospital

In any case in which a veteran is furnished care or services by the Department of Veterans Affairs for a non-service-connected disability, the United States will have the right to recover or collect the reasonable cost of such care or services from the Company to the extent the veteran would be eligible for Benefits from the Company if the care or services had not been furnished by a department or agency of the United States.

The amount the United States may recover will be reduced by the appropriate deductible and coinsurance or copayment amount. The United States will have the right to collect from the Company the reasonable cost of services incurred by the United States on behalf of a military retiree or a military Dependent through a facility of the United States military to the extent that the retiree or Dependent would be eligible to receive reimbursement or indemnification from the Company if the retiree or Dependent were to incur such cost on his or her own behalf. The amount the United States may recover will be reduced by the appropriate deductible, coinsurance and copayment amount.

T. Liability of Plan Affiliates

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Benefit Plan constitutes a contract solely between the Group and Blue Cross and Blue Shield of Louisiana, that Blue Cross and Blue Shield of Louisiana is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association" permitting Blue Cross and Blue Shield of Louisiana to use the Blue

Cross and Blue Shield Service Marks in the State of Louisiana), and that Blue Cross and Blue Shield of Louisiana is not contracting as the agent of the Association. The Group on behalf of itself and its participants further acknowledges and agrees that it has not entered into this Benefit Plan based upon representations by any person other than Blue Cross and Blue Shield of Louisiana and that no person, entity, or organization other than Blue Cross and Blue Shield of Louisiana shall be held accountable or liable to the Group for any of Blue Cross and Blue Shield of Louisiana's obligations to the Group created under this Benefit Plan. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Louisiana other than those obligations created under other provisions of this agreement.

U. Continued Coverage During a Leave of Absence

As stated in the Schedule of Eligibility, an employee must be actively working for his employer/Group to be entitled to coverage under this Benefit Plan. Each of the following provisions are exceptions to the requirement that the employee be actively working in order for coverage to apply. The following provisions are independent of each other and only one need apply for Subscriber and his Dependents to be entitled to continued coverage under this Plan.

1. Company will continue coverage for Subscriber during any leave of absence the Group is required to provide by applicable federal or state law, including the Family and Medical Leave Act of 1993 (FMLA) and any amendments or successor provisions, as long as all other eligibility criteria under the law continues to be met. If Subscriber's coverage is terminated during a leave under the FMLA, upon return to active full-time employment, Subscriber is entitled to re-enroll for coverage without being subject to otherwise applicable Pre-existing Condition Waiting Periods, so long as the Group maintains coverage with Company. If the Subscriber is not restored to active full-time employment by the end of the leave of absence period, the Subscriber will cease to be eligible and coverage for the Subscriber and any Dependents will terminate at the end of the billing period in which the leave of absence period expires, or as otherwise described in "Termination of a Member's Coverage." Subscriber and Dependents may have the right to continue coverage thereafter under the Continuation of Coverage Rights article of this Benefit Plan.
2. When a Subscriber is not actively at work due to a health condition, Company will maintain coverage for the Subscriber and any Dependents, as long as the Subscriber remains a bona fide employee of the Group and premiums are paid. If Group terminates Subscriber's employment, the Subscriber will cease to be eligible and coverage for the Subscriber and any Dependents will terminate as described in "Termination of a Member's Coverage." Subscriber and Dependents may have the right to continue coverage thereafter under the Continuation of Coverage Rights article of this Benefit Plan.
3. When a Subscriber has been granted a documented, approved leave of absence by the employer Group, and the leave of absence is not due to Subscriber's health, Company will maintain coverage for the Subscriber and any Covered Dependents for a period not to exceed ninety (90) days. Premiums must be paid and Subscriber must remain a bona fide employee of Group during the approved leave period. Group will provide Company with proof of the documented leave, upon request. If Group terminates Subscriber's employment, the Subscriber will cease to be eligible and coverage for the Subscriber and any Dependents will terminate as described in "Termination of a Member's Coverage." Subscriber and Dependents may have the right to continue coverage thereafter under the Continuation of Coverage Rights article of this Benefit Plan.

ARTICLE XII. COORDINATION OF BENEFITS

A. Applicability

1. This Coordination of Benefits (“COB”) section applies to This Plan when a Member has healthcare coverage under more than one Plan. “Plan” is defined below.
2. This Section is intended to describe 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 do not exceed 100% of the total Allowable expense.

B. Definitions (Applicable only to this Article of this Contract)

1. “Allowable Expense” means any healthcare service or expense, including deductibles, coinsurance or copayments, that is covered in full or at least in part by any Plan covering the person.
 - a. 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.
 - b. An expense or a portion of an expense that is not covered by any of the Plans is not an allowable expense.
 - c. The following are examples of expenses that are not Allowable Expenses.
 - (1) If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.
 - (2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the Provider in excess of the highest reimbursement amount for a specified benefit is not an Allowable Expense.
 - (3) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 - d. The following are examples of expenses that are Allowable Expenses.
 - (1) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement 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.
 - (2) 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, precertification of admissions, and preferred provider arrangements.
2. “Closed Panel Plan” a plan that provides health 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 benefits for services provided by other Providers, except in cases of emergency or referral by a panel member.

3. "Coordination of Benefits or COB Provision" the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
4. "Custodial Parent"
 - a. the parent awarded custody of a child by a court decree; or
 - b. in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.
5. "Order of Benefit Determination Rules" determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one 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 100% of the total Allowable expense.
6. "Plan" is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
 - a. Plan includes:
 - (1) Group and non-group Insurance Contracts;
 - (2) Health maintenance organization (HMO);
 - (3) group and non-group coverage through closed panel plans;
 - (4) Group-Type Contracts (whether insured or uninsured);
 - (5) the medical care components of long-term care contracts, such as skilled nursing care;
 - (6) the medical benefits under group or individual automobile contracts; and
 - (7) Medicare or other governmental benefits, as permitted by law.
 - b. Plan does not include:
 - (1) hospital indemnity coverage benefits or other fixed indemnity coverage;
 - (2) accident only coverage;
 - (3) specified disease or specified accident coverage;
 - (4) limited benefit health coverage as defined by state law;
 - (5) school accident-type coverage except those enumerated in LSA-R.S. 22:1000 A.3C;
 - (6) benefits provided in long-term care insurance policies for non-medical services;
 - (7) Medicare supplement policies;

- (8) a state plan under Medicaid; or
- (9) coverage under other federal government plans, unless permitted by law.

Each contract for coverage under a or b, listed above, is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

C. Order of Benefit Determination Rules

1. When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:
 - a. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
 - (1) Except as provided in Paragraph (2) below, a Plan that does not contain a coordination of benefits provision that is consistent with this Section is always primary unless the provisions of both Plans state that the complying plan is primary.
 - (2) 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 the supplementary coverage shall be excess to any other parts of the Plan provided by the Policyholder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
 - b. 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.
2. Each Plan determines its order of benefits using the first of the following rules that apply:
 - a. Non-Dependent or Dependent Rule. The Plan that covers the person 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 person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person 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 person 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 Rule. 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:
 - (a) The Plan of the parent whose Birthday falls earlier in the calendar year is the Primary plan; or
 - (b) 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:

- (a) If a court decree states that one of the parents is responsible for the dependent child's healthcare expenses or healthcare coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
 - (b) If a court decree states that both parents are responsible for the dependent child's healthcare expenses or healthcare coverage, the provisions of Subparagraph (2)(b)(1) above shall determine the order of benefits;
 - (c) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the dependent child, the provisions of Subparagraph (2)(b)(1) above shall determine the order of benefits; or
 - (d) If there is no court decree allocating responsibility for the dependent child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
 - The Plan covering the Custodial parent;
 - The Plan covering the spouse of the Custodial parent;
 - The Plan covering the non-custodial parent; and then
 - The Plan covering the spouse of the non-custodial parent.
- (3) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraphs (2)(b)(1) or (2)(b)(2) above shall determine the order of benefits as if those individuals were the parents of the child.
- (4) For a dependent child covered under the spouse's plan:
- (a) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in Subparagraph (2)(e) (Longer or Shorter Length in Coverage) applies.
 - (b) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule above in Subparagraph (2)(b)(1) to the dependent child's parent(s) and the dependent's spouse.
- c. Active Employee or Retired or Laid-off Employee Rule. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person 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 of Subparagraph (2)(a) can determine the order of benefits.
- d. COBRA or State Continuation Coverage Rule. If a person 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 person as an employee, member, subscriber or retiree or covering the person 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 of Subparagraph (2)(a) determine the order of benefits.

- e. Longer or Shorter Length of Coverage Rule. The Plan that covered the person as an employee, member, policyholder, Subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
- f. Fall-Back Rule. If none of the preceding rules determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In any event, This Plan will never pay more than it would have paid had it been the Primary plan.

D. Effects on the Benefits of This Plan

1. 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 expense for that claim. In addition, the Secondary plan shall credit to its plan deductible, coinsurance, copayments and any amounts it would have credited to its deductible in the absence of other healthcare coverage.
2. The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this plan will:
 - a. determine its obligation to pay or provide benefits under its contract;
 - b. determine whether a benefit reserve has been recorded for the covered person; and
 - c. determine whether there are any unpaid allowable expenses during that claims determination period.
3. If there is a benefit reserve, the secondary plan will use the covered person's benefit reserve to pay up to 100 percent of total allowable expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.
4. 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.

You may request a copy in either paper form or electronic form of Appendix C, which provides an explanation for secondary plans on the purpose and use of the benefit reserve and how secondary plans calculate claims. A copy of Appendix C is also available on the Louisiana Department of Insurance's website at https://www.lds.la.gov/docs/default-source/documents/legaldocs/regulations/reg32-appendixc.pdf?sfvrsn=24e14b52_0.

E. Summary

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language above, which determines your benefits.

1. Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers. When you are covered by more than one health plan, state law permits your insurers to follow a procedure called “coordination of benefits” to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses. Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones.

2. Primary or Secondary

You will be asked to identify all the plans that cover members of your family. We need this information to determine whether we are the “primary” or “secondary” benefit payer. The primary plan always pays first when you have a claim. Any plan that does not contain your state’s COB rules will always be primary.

3. When This Plan is Primary

If you or a family member is covered under another plan in addition to this one, we will be primary when:

- a. The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired;
- b. The claim is for your spouse, who is covered by Medicare, and you are not both retired;
- c. The claim is for the healthcare expenses of your child who is covered by This Plan and:
 - (1) You are married and your birthday is earlier in the year than your spouse’s or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual’s birthday. This is known as the birthday rule.;
 - (2) You are separated or divorced and you have informed us of a court decree that makes you responsible for the child’s health care expenses; or
 - (3) There is no court decree, but you have custody of the child.

4. Other Situations

- a. We will be primary when any other provisions of state or federal law require us to be. When we are the primary plan, we will pay the benefits in accordance with the terms of your contract, just as if you had no other health care coverage under any other plan.
- b. We will be secondary whenever the rules do not require us to be primary. When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid, as explained below. An “allowable expense” is a health care service or expense covered by one of the plans, including copayments, coinsurance and deductibles.
 - (1) If there is a difference between the amount the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the contract calls for. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) usually have contracts with their providers.

- (2) We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We will use any savings to pay the balance of any unpaid allowable expenses covered by either plan.
- (3) If the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we will pay for those items as long as there is a balance in your benefit reserve, as explained below.
- (4) We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-certification, as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.

c. **Benefit Reserve**

When we are secondary we often will pay less than we would have paid if we had been primary. Each time we "save" by paying less, we will put that savings into a benefit reserve. Each family member covered by this plan has a separate benefit reserve. We use the benefit reserve to pay allowable expenses that are covered only partially by both plans. To obtain a reimbursement, you must show us what the primary plan has paid so we can calculate the savings. To make sure you receive the full benefit or coordination, you should submit all claims to each of your plans. Savings can build up in your reserve for one year. At the end of the year any balance is erased, and a fresh benefit reserve begins for each person the next year as soon as there are savings on their claims.

F. Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. We have the right to decide which facts We need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming Benefits under This Plan must give Us any facts We need to pay the Claim.

G. Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. We 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. To the extent such payments are made, they discharge Us from further liability. The term "payment made" includes providing benefits in the form of services, in which case the payment made will be deemed to be the reasonable cash value of any benefits provided in the form of services.

H. Right of Recovery

If the amount of the payments that We made is more than it should have paid under this COB section, We may recover the excess. We may get such recovery or payment from one or more of:

1. the persons We have paid or for whom We have paid;
2. insurance companies; or
3. other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

ARTICLE XIII. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

We want to know when a Member is dissatisfied about the care or services he receives from Blue Cross and Blue Shield of Louisiana, United Concordia Dental (UCD) or Participating Providers. If a Member wants to register a Complaint or file a formal written Grievance about Us, UCD or a Provider, please refer to the procedures below.

A Member may be dissatisfied about decisions made regarding Covered Services. UCD considers an Appeal as the Member's request to change an Adverse Benefit Determination.

Your Appeal rights are outlined below, after the Complaint and Grievance procedures.

There is an Expedited Appeals process for situations where the time frame of the standard Dental Necessity Appeal would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function.

A. Complaint and Grievance Procedures

A quality of service concern addresses Our services, access, availability or attitude and those of Our Network Providers. A quality of care concern addresses the appropriateness of care given to a Member.

1. To Register a Complaint

A Complaint is an oral expression of dissatisfaction with Us, Claims Administrator or with Provider services.

Members may call UCD at 1-866-445-5338 to register a Complaint. UCD will attempt to resolve the Member's Complaint at the time of his call.

2. To File a Formal Grievance

A Grievance is a written expression of dissatisfaction with Us, the Claims Administrator or with a Provider.

If the Member does not feel his Complaint was adequately resolved or he wishes to file a formal Grievance, a written request must be submitted within one hundred eighty (180) days of the event that led to the dissatisfaction. UCD Customer Service Department will assist the Member if necessary.

The Member should send his written Grievance to:

United Concordia Dental
Customer Service
P.O. Box 69420
Harrisburg, PA 17106-9420

A response will be mailed to the Member within thirty (30) business days after We receive the Member's written Grievance.

B. Standard Appeal Procedures

Multiple requests to Appeal the same Claim, service, issue, or date of service will not be considered, at any level of review.

UCD offers two (2) levels of Appeal for both Administrative Appeals and Dental Necessity Appeals.

If a Member is an ERISA Member, the Member is required to complete the first level of Appeal prior to instituting any civil action under ERISA section 502(a). The second level of Appeal is voluntary. Any statute of limitations or other defense based on timeliness is tolled during the time any voluntary Appeal is pending. The Member's decision whether or not to submit to this voluntary level of review will have no effect on the Member's rights to any other Benefits under the plan. No fees or costs will be imposed on the Member.

The Member should contact his employer, Plan Administrator, Plan Sponsor, or UCD at 1-866-445-5338 if the Member is unsure which process applies to him.

The Member is encouraged to provide UCD with all available information to help completely evaluate the Appeal, such as written comments, documents, records, and other information relating to the Adverse Benefit Determination.

UCD will provide the Member, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Adverse Benefit Determination.

The Member has the right to appoint an authorized representative to represent him in his Appeals. An authorized representative is a person to whom the Member has given written consent to represent him in a review of an Adverse Benefit Determination. The authorized representative may be the Member's treating Provider, if the Member appoints the Provider in writing.

The Member may also call UCD if they have questions or needs assistance putting the Appeal in writing.

All Appeals including Administrative, Dental Necessity and Expedited should be submitted in writing to:

United Concordia Dental
Appeals Division
P.O. Box 69420
Harrisburg, PA 17106-9420
1-866-445-5338

Providers will be notified of Appeals results only if the Provider filed the Appeal.

C. Standard Appeal Process

We will distinguish a Member's Appeal as either an administrative Appeal or a Dental Necessity Appeal.

1. Administrative Appeals

Administrative Appeals involve contractual issues other than Dental Necessity denials such as Adverse Benefit Determinations based on the Benefit Plan limitations or exclusions.

a. First Level Administrative Appeals

If a Member is not satisfied with the original decision, a written request to Appeal must be submitted within one hundred eighty (180) days of the initial Adverse Benefit Determination for first level Administrative Appeals. Requests submitted to UCD after one hundred eighty (180) days of receipt of the initial Adverse Benefit Determination will not be considered.

UCD will investigate the Member's concerns. If the Administrative Appeal is overturned, UCD will reprocess the Member's Claim, if any. If the Administrative Appeal is upheld, UCD will inform the Member of the right to begin the second level Administrative Appeal process.

The Administrative Appeal decision will be mailed to the Member, his authorized representative, or a Provider authorized to act on the Member's behalf, within thirty (30) days of receipt of the Member's request; unless it is mutually agreed that an extension of time is warranted.

b. Second Level Administrative Appeals

After review of the first level appeal decision, if a Member is still dissatisfied, a written request to Appeal must be submitted within sixty (60) days of the first level Administrative Appeal decision. Requests submitted to UCD after sixty (60) days of the first level Administrative Appeal decision will not be considered.

A committee of persons not involved in previous decisions regarding the initial Adverse Benefit Determination will meet and review the second level Administrative Appeals. The committee's decision is final and binding.

The committee's decision will be mailed to the Member, his authorized representative, or a Provider authorized to act on the Member's behalf, within thirty (30) days of the committee meeting.

2. Dental Necessity Appeals

Dental Necessity Appeals involve a denial or partial denial based on Dental Necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or Investigational.

a. First Level Dental Necessity Appeals

If a Member is not satisfied with the original decision, a written request to Appeal must be submitted within one hundred eighty (180) days of the initial Adverse Benefit Determination for first level Dental Necessity Appeals. Requests submitted to UCD after one hundred eighty (180) days of receipt of the initial Adverse Benefit Determination will not be considered.

UCD will investigate the Member's concerns. If the Dental Necessity Appeal is overturned, UCD will reprocess the Member's Claim, if any. If the Dental Necessity Appeal is upheld, UCD will inform the Member of the right to begin the second level Dental Necessity Appeal process.

The Dental Necessity Appeal decision will be mailed to the Member, his authorized representative, or a Provider authorized to act on the Member's behalf, within thirty (30) days of receipt of the Member's request; unless it is mutually agreed that an extension of time is warranted.

b. Second Level Dental Necessity Appeals

After review of the first level Dental Necessity Appeal decision, if a Member is still dissatisfied, a written request to Appeal must be submitted within sixty (60) days of the first level Dental Necessity Appeal decision. Requests submitted to UCD after sixty (60) days of the first level Dental Necessity Appeal decision will not be considered.

The second level Dental Necessity Appeal will be reviewed by a Dentist who holds a non-restricted license issued in the United States in the same or an appropriate specialty that typically manages the dental condition, procedure or treatment under review. The decision is final and binding.

The decision will be mailed to the Member, his authorized representative, or a Provider authorized to act on the Member's behalf, within thirty (30) days of the review.

D. Expedited Dental Necessity Appeals

An Expedited Appeal process is available for review of the Adverse Benefit Determination involving a situation where the time frame of the standard Dental Necessity Appeal would seriously jeopardize the Member's life, health or ability to regain maximum function. It includes a situation where, in the opinion of the treating Provider, the Member may experience pain that cannot be adequately controlled while awaiting a standard Dental Necessity Appeal decision.

An Expedited Appeal shall be made available to, and may be initiated by the Member, his authorized representative, or a Provider authorized to act on the Member's behalf. Requests for an Expedited Appeal may be verbal or written.

UCD will make a decision no later than seventy-two (72) hours of receipt of an Expedited Appeal.

You may contact the Commissioner of Insurance directly for assistance:

Commissioner of Insurance
P. O. Box 94214
Baton Rouge, LA 70804-9214
1-225-342-5900 or 1-800-259-5300

ARTICLE XIV. ERISA RIGHTS

To the extent this is an ERISA plan, the Member is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). For purposes of this provision, the Group is considered the plan administrator and will be subject to the provisions stated below. ERISA provides that all plan participants (Members) shall be entitled to:

A. Receive Information About the Plan and Benefits

1. A Member may examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the United States Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
2. Upon written request to the plan administrator, a Member may obtain copies of documents governing the operation of the plan, including any applicable insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator may make a reasonable charge for the copies.
3. A Member may receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each Member with a copy of this summary annual report.

B. Continue Group Dental Coverage

A Subscriber may continue Dental Benefits coverage for himself, his Spouse, or his Dependents, if there is a loss of coverage under the plan as a result of a qualifying event. The Subscriber or Dependents may, however, have to pay for such coverage. A Member may also review this document and the summary plan description governing the plan on the rules pertaining to the Member's COBRA continuation of coverage rights.

C. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Members, ERISA imposes duties upon the people who are responsible for the operation of the employee Benefit Plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of the Subscriber and other beneficiaries. No one, including his employer, union or any other person, may fire him or otherwise discriminate against him in any way to prevent him from obtaining a plan benefit or exercising his rights under ERISA.

D. Enforce Member's Rights

1. If a Member's Claim for a plan Benefit is denied or ignored, in whole or in part, the Member has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules.
2. Under ERISA, there are steps the Member can take to enforce the above rights. A Member must exhaust all Claims and Appeal procedures available to him before filing any suit. For instance, if the Member requests a copy of plan documents or the latest annual report from the plan and does not receive them within thirty (30) days, the Member may file suit in Federal Court. In such a case, the court may require the plan administrator to provide the materials and pay the Member up to one hundred and ten dollars (\$110.00) a day until he receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If the Member has a Claim for Benefits, which is denied or ignored, in whole or in part, he may file suit in a state or Federal court. In addition, if he disagrees with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, such Member may file suit in Federal Court. If it should happen that plan fiduciaries misuse the plan's money, or if the Member is discriminated against for asserting his rights, he may seek assistance from the United States Department of Labor, or he may file suit in a Federal Court.
3. The court will decide who should pay court costs and legal fees. If the Member is successful, the court may order the person he has sued to pay these costs and fees. If the Member loses, the court may order him to pay these costs and fees, for example, if it determines that his claim is frivolous.

E. Assistance With Member Questions

If a Member has any questions about his plan, he should contact the plan administrator. If a Member has any questions about this statement or about his rights under ERISA, or if he needs assistance in obtaining documents from the plan administrator, he should contact the nearest office of the Employee Benefits Security Administration, United States Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, United States Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

The Member may also obtain certain publications about his rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ARTICLE XV. MAKING PLAN CHANGES AND FILING CLAIMS

All of the forms necessary to make changes to the plan can be obtained from the employer's personnel office or from Our home office. If the Member needs to submit documentation to Us, the Member may forward it to Our home office at:

Blue Cross and Blue Shield of Louisiana
P.O. Box 98029
Baton Rouge, LA 98029-9029
or to Our street address, 5525 Reitz Avenue, Baton Rouge, LA 70809

All the forms related to filing claims under this Benefit Plan can be obtained by contacting United Concordia Dental at:

United Concordia Dental
Dental Claims
P.O. Box 69441
Harrisburg, PA 17106-9441
1-866-445-5338

If the Member has any questions about any of the information in this section, the Member may speak to his Employer or call UCD. Members may be able to perform many of these functions online at www.bcbsla.com.

CHANGING FAMILY MEMBERS ON THE MEMBER'S PLAN

The Schedule of Eligibility lets the Member know when it is necessary for the Member to apply for coverage to enroll additional family members to the Member's plan.

A Group Enrollment Change Form is the document that We must receive in order to enroll family members not listed on the Member's original application/enrollment form. The Group Enrollment Change Form is used to add newborn children, newborn adopted children, a Spouse, or other Dependents. It is extremely important that You follow the timing rules in the Schedule of Eligibility. If You do not complete and return a required Group Enrollment Change Form to Us within the timeframes set out in the Schedule of Eligibility, it is possible that Your insurance coverage will not be expanded to include the additional family Members. Completing and returning a Group Enrollment Change Form is especially important when Your first Dependent becomes eligible for coverage or when You no longer have any eligible Dependents.

FILING INSURANCE CLAIMS FOR BENEFITS

The Company and most Providers have entered into agreements that eliminate the need for a Member to personally file a Claim for Benefits. Participating Providers will file Claims for Members either by mail or electronically. In certain situations, the Provider may request the Member to file the Claim. If the Member's Provider does request the Member to file directly with the Company, the following information will help the Member in correctly completing the Claim form. If You need to file a paper claim, send it to:

United Concordia Dental
Claims Department
P.O. Box 69441
Harrisburg, PA 17106-9441

The Member's Blue Cross and Blue Shield Identification Card (ID card) shows the way the name of the Subscriber (Member of the Group) appears on the Company records. (If the Member has Dependent coverage, the name(s) are recorded as the Member wrote them on his enrollment form.)

The ID card also lists the Member's contract number (ID #). This number is the identification to the Member's membership records and should be provided to Claims Administrator each time a Claim is filed.

If the Subscriber completes the Claim form and this is a Group plan, remember: the Subscriber is the Employee Member (if this is a group contract). If the Subscriber is the patient, the relationship is SELF. If the Subscriber's wife or husband is the patient, the relationship is SPOUSE.

To assist in promptly handling the Member's Claims, the Member must be sure that:

- a. an appropriate Claim form is used
- b. this contract number (ID #) shown on the form is identical to the number on the ID card
- c. the patient's date of birth is listed
- d. the patient's relationship to the Subscriber is correctly stated
- e. all charges are itemized, whether on the Claim form or on the attached statement
- f. the date of service or date of treatment is correct
- g. the Provider includes a diagnosis and procedure code for each service/treatment rendered (the diagnosis code pointers must be consistent with the Claim form)
- h. the Claim is completed and signed by the Member and the Provider.

IMPORTANT NOTE: The Member must be sure to check all Claims for accuracy. This contract number (ID #) must be correct. It is important that the Member keep a copy of all bills and Claims submitted. If Blue Cross and Blue Shield of Louisiana is a secondary payor, the Member may be required to submit his Explanation of Benefits from his primary payor.

IF A MEMBER HAS A QUESTION ABOUT HIS CLAIM

If a Member has a question about the processing or payment of a Claim, the Member can write Us at the below address or the Member may call Claims Administrator at 1-866-445-5338. If the Member calls for information about a Claim, We can help the Member better if the Member has the information at hand--particularly his contract number, patient's name and date of service.

United Concordia Dental
Customer Service
P.O. Box 69420
Harrisburg, PA 17106-9420

Remember, the Member must ALWAYS refer to his contract number in all correspondence and recheck it against the contract number on the Member's ID card to be sure it is correct.

ARTICLE XVI. GENERAL PROVISIONS – GROUP/POLICYHOLDER ONLY

IN ADDITION TO THE GENERAL PROVISIONS FOR GROUP/POLICYHOLDER AND MEMBERS, THE FOLLOWING GENERAL PROVISIONS WILL ALSO APPLY TO THE GROUP/POLICYHOLDER.

A. Due Date for Group’s Premium Payments

1. Premiums are due and payable from Group/Policyholder in advance, prior to coverage being rendered. Premiums are due and payable beginning with the Effective Date of this Benefit Plan and on the same date each month thereafter. This is the premium due date.
2. Premiums are owed by Group/Policyholder. Premiums may not be paid by third parties, including but not limited to Dentists, Hospitals, Pharmacies, Physicians, automobile insurance carriers, or other insurance carriers. Company will not accept premium payments by third parties unless required by law to do so. The fact that Company may have previously accepted a premium from an unrelated third party does not mean that Company will accept premiums from these parties in the future.
3. If a premium is not paid when due, We may agree to accept a late premium. We are not required to accept a late premium. The fact that We may have previously accepted a late premium does not mean we will accept late premiums in the future. You may not rely on the fact that We may have previously accepted a late premium as indication that We will do so in the future.
4. Premiums must be paid in US dollars. Policyholder will be assessed a twenty-five dollar (\$25.00) NSF fee should its premium be paid with a check that is returned by the bank due to insufficient funds. If multiple payments are returned by the bank, Company may at its sole discretion refuse to reinstate coverage.

B. Change in Premium Amount

1. Premiums for this Benefit Plan may increase after the Group’s first twelve (12) months of coverage and every six (6) months thereafter, except when premiums may increase more frequently as described in the following paragraph. Except as provided in the following paragraph, We will give Group forty-five (45) days written notice of any change in premium rates. We will send notice to the Group’s latest address shown in Our records. Any increase in premium is effective on the date specified in the rate change notice. Continued payment of premium will constitute acceptance of the change.
2. We reserve the right to increase the premiums more often than stated above due to a change in the extent or nature of the risk that was not previously considered in the rate determination process at any time during the life of the Benefit Plan. This risk includes, but is not limited to, the right to increase the premium amount because of: (1) the addition of a newly covered person; (2) the addition of a newly covered entity; (3) a change in age or geographic location of any individual insured or policyholder; (4) or a change in the policy Benefit level from that which was in force at the time of the last rate determination. An increase in premium will become effective on the next billing date following the effective date of the change to the risk. Continued payment of premium will constitute acceptance of the change.

C. Group’s Right to Cancel the Policy

1. This policy is guaranteed renewable at the option of the Group. Group indicates its desire to continue coverage by its timely payment of each premium as it becomes due.
2. Group may cancel this policy for any reason.
3. To cancel the policy the Group must give Company WRITTEN NOTICE of its intent to cancel. GROUP MAY NOT VERBALLY CANCEL THIS COVERAGE. GROUP’S WRITTEN NOTICE OF CANCELLATION MUST BE GIVEN TO COMPANY PRIOR TO OR ON THE EFFECTIVE DATE OF

THE CANCELLATION AND MUST BE ACCOMPANIED BY RETURN OF THE BENEFIT PLAN. If Group's written notice to Company of its intent to cancel is not accompanied by the surrendered policy, Group's cancellation notice to Company shall be deemed to include Group's declaration that the Group made a good faith attempt to locate its policy and the policy is not returned because it has been lost or destroyed.

D. Company's Right to Terminate the Policy for Nonpayment of Premium

1. Premiums are to be prepaid before coverage is rendered. The Group is considered delinquent if premiums are not paid on the due date.
2. The Company offers a thirty (30) day grace period (delinquency period) from the due date of the premium. If premium is not received during the grace period, coverage remains in effect during the grace period pursuant to the provisions of the policy. Company will mail a delinquency/termination notice to the Group's address of record. Company may automatically terminate the policy without further notice to the Group if premium is not paid to Company at its home office within thirty (30) days of the due date (during the grace period). Termination will be effective midnight of the last day for which premiums have been paid. Company will not be liable for any Benefits for services rendered following the last date through which premiums have been paid.

The Company will not be liable for any Benefits for services rendered following the last date through which premiums have been paid.

E. Company's Right to Terminate the Policy for Reasons Other Than Nonpayment of Premium

1. Company may terminate this Benefit Plan if any one of the following occurs:
 - a. Group commits fraud or makes an intentional misrepresentation.
 - b. Group fails to comply with a material plan provision, including, but not limited to provisions relating to eligibility, employer contributions or group participation rules. If the sole reason for termination is that Group's participation falls to less than two (2) employees (there is only one (1) employee covered (or owner, if covered)), termination of Group coverage will be effective on the Group's next anniversary date. Otherwise, termination for a reason addressed in this paragraph will be effective after Group receives sixty (60) days written notice as described below.
 - c. In the case of network plans, there is no longer any enrollee under the Group benefit plan that lives, resides, or works in the service area of the Company or in the area for which the Company is authorized to do business.
 - d. Group's coverage is provided through a bona fide association and the employer's membership in the association ends.
 - e. Company ceases to offer this product or coverage in the market.
2. If Company terminates this coverage because of prongs "a", "b", "c", or "d", We will give Group written notice at least sixty (60) days in advance. Company will give notice by certified mail and shall include the reason for termination. Notice of termination because of prong "e" will be sent to the Group by regular mail ninety (90) days in advance of termination.

F. Proxy Votes

Election of Our Board of Directors and certain significant corporate transactions are determined by a majority vote of Our policyholders, unless a different vote is required by law or Our Articles of Incorporation or Bylaws. A policyholder designates, by means of the application for coverage, the members of Our Board of Directors as his proxy to vote on these important matters. Payment of each premium extends the proxy's effectiveness unless revoked by the policyholder. This proxy may be revoked by the policyholder by giving

written notice of the revocation. This revocation may be in any form of writing either revoking the proxy or designating a different proxy and must be sent to Us at P.O. Box 98029, Baton Rouge, Louisiana 70898-9029. In lieu of giving his proxy in the application for coverage, the policyholder may designate any other policyholder as his proxy by any form of writing which includes the policyholder's name and policy number, sent to Us as indicated above. Notice of meetings to the proxy constitutes notice to the policyholders giving their proxies. Further, notice is hereby given that Our annual meeting is held on the third Tuesday in February or on the next business day following, if a legal holiday. However, additional notice of meetings will be sent to any policyholder or his proxy upon his written request for such notice directed to Our secretary.

G. Health Insurance Portability and Accountability Act (Privacy and Security)

1. For purposes of this provision, the following definitions have the same meaning as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"):
 - a. "Group Health Plan" as defined at 45 CFR Part 160, Sec. 160.103.
 - b. "Protected Health Information" (PHI) as defined at 45 CFR Part 164, Sec. 164.501.
 - c. "Summary Health Information" as defined at 45 CFR Part 164, Sec. 164.504(a).

2. Disclosing Information to the Group

- a. Sharing Summary Health Information With the Group:

The Company may disclose Summary Health Information to the Group if the Group requests Summary Health Information for purposes of obtaining premium bids from health insurers, HMOs or other third party payers under the Group Health Plan; or modifying, amending or terminating the Group Health Plan.

- b. Sharing PHI with the Group:

The Company may disclose PHI to the Group to enable the Group to carry out plan administration functions only upon receipt of a certification from the Group that:

- (1) its plan documents include all of the requirements set forth in 45 CFR Part 164, Sec. 164.504(f)(2)(i), (ii) and (iii);
- (2) it has provided notice to those individuals about whom the PHI relates that meets the requirements of 45 CFR Part 164, Sec. 164.520 (B)(1)(iii)(C); and
- (3) that such PHI will not be used for the purpose of employment-related actions or decisions or in connection with any other Benefits or employee benefits plan of the Group.

- a. The Group hereby agrees to abide by the Company's acknowledgement and authorization policies with regards to the exchange of PHI in an electronic format. For example, if the Company provides data to the Group on a compact disc, the Company may require acknowledgement that the data was received by the Group and the name of the Group representative who received the data.

H. United States Economic Sanctions Laws Compliance

The Group hereby agrees to comply fully with all applicable economic sanctions and export control laws and regulations, including those regulations maintained by the United States Treasury Department's Office of Foreign Assets Control (OFAC). The Group understands that Blue Cross and Blue Shield of Louisiana does not authorize extending coverage to any person to whom the provision of such coverage would be receiving insurance coverage under this or other Blue Cross and Blue Shield of Louisiana Policies, including

Subscribers and their covered Dependents, against all relevant United States Government lists of persons subject to trade, export, financial, or transactional sanctions, including the most current version of OFAC's list of Specially Designated Nationals and Blocked Persons, before providing or agreeing to provide coverage to any person.

The Group agrees that its acceptance of coverage constitutes a representation to Blue Cross and Blue Shield of Louisiana that all applicable laws and regulations have been complied with and that coverage is not being provided to any denied person.

Any extension of coverage in breach of the foregoing shall constitute cause for immediate termination of this Benefit Plan, and denial of Benefits for any Claims made under that coverage, and shall entitle Blue Cross and Blue Shield of Louisiana to indemnification from the Group for any cost, loss, damage, liability, or expense incurred by Blue Cross and Blue Shield of Louisiana as a result thereof. This provision shall survive termination or cancellation of this Benefit Plan.

LLHIGA NOTICE

SUMMARY OF THE LOUISIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

- A. Residents of Louisiana who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Louisiana Life and Health Insurance Guaranty Association, or LLHIGA. The purpose of LLHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, LLHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through LLHIGA is limited. As noted in the disclaimer below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Louisiana Life and Health Insurance Guaranty Association provides coverage of certain claims under some types of policies if the insurer becomes impaired or insolvent. **COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.** Even if coverage is provided, there are significant limits and exclusions. Coverage is generally conditioned upon residence in this state. Other conditions may also preclude coverage. Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy. You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer. The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

LLHIGA

P.O. Drawer 44126
Baton Rouge, Louisiana 70804

Department of Insurance

P.O. Box 94214
Baton Rouge, Louisiana 70804-9214

- B. The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law (the law), and is set forth at R.S.22:2081 et seq. The following is a brief summary of this law's coverage, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change any person's rights or obligations under the law or the rights or obligations of LLHIGA.
- C. Generally, individuals will be protected by the Louisiana Life and Health Insurance Guaranty Association if they live in this state and hold a direct non-group life, health, health maintenance organization, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons may also be protected as well, even if they live in another state; unless they are afforded coverage by the guaranty association of another state, or other circumstances described under the law are applicable.
- D. Exclusion from Coverage
1. A person who holds a direct non-group life, health, health maintenance organization, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract is not protected by LLHIGA if:
 - a. he is eligible for protection under the laws of another state;
 - b. the insurer was not authorized to do business in this state;
 - c. his policy was issued by a profit or nonprofit hospital or medical service organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, an organization that issues charitable gift annuities as is defined by law, or any entity similar to any of these.

2. LLHIGA also does not provide coverage for:

- a. any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- b. any policy of reinsurance (unless an assumption certificate was issued);
- c. interest rate or crediting rate yields, or similar factors employed in calculating changes in value, that exceed an average rate;
- d. dividends, premium refunds, or similar fees or allowances described under the law;
- e. credits given in connection with the administration of a policy by a group contract holder;
- f. employers', associations' or similar entities' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured;
- g. unallocated annuity contracts (which give rights to group contract holders, not individuals), except if qualified by law
- h. an obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the policy owner or contract owner, including but not limited to, claims described under the law;
- i. a policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to "Medicare Part A coverage", "Medicare Part B coverage", "Medicare Part C coverage", or "Medicare Part D coverage" and any regulations issued pursuant to those parts;
- j. interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer, whichever is earlier.

E. Limits on Amounts of Coverage

1. The Louisiana Life and Health Insurance Guaranty Association Law also limits the amount that LLHIGA is obligated to pay out.
2. The benefits for which LLHIGA may become liable shall in no event exceed the lesser of the following:
 - a. LLHIGA cannot pay more than what the insurance company would owe under a policy or contract if it were not an impaired or an insolvent insurer.
 - b. For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of \$300,000 in life insurance death benefits, but not more than \$100,000 in net cash surrender and net cash withdrawal values for life insurance.
 - c. For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of \$500,000 in health insurance benefits, and LLHIGA will pay a maximum of \$250,000 in present value of annuities, including net cash surrender and net cash withdrawal values.
3. In no event, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverages, LLHIGA shall not be liable to expend more than \$500,000 in the aggregate with respect to any one individual.



Blue Cross and Blue Shield of Louisiana
HMO Louisiana
Southern National Life

Nondiscrimination Notice

Discrimination is Against the Law

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc., does not exclude people or treat them differently on the basis of race, color, national origin, age, disability or sex in its health programs or activities.

Blue Cross and Blue Shield of Louisiana and its subsidiaries:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (audio, accessible electronic formats)
- Provide free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, you can call the Customer Service number on the back of your ID card or email **MeaningfulAccessLanguageTranslation@bcbsla.com**. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Blue Cross, one of its subsidiaries or your employer-insured health plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you have the right to take the following steps;

1. If you are fully insured through Blue Cross, file a grievance with Blue Cross by mail, fax, or email.

Section 1557 Coordinator
P. O. Box 98012
Baton Rouge, LA 70898-9012
225-298-7238 or 1-800-711-5519 (TTY 711)
Fax: 225-298-7240
Email: Section1557Coordinator@bcbsla.com

2. If your employer owns your health plan and Blue Cross administers the plan, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Blue Cross or owned by your employer, go to www.bcbsla.com/checkmyplan.

Whether Blue Cross or your employer owns your plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights 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)

Or

Electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

NOTICE

Free language services are available. If needed, please call the Customer Service number on the back of your ID card. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios lingüísticos gratuitos. De necesitarlos, por favor, llame al número del Servicio de Atención al Cliente que aparece en el reverso de su tarjeta de identificación. Clientes con dificultades auditivas, llamen al 1-800-711-5519 (TTY 711).

Des services linguistiques gratuits sont disponibles. Si nécessaire, veuillez appeler le numéro du Service clientèle figurant au verso de votre carte d'identification. Si vous souffrez d'une déficience auditive, veuillez appeler le 1-800-711-5519 (TTY 711).

Có dịch vụ thông dịch miễn phí. Nếu cần, xin vui lòng gọi cho Phục Vụ Khách Hàng theo số ở mặt sau thẻ ID của quý vị. Khách hàng nào bị suy giảm thính lực hãy gọi số 1-800-711-5519 (TTY 711).

我们为您提供免费的语言服务。如有需要，请致电您 ID 卡背面的客户服务号码。听障客户请拨打 1-800-711-5519 (TTY 711)。

الخدمات اللغوية متاحة مجاناً. يرجى، إذا اقتضى الأمر، الاتصال برقم خدمة العملاء المدون على ظهر بطاقة التعريف الخاصة بك. إذا كنت تعاني من إعاقة في السمع، فيرجى الاتصال بالرقم 1-800-711-5519 (TTY 711).

Magagamit ang mga libreng serbisyo sa wika. Kung kinakailangan, pakitawagan ang numero ng Customer Service sa likod ng iyong ID kard. Para sa mga may kapansanan sa pandinig tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 서비스를 이용하실 수 있습니다. 필요한 경우 귀하의 ID 카드 뒤에 기재되어 있는 고객 서비스 번호로 연락하시기 바랍니다. 청각 장애가 있는 분은 1-800-711-5519 (TTY 711)로 연락하십시오.

Oferecemos serviços linguísticos grátis. Caso necessário, ligue para o número de Atendimento ao Cliente indicado no verso de seu cartão de identificação. Caso tenha uma deficiência auditiva, ligue para 1-800-711-5519 (TTY 711).

ພວກເຮົາມີບໍລິການແປພາສາໃຫ້ທ່ານພຣີ. ຖ້າທ່ານຕ້ອງການບໍລິການນັ້ນ, ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ທາງຫຼັງຂອງບັດປະຈຳຕົວຂອງທ່ານ. ຖ້າທ່ານຫຼຸບໍ່ດີ, ຂໍໃຫ້ໂທເບີ 1-800-711-5519 (TTY 711).

無料の言語サービスをご利用頂けます。あなたのIDカードの裏面に記載されているサポートセンターの電話番号までご連絡ください。聴覚障害がある場合は、1-800-711-5519 (TTY 711)までご連絡ください。

زبان سے متعلق مفت خدمات دستیاب ہیں۔ اگر ضرورت ہو تو، براہ کرم اپنے آئی ڈی کارڈ کی پشت پر موجود کسٹمر سروس نمبر پر کال کریں۔
سمعی نقص والے کسٹمرز 1-800-711-5519 (TTY 711) پر کال کریں۔

Kostenlose Sprachdienste stehen zur Verfügung. Falls Sie diese benötigen, rufen Sie bitte die Kundendienstnummer auf der Rückseite Ihrer ID-Karte an. Hörbehinderte Kunden rufen bitte unter der Nummer 1-800-711-5519 (TTY 711) an.

خدمات رایگان زبان در دسترس است. در صورت نیاز، لطفاً با شماره خدمات مشتریان که در پشت کارت شناسایی تان درج شده است تماس بگیرید.
مشتریانی که مشکل شنوایی دارند با شماره 1-800-711-5519 (TTY 711) تماس بگیرند.

Предлагаются бесплатные переводческие услуги. При необходимости, пожалуйста, позвоните по номеру Отдела обслуживания клиентов, указанному на оборотной стороне Вашей идентификационной карты. Клиенты с нарушениями слуха могут позвонить по номеру 1-800-711-5519 (Телефон с текстовым выходом: 711).

มีบริการด้านภาษาให้ใช้ได้ฟรี หากต้องการ โปรดโทรศัพท์ติดต่อฝ่ายการบริการลูกค้าตามหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของท่าน
สำหรับลูกค้าที่มีปัญหาทางการได้ยิน โปรดโทรศัพท์ไปที่หมายเลข 1-800-711-5519 (TTY 711)

