Traditional Blue Dental

Value

LIMITED BENEFIT CONTRACT

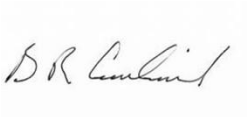
LOUISIANA BLUE

40XX1992 R01/26

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 the ID card and We will do Our best to assist You.

My best to You,



Bryan R. Camerlinck
President and Chief Executive Officer

INDIVIDUAL DENTAL CONTRACT

THIS IS A LIMITED BENEFIT CONTRACT – READ CAREFULLY

provided by

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

www.lablue.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 Your Covered Services on an amount known as the Allowable Charge. The Allowable Charge depends on the specific Provider from whom You receive 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 apples. 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 UCD) 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.lablue.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

The inclusion of any definition in this Article does not denote that any particular benefit, condition, diagnosis, procedure, service, or treatment is covered under this Contract. Please review the Contract in its entirety to determine Your Coverage.

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

A. Dental Necessity, appropriateness, healthcare setting, level of care, effectiveness or treatment that is determined to be experimental or Investigational;

B. the Member's eligibility for coverage under the Contract;

C. any prospective or retrospective review determination; or

D. a Rescission.

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 a Member's authorized representative to change an Adverse Benefit Determination made by Us.

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.

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.

Company – Means Blue Cross and Blue Shield of Louisiana.

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

Cosmetic Surgery/Treatment – Any operative procedure, treatment, or service, or any portion of an operative procedure, treatment or service performed primarily to improve physical appearance. An operative procedure, treatment or service is not considered Cosmetic Surgery if it restores bodily function or corrects deformity to restore function of a part of the body that an Accidental Injury, disease, disorder or covered Surgery has altered.

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:

A. 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;

B. 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

C. 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 treatment 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 of a dental healthcare service or treatment, which involves any of the following:

A. A medical condition for which the time frame for completion of a standard Appeal would seriously jeopardize the life or health of the Member or jeopardize the Member's ability to regain maximum function.

B. In the opinion of the treating Dentist, the Member may experience pain that cannot be adequately controlled while awaiting a standard Appeal decision

C. A decision to not Authorize services concerning availability of care, continued hospital stay, or healthcare service for which a Member has received emergency services, but has not been discharged from the facility.

Expedited External Appeal – A request for immediate review, by an Independent Review Organization, of an Adverse Benefit Determination of a dental healthcare service or treatment in the amount of $250.00 or more, which involves any of the following:

A. 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.

B. A decision to not Authorize continued services for Members currently in the emergency room, under observation, or receiving inpatient care.

C. A denial of coverage based on a determination that the recommended or requested dental healthcare service or treatment is experimental or investigational and the treating Provider 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 or the immediate and serious deterioration of the health of the Member.

External Appeal – A request for review by an Independent Review Organization, to change an initial Adverse Benefit Determination made by UCD or to change a final Adverse Benefit Determination rendered on Appeal. An External Appeal is available upon request by the Member or the Member's authorized representative only for Adverse Benefit Determinations of a dental healthcare service or treatment in the amount of $250.00 or more and that involving Dental Necessity, appropriateness of care, healthcare setting, level of care, effectiveness, experimental or investigational treatment, or a Recision.

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.

Independent Review Organization (IRO) – An entity, not affiliated with UCD, that conducts Dental Necessity reviews for External Appeals and Expedited External Appeals of Adverse Benefit Determinations. The decision of the IRO is binding on both Members and the Company, except to the extent that other remedies are available under state law.

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

Member – A Subscriber or an enrolled Dependent.

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

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.

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.

Over-Age Dependent – A Dependent Child (or Grandchild) who is age 26 or older, reliant on Subscriber for support, and is incapable of sustaining employment because of an intellectual or physical disability that began prior to age 26. Coverage of the Over-Age Dependent may continue after age 26 for the duration of incapacity if, prior to or within 31 days of the Dependent Child reaching age 26, an application for continued coverage with current medical information from the Dependent Child's attending Physician is submitted to Company. Company may require additional or periodic medical documentation regarding the Dependent Child's intellectual or physical disability as often as it deems necessary, but not more frequently than once per year after the two-year period following the child's 26th birthday. Company may terminate coverage of the Over-Age Dependent if Company determines the Dependent Child is no longer reliant on Subscriber for support or is no longer intellectually or physically disabled to the extent he is incapable of sustaining employment.

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

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 Enrollment 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.

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 – Cancellation or discontinuance of coverage that has retroactive effect. This includes a cancellation that treats a policy as void from the time of the group's enrollment or a cancellation that voids Benefits paid up to one year before the cancellation.

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 – A time period set forth in this Contract outside of the Open Enrollment Period when a Subscriber and eligible Dependents may enroll for coverage under this Contract or be removed 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 Joint (TMJ) Disorders – Disorders resulting in pain and/or dysfunction of the temporomandibular 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, THAT IS NOT MANDATED BY STATE OR FEDERAL LAW MAY BE DELETED OR REVISED ON THE SCHEDULE OF BENEFITS OR BY AMENDMENT.

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 twelve (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 eighteen (18) years old.

B. Eligibility

1. Subscriber. A Subscriber is a person of at least eighteen (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 or grandchild who is in the legal custody of and residing with the Subscriber, who is covered on the Plan before turning age twenty-six (26), and is able to remain

covered on the Plan once turning age 26 because he meets the definition and requirements of an Over-Age Dependent.

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 this Contract 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 and 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 and 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 Blue Cross and 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 under the special enrollment provision.

(3) 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:

(4) 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 or Exchange, paying premiums required for coverage, and completing any required forms.

(5) f 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 one (1) 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 three (3) or more years.

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

    d. 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 per lifetime for new patients only.

    b. Bitewing x-rays, limited to one (1) set every twenty-four (24) months for Members age nineteen (19) through twenty nine (29), and one (1) set every three (3) years for Members ages thirty (30) and older.

    c. Periapical intraoral films limited to four (4) every twelve (12) months and only when taken with a problem-focused evaluation or palliative emergency treatment.

3. Oral Cleanings (Prophylaxis)

    a. Limited to one (1) 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. Emergency (Palliative) Treatment one (1) every twelve (12) months.

B. Basic Services

1. Basic Restorations (posterior amalgam and anterior resin)

    a. Replacement of anterior resin-based composite restorations and posterior amalgam restorations only covered when they are not and cannot be made serviceable.

    b. Limited to one (1) per tooth, per surface, every five (5) years.

2. Endodontic (Pulpal) Therapy

    a. Pulpal debridement, limited to one (1) per tooth per lifetime.

3. Root Canal

    a. Limited to permanent teeth, one (1) per tooth per lifetime.

4. Simple Extractions, Surgical Extractions and Oral Surgery

    a. Only the following services will be covered:

        (1) Coronal remnants of primary teeth;

        (2) Simple extractions of erupted teeth or exposed roots;

        (3) Surgical removal of erupted teeth;

        (4) Removal of residual roots, cutting procedures.

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 any federal or state workers' compensation laws and/or related programs including, but not limited to, the Jones Act, Federal Employers Liability Act, Federal Employees Compensation Act, Longshore and Harbor Workers' Compensation Act, Black Lung Benefits Act, Energy Employees Occupational Illness Compensation Program, and Title 23 of the Louisiana Revised Statutes, whether or not coverage under such laws or programs is actually in force, the responsibility of 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. Our right of Subrogation is secondary to the right of the covered insured to be fully compensated for his damages

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

6. Anesthesia, sedation, and 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, maintenance and removal of implants.

11. For diagnostic services and treatment of jaw joint problems by any method. Examples of these jaw joint problems are Temporomandibular Joint (TMJ) Disorders or other conditions of the joint linking the jawbone 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 prosthetic dentures and bridges, or replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.

16. For preventative restorations.

17. For inlays, onlays, crowns, or crown repairs.

18. For surgical and non-surgical periodontics services.

19. For periodontal splinting of teeth by any method.

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

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

22. 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.

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

24. 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.

25. 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).

26. For procedures that are:

    a. part of a service but are reported as separate services; or

    b. reported in a treatment sequence that is not appropriate; or

    c. misreported or that represent a procedure other than the one reported.

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

28. Fees for broken appointments.

29. 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.

30. Fluoride treatments, space maintainers, sealants, and prefabricated stainless steel crowns.

31. 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.

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 according to 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.

1. Grievances must be submitted to the Section 1557 Coordinator within sixty (60) days of the date You become aware of the alleged discriminatory action.

2. 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.

3. 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.

4. The Section 1557 Coordinator will issue a written decision on the grievance no later than thirty (30) days after it is received.

5. You may appeal the decision of the Section 1557 Coordinator by writing to the Section 1557 Grievance Administrator within fifteen (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 thirty (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
1-877-696-6775

Complaint forms are available at: **http://www.hhs.gov/ocr/office/file/index.html**. Such complaints must be filed within one hundred eight (180) days of the date of the alleged discrimination.

Blue Cross and Blue Shield of Louisiana will make appropriate arrangements to ensure that people with disabilities and those with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this process. Such arrangements may include 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 make the 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. The Subscriber will be assessed a twenty-five dollar ($25.00) NSF fee should 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 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. The 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
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. The 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 grace period (delinquency period) from the due date of the premium. If We receive the premium during the grace period, coverage remains in effect pursuant to the provisions of the Contract. If We do not receive the premium due during the grace period, We will mail a delinquency or 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 the Subscriber's premium at Our home office within thirty (30) days of the due date (during the grace 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. The Company will be under no obligation to guarantee later coverage to the Subscriber or his Dependents during the Policy Year.

3. The Subscriber agrees to pay reasonable costs and fees to Us, including reasonable attorney's fees, for Our attempt to collect any amounts owed under this Contract, including, but not limited to, unpaid premium.

J. The 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 and the Participating Provider normally will be reimbursed directly. 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.

In certain situations, and only when permitted by the Claims Administrator, a Member may consent to allow a Non-Participating Provider to be reimbursed directly.

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 send it to:

United Concordia Dental
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, insurer or other carrier even where such insurer or carrier provides Benefits directly to You who are its insured. The acceptance of such Benefits under this Contract will constitute such subrogation. Our right to recover will be contingent on Your right to be fully compensated as determined by settlement of the parties in any claim for recovery or legal action, a ruling in a legal action by a court of competent jurisdiction, or a judgment following a trial. We will be responsible for Our proportionate share of the reasonable attorney fees and costs actually paid by You in pursuing recovery.

2. You will reimburse Us all amounts recovered by suit, settlement, or otherwise from any person, organization, insurer or other carrier, even where such insurer or carrier provides Benefits directly to You who are its insured, to the extent of the Benefits provided or paid under this Contract. Our right to recover will be contingent on Your right to be fully compensated as determined by settlement of the parties in any claim for recovery or legal action, a ruling in a legal action by a court of competent jurisdiction, or judgment following a trial. 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 interests under this Contract. We and Our designees have the right to obtain and review Your medical and billing records if We determine, in Our sole discretion, that such records would be helpful in pursuing Our right of subrogation and reimbursement.

4. You must 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:

Blue Cross and Blue Shield of Louisiana
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 in the month of February with notice of the date of that meeting being given as required by law and the articles and bylaws of the Louisiana Health and Service Indemnity Company. 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.

Y. Our Right to Offer Premium Incentives

We may, at Our discretion, offer rebates, refunds, reductions of premium, or other items of value, in amounts or types determined by Us, for business purposes and healthcare quality and improvement purposes, including but not limited to the following purposes:

1. Encouraging Members and/or policyholders to participate in quality programs;

2. Ensuring Members and/or policyholders are better able to afford benefits packages;

3. Reducing and alleviating social determinants of health;

4. Reducing transition costs for Members and/or policyholders who have changed insurers or have ended self-insured coverage and purchased fully insured coverage;

5. Rewarding Members and/or policyholders for choosing lower cost, quality healthcare providers;

6. Rewarding Members and/or policyholders for selecting lower cost, quality healthcare goods and products;

7. Rewarding Members and/or policyholders for utilizing digital and other paperless forms of communication of information, including but not limited to plan documents and materials; and

8. Reducing enrollment, technology, or administration costs of Members and/or policyholders, when such costs are related to effectuating and/or maintaining coverage.

ARTICLE XI. 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 You want to register a Complaint or file a formal written Grievance about Us, UCD or a Provider, please refer to the procedures below.

You may be dissatisfied about decisions made regarding Covered Services. UCD considers an Appeal as Your 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 the You within thirty (30) business days of receipt of Your written Grievance.

B. Standard Appeal Process

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

UCD will determine if Your Appeal is an administrative Appeal or a Dental Necessity Appeal. The Appeals procedure has two (2) levels, including review by a committee at the second level on an administrative Appeal and a review by an external Independent Review Organization (IRO) on a Dental Necessity Appeal.

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 should be submitted to:

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

1. Administrative Appeals

   Administrative Appeals involve contractual issues, which are not related to Dental Necessity, appropriateness, healthcare setting, level of care, effectiveness or treatment is determined to be experimental or investigational.

   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 receipt of the initial Adverse Benefit Determination for an administrative Appeal. 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 the You, Your authorized representative, or a Provider authorized by You to act on the 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 receipt of the first level administrative Appeal decision. Requests submitted to UCD after sixty (60) days of receipt 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 Appeal. 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.

We offer two (2) standard levels of Dental Necessity Appeals, including an internal review of the initial Adverse Benefit Determination, then an external review for Adverse Benefit Determinations in the amount of $250.00 or more.

a. Internal 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 receipt 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 the right to begin the External Appeal process if the Adverse Benefit Determination meets the criteria.

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.

b. External Dental Necessity Appeals

For Dental Necessity Appeals, the second level will be handled by an external Independent Review Organization (IRO) that is not affiliated with UCD and randomly assigned by the Louisiana Department of Insurance.

You must exhaust all internal Appeal opportunities prior to requesting an External Appeal conducted by an Independent Review Organization.

If You still disagree with the internal Dental Necessity Appeal decision, a written request for an External Appeal must be submitted within four (4) months of receipt of the internal Dental Necessity Appeal decision.

Requests submitted to Us after four (4) months of receipt of the internal Dental Necessity Appeal decision will not be considered. You are required to sign the form included in the internal Dental Necessity Appeal denial notice which authorizes release of medical records for review by the IRO.

Appeals submitted by Your Provider will not be accepted without this form completed with Your signature.

We will provide the IRO all pertinent information necessary to conduct the Appeal. The external review will be completed within forty-five (45) days of receipt of the External Appeal. The IRO will notify You, Your authorized representative, or a Provider authorized to act on Your behalf of its decision.

The IRO decision will be considered a final and binding decision on both You and UCD for purposes of determining coverage under a dental Plan. This Appeals process shall constitute your sole recourse in disputes concerning determinations of whether a service or item is or was Dentally Necessary or Investigational, except to the extent that other remedies are available under State or Federal law.

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 is a request concerning an Admission, availability of care, continued stay, or dental healthcare service for a covered person who is requesting Emergency services or has received Emergency services, but has not been discharged from a facility. Expedited Appeals are not provided for review of services previously rendered.

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.

For verbal Expedited Appeals, call 1-866-445-5338.

For written Expedited Appeals, fax 1-866-335-3969 or mail to UCD.

1. Expedited Internal Dental Necessity Appeals

   In these cases, UCD will make a decision no later than seventy-two (72) hours of receipt of an internal Expedited Appeal request that meets the criteria for Expedited Appeal.

   In any case where the internal Expedited Appeal process does not resolve a difference of opinion between UCD and the Member or the Provider acting on behalf of the Member, the Appeal may be elevated to an Expedited External Appeal.

   If an Expedited internal Dental Necessity Appeal does not meet the Expedited Appeal criteria or does not include the Provider attestation signature, the Appeal will follow the standard Appeal process and timeframe.

2. Expedited External Dental Necessity Appeal

   An Expedited External Appeal is a request for immediate review, by an Independent Review Organization (IRO). The request may be simultaneously filed with a request for an internal Expedited Appeal, since the Independent Review Organization assigned to conduct the expedited external review will determine whether the request is eligible for an external review at the time of receipt. UCD will forward all pertinent information for Expedited External Appeal requests to the IRO so the review may be completed within seventy-two (72) hours of receipt.

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, comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. Louisiana Blue does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

Louisiana Blue and its subsidiaries:

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

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, you can call the Customer Service number on the back of your ID card or email MeaningfulAccessLanguageTranslation@lablue.com. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Louisiana Blue or one of its subsidiaries 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 Louisiana Blue or one of its subsidiaries, file a grievance in person or by mail, fax or email.

   Section 1557 Coordinator
   In Person: 5525 Reitz Ave. Baton Rouge, LA 70809
   Mail: P. O. Box 98012, Baton Rouge, LA 70898-9012
   Phone: (225) 298-7238 or 1-800-711-5519 (TTY 711)
   Fax: (225) 298-7240
   Email: Section1557Coordinator@lablue.com

2. If your employer sponsors a self-funded health plan and Louisiana Blue only serves as the Claims Administrator, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Louisiana Blue or self-funded and sponsored by your employer, go to **www.lablue.com/checkmyplan**.

Whether you are fully insured or covered by a self-funded health plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

Mail: 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201
Phone: 1-800-368-1019, 1-800-537-7697 (TDD)

This notice is available at www.lablue.com.

NOTICE

Free language assistance services and auxiliary aids are available. If needed, please call the Customer Service number at 1-800-495-2583. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios de asistencia lingüística y ayudas auxiliares gratuitas. Si necesita ayuda, llame al Servicio de Atención al Cliente al 1-800-495-2583. Los clientes con discapacidad auditiva pueden llamar al 1-800-711-5519 (TTY 711).

Des services d'assistance linguistique gratuits et des aides auxiliaires sont disponibles. Si nécessaire, veuillez appeler le numéro du service client au 1-800-495-2583. Les clients malentendants peuvent appeler le 1-800-711-5519 (ATS 711).

Có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện hỗ trợ. Nếu cần, vui lòng gọi Dịch vụ khách hàng theo số 1-800-495-2583. Khách hàng khiếm thính vui lòng gọi 1-800-711-5519 (TTY 711).

免费提供语言协助服务和辅助工具。如有需要，请拨打客户服务电话 1-800-495-2583。听障客户请拨打 1-800-711-5519 (TTY 711)。

تتوفر خدمات مساعدة لغوية ووسائل مساعدة إضافية مجانية. وفي حال الحاجة إلى هذه الخدمات، يُرجى الاتصال بخدمة العملاء على الرقم 1-800-495-2583. يُرجى من العملاء ذوي الإعاقة السمعية الاتصال على الرقم 1-800-711-5519 (خدمة الهاتف النصي 711).

Mayroong mga libreng serbisyo sa tulong sa wika at karagdagang tulong. Kung kailangan ito, mangyaring tawagan ang numero ng Serbisyo sa Customer sa 1-800-495-2583. Para sa mga customer na may kapansanan sa pandinig, tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 지원 서비스와 보조 도구를 이용하실 수 있습니다. 필요한 경우 고객 서비스 번호 1-800-495-2583으로 전화해 주시기 바랍니다. 청각 장애가 있는 고객은 1-800-711-5519(TTY 711)로 전화하십시오.

Serviços de assistência de idioma e demais auxílios disponíveis gratuitamente. Se necessário, ligue para o Atendimento ao Cliente no telefone 1-800-495-2583. Clientes com deficiência auditiva devem ligar para 1-800-711-5519 (TTY 711).

ມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ເຄື່ອງຊ່ວຍເສີມຟຣີ. ຖ້າຕ້ອງການ, ກະລຸນາໂທຫາບໍລິການລູກຄ້າ ທີ່ເບີ 1-800-495-2583. ລູກຄ້າທີ່ພິການຫູ ໃຫ້ໂທຫາ 1-800-711-5519 (TTY 711).

無料の言語アシスタンスサービスと介助用補助具をご利用いただけます。必要な場合は、カスタマーサービス番号1-800-495-2583までお電話ください。聴覚に障害のあるお客様は、1-800-711-5519 (TTY 711)までお電話ください。

زبان کے سلسلے میں مفت معاونت کی سہولیات اور اضافی معاونتیں دستیاب ہیں. ضرورت پڑنے پر کسٹمر سروس سے ان نمبر پر رابطہ کریں: 1-800-495-2583. سماعت کی کمی کے شکار افراد اس نمبر پر کال کریں: 1-800-711-5519 (TTY 711)

Bei Bedarf stehen Ihnen kostenlose Sprachhilfen und andere unterstützende Dienste zur Verfügung. Bitte wenden Sie sich dazu telefonisch an den Kundenservice unter 1-800-495-2583. Sollten Sie schwerhörig sein, wählen Sie bitte die 1-800-711-5519 (TTY 711).

خدمات کمک زبانی رایگان و ابزارهای کمکی جانبی در دسترس هستند. در صورت نیاز، لطفاً با «خدمات مشتریان» به شماره 1-800-495-2583 تماس بگیرید. مشتریان کم‌شنوا با 1-800-711-5519 (TTY 711) بگیرند.

Мы предоставляем бесплатные услуги языковой поддержки и вспомогательное оборудование. При необходимости позвоните в службу поддержки клиентов по номеру 1-800-495-2583. Телефон для клиентов с нарушениями слуха — 1-800-711-5519 (TTY 711).

มีบริการช่วยเหลือด้านภาษาและเครื่องสนับสนุนฟรี หากจำเป็น โปรดโทรติดต่อฝ่ายบริการลูกค้าได้ที่หมายเลข 1-800-495-2583 ลูกค้าที่มีความบกพร่องทางการได้ยิน โปรดโทรไปที่หมายเลข 1-800-711-5519 (TTY 711)