Traditional Blue Dental

Preferred and Essential

LIMITED BENEFIT CONTRACT

Louisiana

40XX1984 R01/19

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 Office

INDIVIDUAL DENTAL CONTRACT

THIS IS A LIMITED BENEFIT CONTRACT – READ CAREFULLY

provided by

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

www.bcbsla.com

BLUE DENTAL
INDIVIDUAL DENTAL CONTRACT

NOTICES

If, upon examination of this Contract, the Subscriber is not satisfied, he or she may return it to the Company within ten (10) days after receipt and fees paid by the Subscriber will be refunded.

This Contract is guaranteed renewable at the Subscriber's option, provided premiums are paid in accordance with the Contract requirements and the Subscriber does not violate any of the provisions of the coverage under this Contract.

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.

INDIVIDUAL DENTAL CONTRACT

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ARTICLE I. UNDERSTANDING THE BASICS OF YOUR COVERAGE

The Schedules of Dental Benefits control in regards to which dental Benefits are covered, the Waiting Period that is applicable to each Benefit, and the cost sharing (deductibles, coinsurance) applicable to each Benefit. The Schedule will describe the Section to which it applies. The Benefits offered under both of these Sections are limited as stated in each 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 Network, handling and paying claims, and providing customer services to the Members eligible to receive these benefits and their legal representatives.

The Dental Network consists of a select group of Providers who have contracted with United Concordia Dental to render services to Members for discounted fees. **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 Contract, the Member should verify that a Provider is a United Concordia Dental Network Participating Provider before any service is rendered. To locate a Participating Provider and verify their continued participation in the United Concordia Dental 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 Contract 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 Section. 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, which could be significant, will not accumulate to any Out-of-Pocket Maximum under this Contract. 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, healthcare 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 Contract will allow for a specific service covered under the terms of this Contract.

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.

Authorization (Authorized) – A determination by Claims Administrator regarding a dental healthcare service or supply which, based on the information provided, satisfies the clinical review criteria requirement for Medical Necessity, appropriateness of the healthcare 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 Contract. Benefits are based on the Allowable Charge for Covered Services and the Schedules of Dental Benefits.

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 Contract. 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 Contract.

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.

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

Company – Means Blue Cross and Blue Shield of Louisiana.

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, disorder or covered surgery.

Covered Service – A service or supply specified in this Contract 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.

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

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 Claim 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 Contract as determined by the Schedule of Eligibility. Benefits will begin at 12:01 a.m. on this date.

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 Contract 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 healthcare 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 External 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 healthcare 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.

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.

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.

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.

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 Contract during a Special Period, the Policy Year may be less than 12 months, starting from the date of enrollment until the start of the next policy year.

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.

Rescission of Coverage – Cancellation or discontinuance of coverage that has retroactive effect.

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 Contract.

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 Contract before benefits will be paid for certain Covered Services as shown on the Schedule of Dental Benefits.

ARTICLE III. SCHEDULE OF ELIGIBILITY

ANY ELIGIBILITY REQUIREMENT LISTED IN THIS CONTRACT, WHICH IS NOT MANDATED BY STATE OR FEDERAL LAW, MAY BE DELETED OR REVISED ON THE SCHEDULE OF BENEFITS.

A. Enrollment

A Subscriber and his/her Dependents will be able to enroll in this Contract at any time during the year. The Subscriber will not be permitted to re-enroll himself/herself or his/her Dependents for 12 months (the "Lock-out Period") from the Termination Date if the Subscriber voluntarily terminates the Contract at renewal or on any other date, or if the Contract is terminated for fraud, material misrepresentation, or non-payment of Premium.

If the Subscriber voluntarily terminates a Subscriber and Spouse, Subscriber and Family or Subscriber and Children coverage, and a Dependent of the Subscriber wishes to continue coverage, the Dependent may submit a new application for coverage on his/her own behalf, and will be considered if he/she is at least 18 years old.

B. Eligibility

1. Subscriber. A Subscriber is a person of at least 18 years of age and who has signed the application for this Contract. The Subscriber must be a Louisiana resident at time of application and while covered.

2. Dependent. To be eligible to apply as a Dependent, an individual must meet the following criteria at the time of application. 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 Contract:

   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 periodic proof of continuing incapacity and dependency within thirty-one (31) days of the child's 26th birthday. Subsequent proof once a year after an initial two-year period following the child's 26th birthday may be required.

C. Classes of Coverage

The following classes of coverage are available under this Contract:

1. Subscriber Only coverage means coverage for the Subscriber only.

2. Subscriber and Spouse coverage means coverage for the Subscriber and his/her Spouse.

3. Subscriber and Family coverage means coverage for the Subscriber, his/her Spouse, and one or more Dependent children.

4. Subscriber and Child (or Children) coverage means coverage for the Subscriber and one or more Dependent children.

D. Effective Date of Coverage

1. An individual may apply for coverage under this Contract through the Company and may include any eligible Dependents in such application.

2. No person for whom coverage is sought will be covered under this Contract unless the application for coverage has been approved by the Company and such approval has been evidenced by the issuance of an identification card or other written notice of approval. Payment of premiums to the Company for any person for whom coverage is sought will not effectuate coverage unless and until the Company's identification card or other written approval 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.

3. When an application has been approved and any premiums for coverage have been paid in advance as required by this Contract, coverage will commence on the date the Company assigns as Your Effective Date. No Claims will be paid for dates of service prior to Your Effective Date.

E. Special Enrollment

Certain specified events provide You with the opportunity to enroll or disenroll yourself or eligible Dependents from coverage on this Contract. These are special enrollment events. Enrollment or disenrollment must be made during the Special Enrollment Period specified in this Contract. Members who lose this or other coverage because they do not pay their premium or required contributions or lose this or other coverage for cause (such as filing fraudulent Claims or an intentional misrepresentation of a material fact in connection with the Contract) are not special enrollees and have no special enrollment rights.

1. Examples of special enrollment events for all this Contracts are:

   a. Loss of "minimum essential coverage" during the year as a consequence of:

      (1) Loss of eligibility for coverage under another plan the individual was enrolled in as a result of death, divorce, or loss of dependent status under that health plan;

      (2) Changing residence to an area not served by the health plan under which the individual was enrolled;

(3) Another dental plan stops offering benefits to a certain class of similarly situated individuals of which the individual was a member;

(4) Termination of employer contributions towards a person's coverage under another dental plan in which the individual was enrolled; and

(5) Exhaustion of COBRA continuation coverage.

An individual requesting special enrollment under this section because of loss of other minimal coverage must request enrollment under this Contract within sixty (60) days after the other coverage ends (or after the employer stops contributing toward the other coverage). If such enrollment is received by a Blue Cross and Blue Shield of Louisiana office within sixty (60) days after loss of other coverage, coverage will become effective on the date other coverage is lost. The request will be denied and coverage will not be available if Blue Cross and Blue Shield of Louisiana does not receive the request for enrollment form within sixty (60) days after the loss of other coverage.

b. A Qualified Health Plan violates a material provision of its contract.

c. The Subscriber gaining a Dependent or becoming a Dependent through marriage, birth, adoption, placement for adoption or mandate granting legal or provisional custody of the child or grandchild. The Special Enrollment Period described in this subparagraph is a period of sixty (60) days and shall begin on the later of the date Dependent coverage is made available or the date of the marriage, birth, adoption, legal placement for adoption, or mandate granting legal or provisional custody of a child or grandchild. Premiums may be adjusted for the additional coverage. Your request to enroll yourself or other persons because of these events must be received by Blue Cross Blue Shield of Louisiana within sixty (60) days from the date of the event. If the request for enrollment is not made timely, the request will be denied.

2. Your request to enroll Yourself or other eligible Dependents must be received by Blue Cross Blue Shield of Louisiana within sixty (60) days from the date of the event. If the request for enrollment is not timely made, the request will be denied.

"Minimum essential coverage" for Special Enrollment purposes under this section means those included under that term by Internal Revenue Code Section 5000A, as for example:

a. Medicare.

b. Medicaid.

c. Children's Health Insurance Program (CHIP).

d. Health coverage provided by the U.S. Armed Forces under Chapter 55 of Title 10 of the United States Code, including Tricare.

e. Health coverage program provided by the U.S. Secretary of Veterans Affairs in coordination with the U.S. Secretary of Health and Human Services under Chapters 17 and 18 of Title 38 of the United States Code.

f. The health plan for Peace Corps volunteers under Section 2504(e) of Title 22 of the United States Code.

g. The Non-appropriated Fund Health Benefits Program of the U.S. Department of Defense, established under Section 349 of the National Defense Authorization Act for Fiscal Year 1995.

(1) Health plans bought in the individual health insurance market within a State of the United States.

(2) Coverage under the health benefits risk pool of a State of the United States.

(3) An eligible employer-sponsored health plan which is offered in the small or large group markets within a State of the United States, or a governmental health plan, which is not an "excepted benefit."

Any other plan recognized as "minimum essential coverage" by the U.S. Secretary of Health and Human Services in coordination with the U.S. Secretary of the Treasury for purposes of Internal Revenue Code Section 5000A.

3. Automatic Coverage for Newly Born Infants During Special Enrollment Periods

There is a one month period of automatic coverage for natural born or adopted Newly Born Infants. Any period of automatic coverage for Newly Born Infants runs concurrently with the Special Enrollment Period for requesting the Company to add these infants to this Contract.

a. Newly Born Infants (Newborns) – If a child is born to a Member covered under this Contract, the following will apply:

(1) Such child will be covered automatically for one month from birth or until the child is well enough to be discharged from the Hospital or neonatal Special Care Unit to his home, whichever is longer. This is the automatic coverage period. This period of automatic coverage for the child will be provided if You notify or Blue Cross Blue Shield of Louisiana of the birth of the child. Coverage for the child will continue until the expiration of the period of automatic coverage, unless otherwise determined by the Company, or the Newly Born Infant is added as a Dependent to this Contract. Coverage is made by applying to the Company, paying premiums required for coverage, and completing any required forms.

(2) If the enrollment request is not received with this one month period, coverage for the child will terminate upon the expiration of the automatic coverage period. Any later request to add coverage for the Newly Born Infant must be made at under another special enrollment provision.

b. Newly Born Adopted Infants – If within one month of the birth of a child, the child is either: legally placed into Subscriber's home for adoption following a voluntary act of surrender to the custody of the Subscriber or his legal representative which becomes irrevocable, or is subject to a court order awarding custody to a Subscriber, the following will apply:

(1) The Newly Born Adopted Infant will be covered automatically for one month. The one month period begins to run from the date of legal placement into the Subscriber's home or from the custody order, or if an ill newborn, from the date the child could have been legally placed into the Subscriber's home had he not been ill, until the child is well enough to be discharged from the Hospital or neonatal Special Care Unit, whichever is longer. Coverage for the child will continue until the expiration of the period of automatic coverage, unless otherwise determined by the Company, or the Newly Born Adopted Infant is added as a Dependent to this Contract. Coverage is made by applying to the Company, paying premiums required for coverage, and completing any required forms.

(2) If the enrollment request is not received within this one month period, coverage for the child will terminate upon the expiration of the automatic coverage period. Any later

request to add coverage for the Newly Born Adopted Infant must be made at Renewal or under another special enrollment provision.

F. Making Changes (Changing Family Members) on Your Contract

This Schedule of Eligibility lets You know when You may add additional family Members to Your Contract. If Your coverage was purchased through an agent or through Blue Cross and Blue Shield of Louisiana, You will need to make all policy changes through the agent or through Blue Cross and Blue Shield of Louisiana. A Change of Status Card is the document that We must receive in order to enroll family Members not listed on Your original application/enrollment form. The Change of Status Card is used to add newborn children, newborn adopted children, or add or cancel 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 Change of Status Card 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 or family members may not be removed from coverage. Completing and returning a Change of Status Card is especially important when Your first Dependent becomes eligible for coverage or when You no longer have any eligible Dependents. A Change of Status Card is also required to remove existing family Members listed on Your original application or enrollment form, or shown as covered in Our records.

ARTICLE IV. BENEFITS

This Contract will have a Deductible that will apply to each Member. The "Deductible per Member" is the amount of expenses in covered Benefits each Member will have to pay out of his/her own pocket during the Benefit Period before any Benefits are payable under this Contract.

This Contract has an "Annual Maximum Benefit per Member." Once this Contract pays Benefits in that amount for a Member, no more Benefits will be covered for the rest of the Benefit Period for that Member.

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 Contract will pay for each covered Benefit. Any percentage not covered will be the responsibility of the Member.

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

After the satisfaction of the Deductible, and subject to the Coinsurance and Annual Maximum Benefit Per Member, this Contract 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

    b. 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.

    c. Detailed problem-focused evaluations are limited to one (1) every twelve (12) months per eligible diagnosis.

    d. Limited problem-focused evaluations are limited to one (1) every twelve (12) months.

e. Consultations are diagnostic services provided by a dentist or physician other than the practitioner providing the dental treatment, and are limited to one (1) every twelve (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 twelve (12) 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 three (3) years.

6. Emergency (Palliative) Treatment

   Limited to 2 per 12 months in combination with pulpal debridement

B. Basic Services

1. 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.

2. Basic Restorations (amalgam and 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 twenty four (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.

3. Endodontic (Pulpal) Therapy

a. Eligible teeth limited to primary anterior teeth when there is no permanent tooth to replace it.

b. Limited to one (1) per eligible tooth per lifetime.

4. Root Canal

a. Limited to one (1) per tooth per lifetime.

5. Non-Surgical Periodontics

a. Periodontal scaling and root planing limited to one (1) every twenty four (24) 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.

6. 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. Gingivectomy or gingivoplasty, limited to one every thirty six (36) months;

d. Gingival flap procedure limited to one every thirty six (36) months;

e. Clinical crown lengthening, limited to one (1) for each tooth per lifetime;

f. Osseous surgery, limited to one (1) every thirty six (36) months;

g. Pedicle soft tissue graft, limited to one every 36 months;

h. Free soft tissue graft, limited to one every 36 months;

i. Subepithelial connective tissue graft, limited to one every 36 months;

j. Full mouth debridement to enable comprehensive evaluation and diagnosis, limited to one (1) per lifetime.

7. Simple Extractions

8. Surgical Extractions

a. Surgical removal of erupted tooth with elevation of mucoperiosteal flap and removal of bone and/or section of tooth.

9. 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.

10. General Anesthesia/Sedation

a. If used in conjunction with certain eligible oral surgery services.

b. Limited to sixty (60) minutes per session.

11. 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.

12. 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.

ARTICLE V. EXCLUSIONS

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

1. Specifically listed in the Schedule of Dental Benefits as "Not Covered."

2. Started prior to the Member's Effective Date or after the Termination Date of coverage under this Contract, including, but not limited to multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures.

3. For house or hospital calls for dental services and for hospitalization costs (e.g. facility-use fees).

4. 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. Claim Administrator's benefits would be in excess to the third-party benefits and therefore, Claim Administrator would have right of recovery for any benefits paid in excess.

5. For prescription and non-prescription drugs, vitamins or dietary supplements.

6. Administration of nitrous oxide and/or IV sedation.

7. Cosmetic in nature as determined by Claim Administrator (for example but not limited to, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).

8. Elective procedures (for example but not limited to, the prophylactic extraction of third molars).

9. 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).

10. For dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically indicated in this Contract.

11. 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.

12. For treatment of fractures and dislocations of the jaw.

13. For treatment of malignancies or neoplasms.

14. 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.

15. For replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.

16. For preventative restorations.

17. For periodontal splinting of teeth by any method.

18. For duplicate dentures, prosthetic devices or any other duplicative device.

19. For which in the absence of insurance the Member would incur no charge.

20. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.

21. 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.

22. For treatment and appliances for bruxism (night grinding of teeth).

23. For any claims submitted to Claim Administrator by the Member or on behalf of the Member in excess of fifteen (15) months after the date of service.

24. 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).

25. 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.

26. For specialized procedures and techniques (for example but not limited to, precision attachments, copings and intentional root canal treatment).

27. Fees for broken appointments.

28. 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.

29. Orthodontics treatment.

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 CONTRACT WITH OTHER DENTAL COVERAGE OF WHICH THIS CONTRACT FORMS A PART

If a Member has other coverage for dental Benefits, and this Contract 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

The dental coverage under this Section 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.

A Covered Benefit expense will be deemed incurred as follows:

- For appliances or changes to appliances – on the date the appliance or prosthesis is permanently placed;
- For Crowns, dentures or bridgework – on the date the impression is taken;
- For Root Canal therapy -- on the date the pulp chamber is opened; or
- For all other dental expenses -- on the date the service is rendered or the supply is furnished.
- For orthodontic treatment, if covered under the Plan, coverage will be extended through the end of the month of the Member's Termination Date.

ARTICLE X. GENERAL PROVISIONS

A. This Contract

1. This Contract, the Application expressing the entire money and other consideration for coverage, the Schedule of Dental Benefits, and any amendments or endorsements, constitutes the entire Contract between the parties.

2. This Contract is guaranteed renewable at the Subscriber's option, subject to eligibility determinations and redeterminations by the Company. Subscriber indicates his desire to continue coverage by his timely payment of each premium as it becomes due. We shall renew or continue coverage under this Contract on a month-to-month basis, at Your option.

3. The Company reserves the right to enter into any contractual agreements with subcontractors, healthcare providers, or other third parties relative to this Contract. Any function to be performed by the Company under this Contract may be performed by the Company or any of its subsidiaries, affiliates, subcontractors, or designees.

4. Our liability is limited to the Benefits specified in this Contract. Benefits for Covered Services specified in this Contract will be provided only for services and supplies rendered on and after Your Effective Date by a Provider specified in this Contract and regularly included in such Provider's charges.

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. Non-Responsibility for Acts of Providers

We will not be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance or malpractice on the part of any Hospital or other institution, or any agent or employee thereof, or on the part of any Dentist, physician, allied provider, nurse, technician, assistant or other person participating in or having to do with Your care or treatment.

D. Identification Cards

We will issue an identification card to You. You must present Your identification card whenever Covered Services are rendered. Identification cards are not transferable. Unauthorized use of the identification card by any person can result in termination of Your coverage. The identification card serves only to identify the covered Member and confers no right to Covered Services or Benefits. To be entitled to Covered Services or Benefits an identification cardholder must, in fact, be a Member on whose behalf all applicable premiums have actually been paid. A Member must carry the identification card with them at all times to assure prompt receipt of Covered Services. If a card is lost or stolen, please notify Us immediately.

E. Contract Changes

Subject to applicable laws, no agent may change this Contract other than by amendment or endorsement issued by Us to form a part of this Contract. This amendment or endorsement must be signed by one of Our executive officers or his delegate. No representation of any agent of the Plan at any time shall change the terms of this Contract. Changes will be effective upon renewal of the Contract and preceded by not less than sixty (60) day notice to You.

F. Due Date for Premium Payments

1. Premiums are due and payable from Subscriber in advance, prior to the coverage being rendered. Premiums are due and payable beginning on the Effective Date of the first Policy Year of this Contract and on the same date each month thereafter. This is the premium due date. This Contract is renewable on a monthly basis by the timely payment of each premium as it becomes due.

2. Premiums are owed by Subscriber. Premiums may not be paid by third parties, unless related to the Subscriber by blood or marriage. Premiums may not be paid by Hospitals, Pharmacies, Dentists, 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 We may have previously accepted a premium from an unrelated third party does not mean that we will accept premiums from these parties in the future. Company will accept advance payment of premium tax credits from the federal government.

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 a premium 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.

G. Change in Premium Amount

1. This Contract is renewable at Your option. Any renewal of this Contract will be subject to premium changes based on the rates then applicable.

2. Except as provided in the following paragraph, We will give forty-five (45) days written notice to You of a premium change, at Your last address shown in Our records. Any change in premium will become effective on the date specified in the notice. Continued payment of premium will constitute acceptance of the change.

3. Premiums are guaranteed for the Policy Year. However, We reserve the right to change premiums more often 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 Contract. This risk includes, but is not limited to, the addition of a newly covered person. Additionally, We reserve the right to change the premium if You request a change in Contract Benefits from that which was in force at the time of the last rate determination.

4. If Your age was misstated, any amount payable or any indemnity accruing under this Contract shall be such as the premium paid would have purchased at the correct age. A clerical error will not void insurance which should be in force nor will it continue insurance which should have ended.

5. If non-tobacco premiums are charged when tobacco premiums should have been charged, Company may retroactively adjust the premium and collect the appropriate premium.

H. Subscriber's Right to Cancel This Contract

1. Subscriber may cancel this Contract by giving notice in writing to the Company, as applicable, at least fourteen (14) days before the date of cancellation.

2. If written notice is given to Company, it should be sent to the Company at the home office, attention "Individual Membership and Billing":

Blue Cross and Blue Shield of Louisiana
Attention: Individual Membership and Billing
P. O. Box 98029
Baton Rouge, LA 70898-9029

3. SUBSCRIBER MAY NOT VERBALLY CANCEL THIS COVERAGE. SUBSCRIBER'S WRITTEN NOTICE OF CANCELLATION MUST BE ACCOMPANIED BY RETURN OF THIS CONTRACT. If Subscriber's written notice to Company of his intent to cancel is not accompanied by the surrendered Contract, Subscriber's cancellation notice to Company shall be deemed to include Subscriber's declaration that the Subscriber made a good faith attempt to locate his Contract and the Contract is not being returned because it was lost or destroyed.

4. If Subscriber gives cancellation notice to Company, the Contract will be canceled effective on the date that is fourteen (14) days from the date of the Subscriber's cancellation notice or any later date requested by the Subscriber in his/her written notice to Company, or on a date required by law.

I. Company's Right to Terminate This Contract for Nonpayment of Premium

1. Premiums are to be prepaid before coverage is rendered. The Subscriber is considered delinquent if premiums are not paid on the due date.

2. Subscribers have a thirty (30) day delinquency period (grace period) from the due date of the premium. If We receive the premium during the delinquency period, coverage remains in effect pursuant to the provisions of the Contract. If We do not receive the premium due during the delinquency period, We will mail a delinquency/lapse notice to the Subscriber's address of record. We may also mail a termination notice to the Subscriber's address of record, We may automatically terminate the Contract without further notice to the Subscriber if we do not receive Subscriber's premium at Our home office within thirty (30) days of the due date (during the delinquency period). If we terminate this Contract for nonpayment of premium, termination will be effective midnight of the last day for which premiums have been paid. The Company will not be liable for payment of Benefits for services rendered following the last date through which premiums have been paid. Company will be under no obligation to guarantee later coverage to Subscriber or his Dependents during the Policy Year.

J. Company's Right to Rescind Coverage, Terminate or Non-Renew the Contract for Reasons Other Than Nonpayment of Premium

1. Causes for the rescission (retroactive termination) of this Contract:

   Subscriber or a Covered Member performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the terms of this Contract. The issuance of this Contract is conditioned on the representations and statements contained on the application. All representations made on the application are material to the issuance of this Contract. Any information provided on the application, or intentionally omitted therefrom, as to any proposed Subscriber or Covered Member shall constitute an intentional misrepresentation of material fact.

   If You enroll someone that is not eligible for coverage, it will be considered an act of fraud or intentional misrepresentation of material fact. In such event, Company will give Subscriber thirty (30) days advance written notice by certified mail and will include the reason for rescission. Rescission could be retroactive to the Effective Date of coverage.

2. Causes for termination of coverage or non-renewal of this Contract:

   a. Subscriber fails to comply with a material plan provision or obligation under this Contract. In such event, Company will give Subscriber sixty (60) days advance written notice by certified mail and will include the reason for termination or non-renewal. The effective date of the termination or non-renewal will be provided in the notice.

   b. A Member no longer lives or resides in the service area where Company is authorized to do business. In such event, Company will give Subscriber sixty (60) days advance written notice by certified mail and will include the reason for termination or non-renewal. The effective date of the termination or non-renewal will be provided in the notice.

   c. Company ceases to offer this product or coverage in the market. In such event, Company will give Subscriber written notice by regular mail ninety (90) days in advance of the termination or non-renewal. The effective date of the termination or non-renewal will be provided in the notice.

   d. A Member becomes newly eligible for enrollment in a Medicaid, Children's Health Insurance Program (CHIP) or Basic Health Program (BHP) plan. In such event, coverage will be terminated effective on the day before coverage in the Medicaid, CHIP or BHP plan begins.

K. Termination of a Member's Coverage

1. All coverage will end at the end of the period for which premiums have been paid. No Benefits are available for Covered Services rendered after the date of termination of coverage.

2. Coverage for Subscriber's Spouse terminates automatically, without notice, at the end of the period for which premiums have been paid, when a final decree of divorce or other legal termination of marriage is rendered.

3. Coverage for Dependents terminates automatically, without notice, at the end of the year the Dependent ceases to be an eligible Dependent, unless it is specifically otherwise stated in this Contract or as provided by law. Premiums are required to be paid in order to retain coverage until the Dependent ceases to be eligible.

4. Upon the death of the Subscriber, all coverage on this Contract ends for all Covered persons on the Contract. Termination is automatic and without notice. Termination is effective at the end of the billing period in which the Subscriber's death occurred, if premiums have been paid through that billing cycle.

5. In the event of circumstances stated in paragraphs 2, 3, or 4 above, the Spouse or other covered Dependents may elect to continue coverage. The Member must notify Us of the desire to continue coverage. Notification must be received by a Blue Cross and Blue Shield of Louisiana office within thirty (30) days after the date of termination.

6. In the event that You move outside Our Service Area with the intent to relocate or establish a new residence outside Our Service Area, Your coverage will be terminated.

7. We reserve the right to automatically change the class of coverage and charge appropriate premium on this Contract to reflect the membership on the Contract.

L. 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.

Claims Administrator and Participating 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 Your Provider does request You to file directly with the Company, the following information will help You in correctly completing the Claim form.

We will, upon receipt of a notice of claim, furnish to You such forms as are usually furnished by Us for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, You will be deemed to have complied with the requirements of this Contract as to proof of loss upon submitting, within the time fixed in this Contract for filing proofs of loss, any affirmative written proof covering the occurrence, the character and the extent of the loss for which the claim is made.

If You have any questions about any of the information in this section, You may call Your insurance agent or Our Customer Service Department at the number shown in Your ID Card.

Your Blue Cross and Blue Shield of Louisiana ID Card shows the way Your name appears on the Company records. (If You have Dependent coverage, the name(s) are recorded as You wrote them on Your application card.) The ID Card also lists Your Contract number (ID #). This number is the identification to Your Membership records and should be provided to Us each time a Claim is filed.

To assist in promptly handling Your Claims, please be sure that:

1. an appropriate claim form is used

2. the Contract number (ID #) shown on the form is identical to the number on the ID Card

3. the patient's date of birth is listed

4. the patient's relationship to the Subscriber is correctly stated

5. all charges are itemized in a statement from the Provider

6. the itemized statement from the Provider contains the Provider's name, address and tax ID number and is attached to the Claim form

7. the date of service (Admission to a Hospital or other Provider) or date of treatment is correct

8. the Provider includes a diagnosis code and a procedure code for each service/treatment rendered

9. the claim is completed and signed by the Member.

If You need to submit documentation to Us, please sent it to:

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

M. Applicable Law and Conforming Policy

This Contract will be governed and construed in accordance with the laws and regulations of the State of Louisiana except when preempted by federal law. This Contract is not subject to regulation by any state other than the State of Louisiana. If any provision of this Contract is in conflict with any applicable law of the State of Louisiana or the United States of America, the Contract shall be 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.

N. 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.

O. 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 Our discretion the same should be disclosed.

P. Assignments

A Member's rights and Benefits under this Contract 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 health coverage shall be construed to make the health plan or Us liable to any third party to whom a Member may be liable for the cost of dental care, treatment or services.

Q. Member/Provider Relationship

1. The choice of a Provider is solely Yours.

2. We 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 You receive. We are not liable for any act or omission of any Provider, or for any Claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by You while receiving care from any network Provider or in any network Provider's facilities. We have no responsibility for a Provider's failure or refusal to render Covered Services to You.

3. The use or non-use of an adjective such as network, Participating, and Non-Participating in referring to any Provider is not a statement as to the ability of the Provider.

R. Subrogation

1. To the extent that Benefits for Covered Services are provided or paid under this Contract, We will be subrogated and will succeed to Your right for the recovery of the amount paid under this Contract 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 Your right to be "made whole." We will be responsible for Our proportionate share of the reasonable attorney fees and costs actually incurred by You in pursuing recovery.

2. You will reimburse Us 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 Contract. Our right to reimbursement shall be subordinate to Your right to be "made whole." We agree that We will be responsible for Our proportionate share of the reasonable attorney fees and costs actually paid by You in pursuing recovery.

3. You will take such action, furnish such information and assistance, and execute such papers as We may require to facilitate enforcement of Our rights, and will take no action prejudicing Our rights and interest under this Contract. Company and its designees have the right to obtain and review Your medical and billing records, if Company determines in its sole discretion, that such records would be helpful in pursuing its right of subrogation and/or reimbursement.

4. You are required to notify Us of any Accidental Injury.

S. Right of Recovery

Whenever any payment for Covered Services has been made by Us in an amount that exceeds the maximum Benefits available for such services under this Contract or exceeds the Allowable Charge, or whenever payment has been made in error by Us for non-Covered Services, We will have the right to recover such payment from You or, if applicable, the Provider. As an alternative, We reserve the right to deduct from any pending Claim for payment under this Contract any amounts We are owed by You or the Provider.

T. 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 Us to the extent the veteran would be eligible for Benefits for such care

or services from Us if the care or services had not been furnished by a department or agency of the United States. The amount that the United States may recover will be reduced by the appropriate Deductible Amount and Coinsurance amount.

The United States will have the right to collect from Us the reasonable cost of dental 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 Us if the retiree or Dependent were to incur such cost on his own behalf. The amount that the United States may recover will be reduced by the appropriate Deductible Amount and Coinsurance amount.

U. 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.

V. Extension of Time Limitations

If any limitation for giving notice of Claim or bringing any action on this Contract is less than that allowed by the state, district or territory where You reside at the time this Contract is issued, the limitation is extended to comply with the law.

W. Liability of Plan Affiliates

You expressly acknowledge Your understanding that this Contract constitutes a Contract solely between You and Blue Cross and Blue Shield of Louisiana (the "Plan"), which 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 the Plan to use the Blue Cross and Blue Shield Service Marks in the State of Louisiana, and that the Plan is not contracting as the agent of the Association. You further acknowledge and agree that You have not entered into this Contract based upon representations by any person other than the Plan and that no person, entity, or organization other than the Plan shall be held accountable or liable to You for any of the Plan's obligations to You created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of the Plan other than those obligations created under other provisions of this Contract.

X. Out-of-Area Services

United Concordia Dental has a dental network that goes beyond the State of Louisiana, and extends to all 50 continental states, Hawaii, the District of Columbia and some U.S. territories. As a Member under this Contract you have access to this network. Please go to **www.ucci.com** or call 1-866-445-5338 to request information about Participating Providers near you.

The benefits under this Contract are not available through the Blue Cross and Blue Shield Association's BlueCard® Program.

ARTICLE XI. 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 healthcare 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 healthcare 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 healthcare 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:

The Plan of the parent whose Birthday falls earlier in the calendar year is the Primary plan; or

If both parents have the same Birthday, the Plan that has covered the parent the longest is the Primary plan.

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

(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 healthcare 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.

   a. 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.

b. 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. 0 A copy of Appendix C is also available on the Louisiana Department of Insurance's website at https://www.ldi.la.gov/docs/default-source/documents/legaldocs/regulations/reg32-appendixc.pdf?sfvrsn=24e14b52 .

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 healthcare 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 healthcare 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 are covered under another plan in addition to this one, we will be primary when:

   a. The claim is for your own healthcare 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 healthcare 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 healthcare 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 healthcare 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 healthcare 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 XII. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

We want to know when You are dissatisfied about the care or services received 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 written 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 the services, access, availability or attitude and those of Participating Providers. A quality of care concern addresses the appropriateness of care given to You.

1. To Register a Complaint

A Complaint is an oral expression of dissatisfaction with Us, UCD or with Provider services.
You may call UCD at 1-866-445-5338 to register a Complaint. UCD will attempt to resolve Your Complaint at the time of the call.

2. To File a Formal Grievance

A Grievance is a written expression of dissatisfaction with Us, UCD or with Provider services. If You do not feel Your Complaint was adequately resolved or You wish to file a formal Grievance, You must submit this in writing within one hundred eighty (180) days of the event that lead to the dissatisfaction. UCD Customer Service Department will assist You if necessary.

Send Your written Grievance to:

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

A response will be mailed to You within thirty (30) business days of receipt of Your written Grievance.

B. Standard Appeal Procedures

UCD will distinguish if Your Appeal is an administrative Appeal or a Dental Necessity Appeal.

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

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

Upon Your request and free of charge, we will provide You reasonable access to and copies of all documents, records, and other information relevant to Adverse Benefit Determination.

You have the right to appoint an authorized representative to speak on Your behalf in Your Appeals. An authorized representative is a person to whom You have given written consent to represent You in a review of an Adverse Benefit Determination. The authorized representative may be Your treating Provider, if You appoint the Provider in writing.

You may call UCD if You have questions or need assistance putting Your Appeal in writing.

All Appeals including administrative Appeals, Dental Necessity Appeals and Expedited Appeals should be submitted to:

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

1. Administrative Appeals

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

a. First Level Administrative Appeals

If You are 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 your concerns. If Your administrative Appeal is overturned, UCD will reprocess Your Claim, if any. If the administrative Appeal is upheld, UCD will inform You of Your right to begin the second level administrative Appeal process.

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

b. Second Level Administrative Appeals

After review of the first level administrative Appeal decision, if You are 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 You, Your authorized representative, or a Provider authorized by You to act on Your 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, healthcare setting, level of care, or effectiveness or is determined to be experimental or Investigational.

First Level Dental Necessity Appeals

If You are 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 Your concerns. If the Dental Necessity Appeal is overturned, UCD will reprocess Your Claim, if any. If the Dental Necessity Appeal is upheld, UCD will inform You of Your right to begin the second level Dental Necessity Appeal process.

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

a. Second Level Dental Necessity Appeals

After review of the first level Dental Necessity Appeal decision, if You are 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.

Your 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 You, Your authorized representative, or a Provider authorized by You to act on Your behalf, within thirty (30) days of the review.

C. 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 Your life, health or ability to regain maximum function. It includes a situation where, in the opinion of the treating Provider, You 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 You, Your authorized representative, or a Provider authorized to act on Your 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

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 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).

ພວກເຮົາມີບໍລິການແປພາສາໃຫ້ທ່ານຟຣີ. ຖ້າທ່ານຕ້ອງການບໍລິການນັ້ນ, ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ ທາງຫຼັງຂອງບັດປະຈຳຕົວຂອງທ່ານ. ຖ້າທ່ານຫູບໍ່ດີ, 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)