

Group Blue Dental

LIMITED BENEFIT CONTRACT

LOUISIANA BLUE

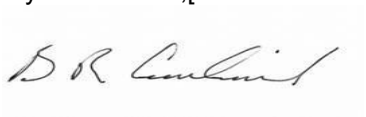
Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

97176EX-040 R01/27

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

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association

GROUP DENTAL BENEFIT PLAN

THIS IS A LIMITED BENEFIT PLAN – READ CAREFULLY

provided by



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

www.lablue.com

NOTICES

HEALTHCARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTHCARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE OUT-OF-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR COPAYMENTS, COINSURANCE, DEDUCTIBLES, AND NON-COVERED SERVICES.

SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT **WWW.LABLUE.COM** OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER OF YOUR HEALTH PLAN.

YOUR SHARE OF THE PAYMENT FOR HEALTHCARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.

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.

Important information regarding this Plan will be sent to the mailing address You provided on the Employee Enrollment / Change Form. **You are responsible for keeping Us and the Group informed of any changes in Your address of record.**

BLUE DENTAL
GROUP DENTAL BENEFIT PLAN

TABLE OF CONTENTS

ARTICLE I.	**UNDERSTANDING THE BASICS OF YOUR COVERAGE**	**5**
ARTICLE II.	**DEFINITIONS**	**6**
ARTICLE III.	**SCHEDULE OF ELIGIBILITY**	**11**
ARTICLE IV.	**PEDIATRIC BENEFITS**	**17**
ARTICLE V.	**EXCLUSIONS FOR PEDIATRIC BENEFITS**	**23**
ARTICLE VI.	**ADULT BENEFITS**	**25**
ARTICLE VII.	**EXCLUSIONS FOR ADULT BENEFITS**	**28**
ARTICLE VIII.	**PRE-DETERMINATIONS**	**30**
ARTICLE IX.	**ALTERNATE BENEFITS**	**31**
ARTICLE X.	**COORDINATION OF THIS BENEFIT PLAN WITH OTHER DENTAL COVERAGE OF WHICH THIS BENEFIT PLAN FORMS A PART**	**32**
ARTICLE XI.	**BENEFIT EXTENSION PERIOD AFTER TERMINATION OF COVERAGE**	**33**
ARTICLE XII.	**CONTINUATION OF COVERAGE RIGHTS**	**34**
ARTICLE XIII.	**GENERAL PROVISIONS – GROUP/POLICYHOLDER AND MEMBERS**	**35**
ARTICLE XIV.	**COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES**	**48**
ARTICLE XV.	**ERISA RIGHTS**	**52**
ARTICLE XVI.	**MAKING PLAN CHANGES AND FILING CLAIMS**	**54**
ARTICLE XVII.	**GENERAL PROVISIONS – GROUP/POLICYHOLDER ONLY**	**56**

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. There are two possible Schedules of Dental Benefits available for this Contract: one that applies to the Pediatric Benefits Section, and one that applies to the Adult Benefits Section. The Schedule will describe the Section to which it applies. The Benefits offered under both of these Sections are limited as stated in each Section.

UNITED CONCORDIA DENTAL

United Concordia Companies, Inc. d/b/a United Concordia Dental (hereinafter United Concordia Dental or 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 Section, 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.

THIS COVERAGE AND THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (the Affordable Care Act) were signed into law in March, 2010. Many of the provisions of the Affordable Care Act become effective at the Contract effective date in 2014. This coverage is compliant with the Affordable Care Act and, if children under age 19 are enrolled, provides the pediatric dental benefits that are part of the Essential Health Benefits required by law.

Coverage under the Affordable Care Act can be purchased either (1) through the SHOP, with or without the assistance of an agent/producer; or (2) through Blue Cross and Blue Shield of Louisiana directly, or through an agent/producer. The SHOP is the Small Employer Health Options marketplace that is operated by the federal government for the State of Louisiana. Coverage purchased through the SHOP is called On-SHOP coverage. Coverage purchased directly from Company or from an agent/producer is called Off-SHOP coverage. **Several important parts and provisions of this Contract are different based on whether this coverage was purchased On-SHOP or Off-SHOP. Please refer to the Schedule of Benefits to determine if your coverage is On-SHOP or Off-SHOP coverage so you will know which Contract language applies to you.**

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 Benefit Plan. Please review the Benefit Plan 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 Benefit Plan;
C. any prospective or retrospective review determination;
D. a Rescission.

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

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

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

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

Benefit Plan – Means this Group Dental Benefits Contract.

Child Member – A Subscriber or Dependent that is under age 21 on this Benefit Plan's Effective Date.

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

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

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

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

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

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

Cosmetic Surgery/Treatment – Any 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 or treatment if 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 Benefit Plan for which Benefits are available when rendered by a Provider.

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

Deductible – The dollar amount, if shown in the Schedule of Dental Benefits, of Allowable Charges for Covered Services that each Member must pay within a Benefit Period before payments are made under this Benefit Plan. If shown in the Schedule of Benefits, the Deductible 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 UCD 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 UCD.

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.

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.

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

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

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

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

Exchange – The health insurance marketplace that is operated by the federal government for the State of Louisiana under Section 1311 of the Patient Protection and Affordable Care Act. Group coverage purchased through this health insurance marketplace, with or without the assistance of an agent/producer, is called On-

Exchange or On-SHOP coverage. Coverage purchased by the Group either directly from Company or through and agent/producer is called Off-Exchange or Off-SHOP coverage.

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 involving Dental Necessity, appropriateness of care, healthcare setting, level of care, effectiveness, experimental or investigational treatment or a Rescission.

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

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

Gingivectomy – Surgical removal of gum tissue.

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

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

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

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.

Maxillofacial Prosthetics – Artificial devices that replace missing body parts of the head and neck region due to cancer, surgery, trauma, or birth defects.

Member – A Subscriber or an enrolled Dependent.

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.

Occlusal Guard – A horseshoe shaped piece of plastic which is worn over the teeth to protect them against damage caused by clenching or grinding. It works by creating a physical barrier between the patient's upper and lower teeth so that he/she bites against the plastic rather than wearing down his/her teeth.

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

Orthodontics – A dental specialty that treats misalignment of teeth.

Open Enrollment Period – A period of time each year designated by the Group or by federal government, during which a Subscriber and his eligible Dependents may enroll for coverage under this Benefit Plan. For enrollment through the SHOP, the Open Enrollment Period shall be thirty (30) days or longer, as required by federal law.

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.

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.

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 UCD. 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.

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

Provider Agreement – An agreement for payment contracted by UCD 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 UCD and the Participating Provider.

Qualified Health Plan – A plan that is determined as qualified to be sold through the Exchange under Section 1301 of the Patient Protection and Affordable Care Act.

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.

SHOP – The Small Group Health Insurance Options Program marketplace that is operated by the federal government for the State of Louisiana under Section 1311 of the Patient Protection and Affordable Care Act. Coverage purchased through this health insurance marketplace is called On-SHOP coverage. Coverage purchased either directly from Company or through and agent/producer is called Off-SHOP coverage.

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 Benefit Plan outside of the Open Enrollment Period when a Subscriber and eligible Dependents may enroll for coverage under this Benefit Plan or be removed from coverage under this Benefit Plan.

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.

Resin-Based Composite – Material composed of plastic with small glass or ceramic particles, which resemble the appearance of natural teeth.

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.

Traditional Orthodontic Services – Treatment for poor alignment and occlusion of teeth that is not considered to be Medically or Dentally Necessary.

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

ARTICLE III. SCHEDULE OF ELIGIBILITY

FOR COVERAGE PURCHASED OFF-SHOP: THE COMPANY WILL ESTABLISH AN ENROLLMENT PROCESS AND DETERMINE ELIGIBILITY FOR GROUP AND ITS ELIGIBLE MEMBERS.

FOR COVERAGE PURCHASED ON-SHOP: THE SHOP WILL ESTABLISH AN ENROLLMENT PROCESS AND DETERMINE ELIGIBILITY FOR GROUP AND ITS ELIGIBLE MEMBERS.

COMPANY'S ENROLLMENT PROCESSES ARE DESCRIBED BELOW. WHEN COVERAGE IS PURCHASED ON-SHOP (THROUGH THE SHOP), THE SHOP WILL APPLY ITS PROCESSES AND MAKE ELIGIBILITY, ENROLLMENT, AND EFFECTIVE DATE DETERMINATIONS WHICH MAY DIFFER FROM COMPANY'S PROCESSES SET FORTH BELOW.

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

NO ONE MAY BE ENROLLED SIMULTANEOUSLY AS AN EMPLOYEE AND AS A DEPENDENT UNDER THE BENEFIT PLAN, NOR MAY A DEPENDENT BE COVERED BY MORE THAN ONE EMPLOYEE.

A. Eligibility

1. Subscriber. To be eligible to enroll as a Subscriber, an individual must be:

   a. an Eligible Employee of Group who has satisfied any criteria designated by Company or SHOP to subscribe to this policy, has satisfied any Eligibility Waiting Period required by the Group, and who is working the number of hours required by the Company to enroll in this coverage.

   b. a retiree who satisfies any criteria designated by Us, and if shown as covered in this Group's Benefit Plan Schedule of Dental Benefits.

   c. an elected official who satisfies any criteria designated by Us, and if shown as covered in this Group's Benefit Plan Schedule of Dental Benefits.

2. Dependent. To be eligible to apply as a Dependent, an individual must meet the following criteria at the time of enrollment. To be eligible to maintain Dependent coverage, an individual must continue to meet the criteria. Failure to continually meet the criteria thereafter may result in a determination by the Company that the Dependent is no longer eligible for coverage and Dependent Benefits may be terminated in the manner described in this Benefit Plan:

B. Spouse

1. CHILDREN: A child under age twenty-six (26) who is one of the following:

   a. born of the Subscriber; or

   b. legally placed for adoption with the Subscriber; or

   c. legally adopted by the Subscriber; or

   d. 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

   e. a child supported by the Subscriber pursuant to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN); or

   f. a stepchild of the Subscriber; or

g. a grandchild residing with the Subscriber, provided the Subscriber has been granted legal custody or provisional custody by mandate of the grandchild; or

h. 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. Application for Coverage

When coverage is purchased through the SHOP, applications, changes, and terminations must be made through the SHOP. The SHOP will determine and verify eligibility to enroll in this Contract and establish an Effective Date for coverage. Application for enrollment must be made through the SHOP during the Group's annual Open Enrollment Period each year, which will be at least 30 days in length. After the initial Open Enrollment Period, qualified persons generally may enroll in or change coverage only during subsequent Open Enrollment Periods or, if an individual becomes eligible outside the annual Open Enrollment Period, he may apply for coverage beginning on the date he becomes eligible. A qualified individual may also enroll in coverage during a Special Enrollment Period available after certain trigger events occur.

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

Every Eligible Person may enroll for coverage under this Benefit Plan and may include any eligible Dependents on such enrollment form.

The Group will submit any such enrollment forms to the Company as a prerequisite to coverage under this Benefit Plan.

No person will be covered under this Benefit Plan unless the Company has accepted the enrollment form and has been issued an identification card or other written notice of acceptance. Payment of premiums to the Company for any person will not effectuate coverage unless and until the Company's identification card or other written acceptance has been issued, and in the absence of such issuance, the Company's liability will be limited to refund of the amount of premiums paid.

This Group dental Benefit Plan and coverage under it will not be issued or renewed unless the percentage of Eligible Persons specified in the Application for Group Coverage is enrolled.

D. Available Classes of Coverage as Selected by the Group

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

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

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

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

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

5. Subscriber and Dependent coverage means coverage for the Subscriber and one Dependent.

E. Effective Date

On-Exchange coverage: The SHOP will establish the Effective Date of coverage. In the event that any Effective Date established by the SHOP does not fall on the first day of a month, the group will be charged the corresponding premium for the portion of the month for which the Member(s) is (are) enrolled.

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

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

If a person becomes an Eligible Person after this Group's Benefit Plan Date, and enrolls for coverage for self or for self and any eligible Dependent(s) and the enrollment form is received by the Company within thirty (30) days of the eligibility date, the Effective Date of coverage will be the eligibility date.

If an Eligible Person's application for coverage for self or for self and any eligible Dependent(s) is not received by Us within thirty (30) days of the eligibility date or Special Enrollment Period as described below, the request for enrollment will be denied. The Eligible Person shall be eligible to enroll for coverage during the next Open Enrollment Period. If the Eligible Person timely enrolls during the next Open Enrollment Period.

If a child is born to a Subscriber holding coverage which includes Dependent children (Subscriber and Family coverage or Subscriber and Child(ren) coverage), and the enrollment form is received by the Company within one hundred eighty (180) days of the date of birth, the Effective Date of coverage will be the date of birth.

F. Court Ordered Determination

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

G. Special Enrollment

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

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

1. The Eligible Person must be eligible for coverage under the terms of this Benefit Plan; and

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

3. Examples of Special Enrollment events are:

4. Enrollment or non-enrollment in this Benefit Plan was due to an error, misrepresentation or inaction of an officer, employee or agent of the SHOP or the United States Department of Health and Human Services, or their instrumentalities.

5. Company's substantial violation of a material provision of this Benefit Plan.

6. Gaining access to new Qualified Health Plans because of a permanent move.

7. Being an Indian, as defined in Section 4 of the Indian Health Care Improvement Act.

8. Meeting other exceptional circumstances as determined by the SHOP.

9. The Subscriber gaining a Dependent or gaining dependent status under another health plan through marriage, birth, adoption, placement for adoption or mandate granting legal or provisional custody. Premiums may be adjusted for the additional coverage if adding the new Dependent changes the class of coverage under the Benefit Plan.

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

   a. If not already participating, Eligible Employee may enroll with the Dependent if he has served any applicable Eligibility Waiting Period but has not enrolled during a previous enrollment period. In the case of the birth, adoption, or placement for adoption of a child, the Spouse of the employee may be enrolled as a Dependent if the Spouse is otherwise eligible for coverage.

   b. If the Group offers multiple health plan options, another option may be chosen by the Eligible Employee for himself and Dependents when special enrollee status applies.

   c. There may be a thirty (30) day period of automatic coverage for Newly-Born Infants (natural born or adopted), as described below. Any period of automatic coverage runs concurrently with the Special Enrollment Period for adding these infants to this Benefit Plan.

   d. The Special Enrollment Period described in this subparagraph is a period of no less than thirty (30) days and shall begin on the later of the date Dependent coverage is made available or the date of the marriage, birth, adoption, or placement for adoption. If the request for enrollment is not made timely, the request will be denied and any period of automatic coverage for Newly-Born Infants will end.

   e. In the case of a birth, adoption, or placement for adoption, a current employee may enroll himself, his Spouse and/or the newborn/adopted child and other eligible Dependent children, the enrollment must be requested no later than thirty (30) days after the birth, adoption, or placement for adoption. If the enrollment form is received by a Blue Cross and Blue Shield of Louisiana office or the SHOP no later than thirty (30) days of the birth, adoption, or placement for adoption, coverage will become effective on the date of birth for a natural Newly Born Infant, and upon the date of adoption, or placement for adoption for an adopted Newly Born Infant. The SHOP will assign the Effective Date of coverage if special enrollment is made through the SHOP. A Subscriber may enroll an unborn natural child prior to birth; however, coverage will not be effective until the date of birth. Adopted children will not be effective on the date of birth. If the request for enrollment is not made and received by Us or the SHOP within thirty (30) days of birth, adoption or placement for adoption, the request for Special Enrollment will be denied and any automatic coverage period will end.

   f. In the case of marriage, a current Eligible Employee may enroll himself and the new Dependents acquired because of the marriage. The enrollment must be requested within thirty (30) days of the marriage. The Special Enrollment will be denied if the enrollment is not requested within thirty (30) days of the marriage.

10. Loss of minimum essential coverage during the Plan Year as that term is defined under Internal Revenue Code Section 5000A, such as:

    a. Medicare.

    b. Medicaid or the Children's Health Insurance Program (CHIP), if either:

(1) The Eligible Employee or Dependent is covered under Medicaid or Children's Health Insurance Program (CHIP), and lose that coverage because of loss of eligibility; or

(2) the Eligible Employee or Dependent becomes eligible for premium assistance under the CHIP program.

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

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

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

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

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

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

g. Health plans purchased in the individual health insurance market within a State of the United States.

h. Coverage under the health benefits risk pool of a State of the United States.

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

j. Another employer-sponsored plan.

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

(1) Termination of employment (except for gross misconduct),

(2) Reduction of work hours,

(3) Death,

(4) Divorce,

(5) Loss of dependent status,

(6) Termination of employer contributions towards a person's coverage,

(7) The plan stops offering benefits to a certain class of similarly situated individuals,

(8) Changing residence to an area not served by the plan, or

(9) Exhaustion of COBRA continuation coverage because of:

(a) the full COBRA continuation period was exhausted;

(b) the employer or other responsible entity failed to remit required premiums on a timely basis;

(c) the individual whose coverage is through a Health Maintenance Organization (HMO), no longer lives, resides or works in the service area the HMO services, whether or not the choice of the individual in the service area, and there is no other COBRA coverage available;

(d) the individual incurs a Claim that would meet or exceed a lifetime limit on all Benefits and there is no other COBRA continuation coverage available to the individual;

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

ARTICLE IV. PEDIATRIC BENEFITS

The dental benefits described in this Section are available only for Members under 21 years old. Members that were under 21 years old when they enrolled in this Benefit Plan, and during the Policy Year attain age 21, will continue to be covered under this Section until the end of that Policy Year.

In accordance with federal law, We will provide benefits for all required pediatric dental services. Services will be subject to any duration and frequency limits and exclusions as identified in the federal benchmark plan.

For the In-Network unlimited Dental Benefits, the Schedule of Dental Benefits will contain an Out of Pocket (OOP) Yearly Maximum per Child Member, and an Out of Pocket (OOP) Yearly Maximum per 2 or more Child Members. Each will apply depending on how many Child Members are covered under this Benefit Plan.

If there is only one Child Member, the Out of Pocket (OOP) Yearly Maximum per Child Member will apply, which is the maximum dollar amount that the Child Member will have to pay out of his/her own pocket during a Policy Year. Once the Child Member pays the maximum OOP in deductible and coinsurance for covered Benefits, the Member's Benefits will be 100% covered until the end of the Policy Year. To the contrary, if there are two or more Child Members covered under this Benefit Plan, the Out of Pocket (OOP) Yearly Maximum per 2 or more Child Members will apply. Once that maximum OOP amount is paid in deductible and coinsurance for covered Benefits by any Child Member, all the Child Members will be 100% covered until the end of the Policy Year.

These OOP maximums are accumulated when the covered Benefits are received by the Child Member from Participating Providers. Any out of pocket amounts paid by Members for services received from Non-Participating Providers will not accrue to any of these OOP maximums.

If included, Traditional Orthodontic Services will be subject to a Traditional Orthodontic Services Lifetime Maximum, as described below. Once this Lifetime Maximum is reached, no more Benefits will be available for the life of the Member.

After any applicable Waiting Period, and after the Member's payment of the corresponding deductible and coinsurance, according to the Schedule of Dental Benefits, this Benefit Plan will cover:

A. Diagnostic and Preventive Services

1. Oral Exams

    a. One periodic, limited problem-focused or comprehensive oral exam every 6 months.

    b. One detailed problem-focused oral evaluation per patient per provider every 12 months per eligible diagnosis.

2. Oral Cleanings (Prophylaxis)

    a. Limited to one every 6 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.

3. Fluoride Treatment

    a. Limited to children under 19 years old, and

    b. Limited to two topical application every 12 months.

4. Sealants

    a. Limited to children under 19 years old, and only for permanent first and secondary molars, and

    b. Limited to one per tooth every 36 months.

5. Consultations

    a. Diagnostic services provided by a dentist or physician other than the practitioner providing the dental treatment.

6. Emergency (Palliative) Treatment

    a. Limited to 2 per 12 months in combination with pulpal debridement.

7. Oral Radiographs (x-rays)

    a. Complete series intraoral x-rays or panoramic film x-rays, limited to one film every 60 months.

    b. Bitewing x-rays, limited to one set every 6 months.

8. Space Maintainers

    a. Covered when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars or deciduous molars and permanent first molars that have not , or will not, develop; and

    b. Includes coverage for recementation of space maintainer.

    c. Limited to members under age 14.

    d. Limited to 1 per tooth per 5 years.

B. Basic Services

1. Simple Extractions

    a. Extraction of erupted tooth or exposed root.

2. Amalgam Restorations (Metal Fillings)

3. Resin-Based Composite Restorations (White Fillings)

4. Crown Repairs

    a. Recementation, restoration and pin retention

        (1) Recementation that becomes necessary during the first 12 months following insertion by the same Provider is considered to be a part of the original benefit.

5. Prefabricated Stainless Steel Crowns

    a. Limited to Members under 15 years old; and

    b. Limited to one per tooth every 60 months.

6. Endodontic (Pulpal) Therapy

    a. Only covered if performed after 45 days from a Root Canal, otherwise will be considered part of the Root Canal.

    b. Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11.

    c. Limited to one per eligible tooth per lifetime.

7. Root Canal

8. Surgical Periodontics

    a. Gingivectomy or Gingivoplasty, limited to one every 36 months.

    b. Gingival flap procedure, limited to one every 36 months.

    c. Clinical crown lengthening, limited to 1 per tooth per lifetime.

    d. Osseous surgery, limited to one every 36 months.

    e. Guided tissue regeneration, limited to one per tooth per lifetime.

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

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

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

    i. Full mouth debridement to enable comprehensive evaluation and diagnosis, limited to one per lifetime.

9. Non-Surgical Periodontics

    a. Periodontal scaling and root planing, limited to one every 24 months for each area of the mouth.

10. Periodontal Maintenance

    a. Limited to 4 every 12 months in addition to routine Prophylaxis.

11. Surgical Extractions

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

12. Oral Surgery

    a. Removal of impacted tooth.

    b. Surgical removal of residual tooth roots.

    c. Coronectomy-intentional partial tooth removal.

    d. Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.

    e. Surgical access to an unerupted tooth, limited to 1 per tooth per lifetime.

    f. Alveoloplasty.

    g. Removal of exostosis.

    h. Incision and drainage of intraoral soft tissue abscess.

    i. Suture of recent small wounds.

    j. Excision of pericoronal gingiva.

13. Anesthesia

a. Anesthesia for dental services covered only when Dentally Necessary.

b. Includes:

(1) Deep sedation/general anesthesia; and

(2) Nitrous oxide or intra-venous conscious sedation/analgesia.

14. Adjustments and Replacement of Prosthetic Dentures.

15. Other Prosthetic Services

a. Rebase, repair or reline of mandibular or maxillary complete or partial dentures, limited to one every 36 months.

b. Covered only after 6 months after the initial installation.

c. Recementation or repair of fixed partial denture

(1) Recementation during the first twelve months following insertion from the same Dentist is included in the Prosthetic Dentures Benefit.

C. Major Services

1. Prosthetic Dentures

a. Includes complete, fixed, partial or removable partial dentures.

b. Limited to one every 60 months.

2. Inlays, Onlays and Crowns

a. Crowns, inlays, onlays, core buildup including pins, and prefabricated post and core; and

b. All limited to one per tooth every 60 months.

3. Dental Implants

a. Implants must be Dentally Necessary and are covered only when the arch cannot be restored with a standard prosthesis or restoration.

b. The following implant benefits are limited to one every 60 months:

(1) endosteal, eposteal, and transosteal implants;

(2) implant supported complete or partial dentures;

(3) connecting bar;

(4) prefabricated abutment;

(5) abutment supported crowns;

(6) implant supported crowns;

(7) abutment supported retainers for dentures;

(8) implant supported retainers for dentures;

(9) implant maintenance procedures;

(10) repair of implant prosthesis;

(11) replacement of semi-precision or precision attachment;

(12) repair of implant abutment;

(13) implant removal; and

(14) implant index.

c. Implant supported complete or partial dentures.

4. Occlusal Guard

a. Limited to one every 12 months; and

b. Limited to patients that are 13 years of age and older.

5. Adjunctive General Services

a. Therapeutic drug injection

b. Treatment of complications from oral surgery in unusual circumstances (for example but not limited to, treatment of dry socket following extraction or removal of bony sequestrum).

D. Traditional Orthodontic Services

If shown as included in the Schedule of Dental Benefits, Traditional Orthodontic Services will be covered for Members under age 19. This Benefit will be subject to the Traditional Orthodontic Services Lifetime Maximum specified in the Schedule of Dental Benefits.

Authorization is required for coverage. An explanation of the plan of treatment must be submitted to UCD. Upon review of the information, UCD will notify You and Your dentist of the reimbursement schedule, frequency of payment over the course of the treatment, and Your share of the cost.

Benefits include services for limited, interceptive and comprehensive Orthodontic treatment of the primary, transitional and adolescent dentition in addition to removable and fixed appliance therapy. Treatment visits are provided for pre-orthodontic, periodic orthodontic and orthodontic retention.

E. Medically Necessary Orthodontics

Orthodontic services will only be covered under this Section if the Member fits the following criteria:

1. Members must have a fully erupted set of permanent teeth to be eligible for comprehensive orthodontic services.

2. All orthodontic services require Authorization**,** a written plan of care, and must be rendered by a Provider.

3. Orthodontic treatment must be considered medically necessary and be the only method considered capable of:

a. Preventing irreversible damage to the member’s teeth or their supporting structures.

b. Restoring the member’s oral structure to health and function.

4. A medically necessary orthodontic service is an orthodontic procedure that occurs as a part of an approved orthodontic treatment plan that is intended to treat a severe dentofacial abnormality or serious handicapping malocclusion. **Orthodontic services for cosmetic purposes are not covered.**

5. Orthodontia procedures will only be approved for dentofacial abnormalities that severely compromise the member's physical health or for serious handicapping malocclusions. Presence of a serious handicapping malocclusion is determined by the magnitude of the following variables: degree of malalignment, missing teeth, angle classification, overjet and overbite, open bite, and crossbite.

6. Dentofacial abnormalities that severely compromise the member's physical health may be manifested by:

    a. Markedly protruding upper jaw and teeth, protruding lower jaw and teeth, or the protrusion of upper and lower teeth so that the lips cannot be brought together.

    b. Under-developed lower jaw and receding chin.

    c. Marked asymmetry of the lower face.

7. A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the recipient by causing:

    a. Obvious difficulty in eating <u>because of the malocclusion,</u> so as to require a liquid or semisoft diet, cause pain in jaw joints during eating, or extreme grimacing or excessive motions of the orofacial muscles during eating because of necessary compensation for anatomic deviations.

    b. Obvious severe breathing difficulties <u>related to the malocclusion,</u> such as unusually long lower face with downward rotation of the mandible in which lips cannot be brought together, or chronic mouth breathing and postural abnormalities relating to breathing difficulties.

    c. Lisping or other speech articulation errors that are <u>directly related to orofacial abnormalities</u> and cannot be corrected by means other than orthodontic intervention.

ARTICLE V. EXCLUSIONS FOR PEDIATRIC BENEFITS

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

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

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

3. The responsibility of 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 treating any automobile-related injury in which the Member is entitled to payment under an automobile insurance policy. Benefits would be more than the third-party benefits and therefore, We would have right of recovery for any benefits paid in excess. Our right of Subrogation is contingent on the right of the covered insured 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.

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

5. Maxillofacial prosthetics.

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

7. For congenital mouth malformations or skeletal imbalances (for example, but not limited to, treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment). Coverage for Cleft Lip and Cleft Palate Services is provided in the Other Covered Services, Supplies or Equipment Article of this Benefit Plan.

8. For diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Certificate. 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.

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

10. For treatment of malignancies or neoplasms.

11. 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.

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

13. For periodontal splinting of teeth by any method.

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

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

16. For plaque control programs, oral hygiene and dietary instructions.

17. 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.

18. For treatment and appliances for bruxism (night grinding of teeth), with exception of an Occlusal Guard.

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

20. 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).

21. 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.

22. For specialized procedures and techniques (for example but not limited to, precision attachments, copings and intentional Root Canal treatment).

23. Fees for broken appointments.

24. 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 UCD will apply.

25. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.

ARTICLE VI. ADULT BENEFITS

The Benefits under this Section apply to Members age 21 and older. After any applicable Waiting Period, and after the Member's payment of the corresponding deductible and coinsurance, according to the Schedule of Dental Benefits, this Benefit Plan will cover the Benefits as described in this Section. Benefits will be covered up to the Annual Maximum Benefit per Member stated in the Schedule of Dental Benefits.

A. Diagnostic and Preventive Services

1. Oral Exams

    a. Two periodic or comprehensive oral exams every 12 months.

    b. Once a comprehensive evaluation is paid, the Member is not eligible to undergo the same service with the same Provider, unless there is a significant change in health condition or the Member is absent from the Provider for 3 or more years.

    c. One limited problem-focused oral exam and consultations per Provider per patient per 12 months.

    d. One detailed problem-focused oral evaluation per Provider, per patient per diagnosis every 12 months.

2. Oral Cleanings (Prophylaxis)

    a. Limited to two every 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.

3. Consultations

    a. Diagnostic services provided by a dentist or physician other than the practitioner providing the dental treatment limited to 1 every 12 months.

4. Emergency (Palliative) Treatment

    a. Limited to 2 per 12 months in combination with pulpal debridement.

5. Oral Radiographs (x-rays)

    a. Complete series intraoral x-rays or panoramic film x-rays, limited to once every 60 months.

    b. Bitewing x-rays, limited to one set every 18 months.

B. Basic Services

1. Simple Extractions

    a. Extraction of erupted tooth or exposed root.

2. Amalgam Restorations (Metal Fillings)

3. Resin-Based Composite Restorations (White Fillings)

    a. Replacement of restorative services only when they are not and cannot be made serviceable.

    b. Basic restoration will not be covered if replaced within 24 months of previous placement of any basic restoration.

4. Crown Repairs

    a. Recementation, restoration and pin retention

        (1) Limited to one every 36 months.

        (2) During the first 12 months following insertion of any preventive, restorative or prosthodontics service by the same Provider, this benefit is considered included in the preventive, restorative or prosthodontics service benefit.

5. Endodontic (Pulpal) Therapy

    a. Only covered if performed after 45 days from a Root Canal, otherwise will be considered part of the Root Canal.

    b. Eligible teeth limited to primary anterior teeth and primary posterior molars when there is no permanent tooth to replace it.

    c. Limited to one per eligible tooth per lifetime.

6. Root Canal

    a. Limited to one per tooth per lifetime.

7. Surgical Periodontics

    a. Gingivectomy or gingivoplasty, limited to one every 36 months;

    b. Gingival flap procedure limited to one every 36 months;

    c. Clinical crown lengthening, limited to 1 per tooth per lifetime;

    d. Osseous surgery, limited to one every 36 months;

    e. Guided tissue regeneration, limited to one per tooth per lifetime;

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

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

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

    i. Full mouth debridement to enable comprehensive evaluation and diagnosis, limited to one per lifetime.

8. Non-Surgical Periodontics

    a. Periodontal scaling and root planing limited to one every 36 months for each area of the mouth.

9. Periodontal Maintenance

    a. Limited to 2 every 12 months in addition to routine Prophylaxis.

10. Surgical Extractions

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

11. Oral Surgery

a. Removal of impacted tooth;

b. Surgical removal of residual tooth roots;

c. Coronectomy-intentional partial tooth removal;

d. Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth;

e. Surgical access to an unerupted tooth, limited to 1 per tooth per lifetime;

f. Alveoloplasty in conjunction with extraction;

g. Removal of exostosis;

h. Excision of pericoronal gingiva.

12. Anesthesia

a. Anesthesia for dental services covered only when Dentally Necessary.

b. Includes:

(1) Deep sedation/general anesthesia;

(2) Intra-venous conscious sedation/analgesia.

13. Adjustments and Repairs of Prosthetic Dentures

14. Other Prosthetic Services

a. Rebase or reline of mandibular or maxillary complete or partial dentures, limited to one every 36 months.

(1) Covered only after 6 months after the initial installation.

b. Recementation or repair of fixed partial denture.

(1) Limited to one every 36 months.

(2) Recementation during the first twelve months following insertion from the same Dentist is included in the Prosthetic Dentures Benefit.

C. Major Services

1. Prosthetic Dentures

a. Complete, Fixed, Removable or Partial Dentures

b. Limited to one every 60 months.

2. Inlays, Onlays and Crowns

a. Crowns, inlays, onlays, core buildup including pins, and prefabricated post and core.

b. All limited to one per tooth every 60 months.

3. Adjunctive General Services

ARTICLE VII. EXCLUSIONS FOR ADULT BENEFITS

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

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

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

3. The responsibility of 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. UCD's benefits would be in excess to the third-party benefits and therefore, UCD would have right of recovery for any benefits paid in excess. Our right of Subrogation is secondary to the right of the covered insured to be fully compensated for his damages.

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

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

6. Preventive resin restoration of permanent tooth.

7. Administration of nitrous oxide.

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). This Exclusion does not apply to cleft lip and cleft palate.

10. For dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically indicated on the Schedule of Benefits.

11. For diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Certificate. Examples of these jaw joint problems are Temporomandibular Joint (TMJ) Disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint. This Exclusion does not apply to cleft lip and cleft palate.

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

13. Maxillofacial Prosthetics.

14. For treatment of malignancies or neoplasms.

15. 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.

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

17. For preventative restorations.

18. For periodontal splinting of teeth by any method.

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

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 UCD 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 UCD will apply.

30. For space maintainers, fluoride treatment, sealants, and prefabricated, stainless steel crowns.

31. Orthodontic treatment.

32. Services for treatment of any Member detained in a correctional facility and who has been adjudicated or convicted of the criminal offense causing the detention.

33. Benefits are excluded for virtual reality services, supplies, technologies, treatment, devices, or expenses related thereto no matter the setting in which virtual reality is used, including, but not limited to, Surgery.

ARTICLE VIII. PRE-DETERMINATIONS

Predetermination of dental benefits is a service available through UCD. 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. UCD 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 IX. ALTERNATE BENEFITS

If UCD 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, UCD reserves the right to determine if an Alternate Benefit is applicable to the actual services rendered.

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

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

ARTICLE XI. BENEFIT EXTENSION PERIOD AFTER TERMINATION OF COVERAGE

THE DENTAL COVERAGE UNDER THIS BENEFIT PLAN WILL BE EXTENDED AFTER THE DATE THE COVERAGE FOR THE MEMBER TERMINATES ONLY IF:

1. A Covered Benefit for such service was incurred while coverage was in effect; and
2. Such Covered Benefit is completed within thirty-one (31) days after coverage terminates.
3. A Covered Benefit expense will be deemed incurred as follows:
4. For appliances or changes to appliances – on the date the appliance or prosthesis is permanently placed;
5. For Crowns, dentures or bridgework – on the date the impression is taken;
6. For Root Canal therapy -- on the date the pulp chamber is opened; or
7. For all other dental expenses -- on the date the service is rendered or the supply is furnished.
8. For orthodontic treatment, if covered under the Plan, coverage will be extended through the end of the month of the Member's Termination Date.

ARTICLE XII. CONTINUATION OF COVERAGE RIGHTS

A. Surviving Spouse Continuation

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

    a. Coverage is automatic during the ninety (90) day election period. Premium is owed for this coverage. If continuation is not chosen, or if premium is not received for the ninety (90) days of automatic coverage, the ninety (90) days of automatic coverage is terminated retroactive to the end of the billing cycle in which the death occurred.

    b. If the continuation coverage is chosen within the ninety (90) day period, coverage will continue without interruption. Premium is owed from the last date for which premium has been paid. No physical exams are required. Premium for continuing coverage will not exceed the premium assessed for each Subscriber by class of coverage under the Group Benefit Plan.

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

3. Coverage continues, as long as premium is paid timely, until the earliest of:

    a. the date premium is due and is not paid on a timely basis;

    b. the date the surviving Spouse or a Dependent becomes eligible for Medicare; or

    c. the date the surviving Spouse or a Dependent becomes eligible to participate in another group health plan;

    d. the date the surviving Spouse remarries or dies;

    e. the date this Group Benefit Plan ends; or

    f. the date a Dependent is no longer eligible.

B. State Continuation

State continuation is available only if the Group is not subject to continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 and any amendments thereto. The Subscriber or the Dependent requesting continuation must have been continuously covered under this Benefit Plan (or another group policy that this Benefit Plan replaced) for the three (3) consecutive months immediately preceding the date this coverage would otherwise have ended.

1. A Subscriber or a Dependent may be entitled to continue the coverage under this Benefit Plan when eligibility for coverage ends because of:

    a. the death of the Subscriber;

    b. the termination of the Subscriber’s active employment; or

    c. the divorce of the Subscriber.

2. Continuation of coverage for a Subscriber or a Dependent is not available if:

a. within thirty-one (31) days of termination of coverage, the Subscriber or the Dependent is or could have been covered by other group coverage or a government-sponsored health plan such as Medicare or Medicaid;

b. the coverage under this Benefit Plan terminated due to fraud or the failure to pay any required contribution to premium; or

c. the Subscriber or the Dependent is eligible for continuation of coverage under COBRA.

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

3. Continuation of insurance under the Group Benefit Plan for any Subscriber or Dependent shall terminate on the earliest of the following dates:

a. twelve (12) calendar months from the date coverage would have otherwise ended;

b. the date ending the period for which the Subscriber or the Dependent makes the last required premium contribution for the coverage;

c. the date the Subscriber or the Dependent becomes or is eligible to become covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured, including Medicare of Medicaid;

d. the date on which the Group terminated this Benefit Plan;

e. the date on which an enrolled Subscriber or Dependent of a health maintenance organization legally resides outside the service area of the Company.

C. COBRA Continuation Coverage

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

What is COBRA continuation coverage?

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

Do I have other alternatives to COBRA continuation coverage?

COBRA continuation coverage is not the only alternative Members may have when they lose coverage under this plan. You and Your family may have other coverage options.

For example, You could qualify to buy individual coverage through the Health Insurance Marketplace. Losing coverage under this Benefit Plan gives You a special enrollment opportunity in the Marketplace, even when it happens outside of the Marketplace's Open Enrollment Period. You have sixty (60) days from when You lose coverage under this Benefit Plan to apply for special enrollment through the Marketplace. In the

Marketplace, You could be eligible for a tax credit that lowers Your monthly premiums right away, and You can see what Your premium, Deductible Amounts, and Out-of-Pocket Amounts will be before You make a decision to enroll. Being eligible for COBRA does not limit Your eligibility for coverage or for a tax credit through the Marketplace. However, it is important that You know that if You or any of Your Dependents choose COBRA continuation coverage instead of Marketplace coverage, You will lose the special enrollment opportunity for the Marketplace, and You will not be able to enroll until the Marketplace's normal enrollment period opens or Your COBRA continuation coverage is exhausted.

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

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

What if I choose to get COBRA continuation coverage?

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

What are the qualifying events?

A qualifying event is any of the following events:

1. termination of employment of a covered Employee for reasons other than gross misconduct;

2. loss of eligibility by a covered Employee due to a reduction in the number of work hours of the Employee;

3. death of a covered Subscriber;

4. divorce or legal separation between a covered Subscriber and his or her Spouse;

5. the covered Subscriber becomes entitled to Medicare benefits resulting in the loss of coverage for Dependents;

6. a Dependent child ceases to be an eligible Dependent under the terms of this Benefit Plan; or

7. the Employer files for a Chapter 11 bankruptcy proceeding, but only with respect to covered former Employees who retired from the Employer at any time.

NOTE: Special rules apply for certain retirees and their dependents who lose coverage because of an employer's Chapter 11 bankruptcy. In this event, certain retirees may elect lifetime COBRA coverage. Eligible dependents of retirees may continue coverage until the retiree's death. When the retiree dies, dependents may elect an additional thirty-six (36) months of coverage from the date of the retiree's death. In all cases, these qualified beneficiaries must pay for the coverage elected. COBRA coverage under these circumstances will terminate early for a number of reasons including, but not limited to: the employer ceases to provide any group health plan to any employees or the qualified beneficiaries fail to pay the required premiums or become covered under another employer's group health plan that does not exclude or limit benefits for a qualified beneficiary's Pre-Existing Conditions. COBRA continuation coverage rights under Chapter 11 bankruptcy proceedings will be determined by the bankruptcy court, and the coverage eligible beneficiaries could receive may not be the same as the ones they had under the retiree plan before the employer filed for Chapter 11 bankruptcy.

Do I have to provide notification of any qualifying event?

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

1. divorce or legal separation;

2. becoming entitled to Medicare; or

3. a Dependent losing eligibility for coverage as a dependent child.

The Group will advise a qualified beneficiary of their rights under COBRA when any qualifying event occurs or after the timely notice of a qualifying event when such notice is required to be given by the qualified beneficiary.

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

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

1. begins no later than the date on which a Member otherwise would lose coverage under the Group health plan (the coverage end date); and

2. ends sixty (60) days after the coverage end date or sixty (60) days after the Member is notified of their right to continue coverage, whichever is the latest.

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

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

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

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

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

1. eighteen (18) months after the qualifying event in the case of termination of employment or reduction in work hours. When the Employee became entitled to Medicare benefits less than eighteen (18) months before the termination of employment or reduction of work hours, continuation coverage for qualified beneficiaries other than the Employee will last the longer of thirty-six (36) months from the date of Medicare entitlement or eighteen (18) months from the qualifying event; or

2. thirty-six (36) months after the qualifying event when such event is other than termination of employment or reduction of work hours; or

3. the date the Employer ceases to maintain any group health plan for its Employees; or

4. the date coverage ceases because of nonpayment of required premiums when due; or

5. the date the qualified beneficiary first becomes covered under another group health plan and benefits under that other plan are not excluded or limited with respect to a Pre-Existing Condition (NOTE: There are limitations on plans imposing Pre-Existing Condition exclusions and such exclusions became prohibited in 2014 under the Affordable Care Act).; or

6. the date the qualified beneficiary becomes entitled to Medicare (under Part A, Part B, or both).

Can I extend my COBRA continuation coverage?

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

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

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

1. the Employee or former Employee dies;

2. the Employee or former Employee becomes entitled to Medicare (under Part A, Part B, or both);

3. the Employee or former Employee and Dependent Spouse divorce;

4. the Dependent child is no longer eligible under the plan as a Dependent.

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

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

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

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

D. Keep Your Group Informed of Address Changes

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

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

Employees going on a military leave of absence to perform service in the United States uniformed services (as that term is defined under USERRA) may elect to continue coverage under this Benefit Plan for up to 24 months from the date that the employee leaves for service. Only a covered employee may elect continuation coverage under USERRA for himself/herself and for those eligible Dependents that were covered under the

Plan immediately before him/her leaving for military service. Dependents do not have any independent right to elect USERRA continuation coverage.

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

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

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

1. The employee fails to pay the required premiums timely, or

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

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

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

ARTICLE XIII. GENERAL PROVISIONS – GROUP/POLICYHOLDER AND MEMBERS

THE FOLLOWING GENERAL PROVISIONS ARE APPLICABLE TO THE GROUP/POLICYHOLDER AND ALL MEMBERS.

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

A. The Benefit Plan

1. This Benefit Plan, including the Group's acceptance of the Company's proposal, Application, Enrollment Forms, Benefit change forms and renewal forms and documentation, expressing the entire money and other consideration for coverage, the Schedule of Benefits, and any amendments or endorsements, constitutes the entire contract between the parties.

2. Except as specifically provided herein, this Benefit Plan will not make the Company liable or responsible for any duty or obligation imposed on the Employer by federal or state law or regulations. To the extent that this Benefit Plan may be an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 (ERISA), as amended, the Group will be the administrator of employee welfare benefit plan and will be solely responsible for meeting any obligations imposed by law or regulation on the administrator of the plan, except those specifically undertaken by the Company herein. To the extent this Benefit Plan provides Benefits for the treatment of certain injuries, exclusions to those covered Benefits do not apply to an extent inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. Benefits are available to the Member for illness or bodily injury otherwise covered under the Benefit Plan when the illness or bodily injury arises out of an act of domestic violence or a medical condition, including both physical and mental health conditions or for Emergency Medical Services. To the extent this Benefit Plan is subject to COBRA, the Group, or its contracted designee, will be the administrator for the purposes of COBRA. The Group is responsible for establishing and following all required COBRA procedures that may be applicable to the Group. The Group will indemnify and hold the Company harmless in the event the Company incurs any liability as a result of the Group's failure to do so.

3. The Company will not be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance or malpractice on the part of any Hospital or other institution, or any agent or Employee, or on the part of any Physician, Allied Provider, nurse, technician or other person participating in or having to do with Your care or treatment.

4. The Company has full discretionary authority to figure eligibility for Benefits or to construe the terms of this Benefit Plan. Members that disagree with the Company's determination may pursue any applicable procedures available under the terms of this Benefit Plan and the law.

5. The Company shall have the right to enter into any contractual agreements with subcontractors, healthcare providers or other third parties for this Plan. Any of the functions to be performed by the Company under this Benefit Plan may be performed by the Company or any of its subsidiaries, affiliates, subcontractors, or designees.

B. Section 1557 Grievance Procedure

Blue Cross and Blue Shield of Louisiana does not 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 eighty (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. Benefit Plan Changes

The Company reserves the right to modify the terms of this Benefit Plan. Changes will be effective upon renewal of the Contract and proceeded by not less than sixty (60) day notice to the Group. No change or

waiver of any Benefit Plan provision will be effective until approved by the Company's chief executive officer or other person authorized to make changes.

D. Identification Cards and Benefit Plans

We will prepare an identification card for each Subscriber. We will issue a Benefit Plan to the Group and print a sufficient number of copies of the Benefit Plan for Group's Subscribers. At the direction of Group, We will either deliver all materials to the Group for Group's distribution to the Subscribers, or We will deliver the Subscriber materials directly to each Subscriber. The Subscriber's copy of the Benefit Plan shall serve as his certificate of coverage. Unless otherwise agreed between the Group and Us, the Group has the sole responsibility for distributing all such documents to Subscribers.

E. Payment of Premiums

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

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

3. Premiums are due and payable beginning with the Effective Date of this Benefit Plan and on the same date each month thereafter. The Group is considered delinquent if premiums are not paid as of the due date.

4. If the Group does not make payment to the Company home office within thirty (30) days of the due date, this Benefit Plan will be cancelled effective midnight of the last day for which premiums have been paid. The Company will not be liable for any Benefits for services rendered following the date of cancellation.

F. Benefits to Which Members are Entitled

The liability of the Company is limited to the Benefits specified in this Benefit Plan.

Benefits for Covered Services specified in this Benefit Plan will be provided only for services and supplies rendered on and after the Member's Effective Date by a Provider specified in this Benefit Plan and regularly included in such Provider's charges.

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

The Group is solely responsible for furnishing the information that is required by the Company for purposes of enrolling Members of the Group under this Benefit Plan, processing terminations, and effecting changes in family and membership status. Acceptance of payments for persons no longer eligible for coverage will not obligate the Company to provide Benefits under this Benefit Plan.

All notification of membership or coverage changes must be on forms approved by the Company or the SHOP and include all information required by Company and the SHOP to effect changes.

The Group must notify the Company's Membership & Billing Department or the SHOP (if this Benefit Plan was purchased through the SHOP) of a Member's termination of coverage by completing a cancellation form (or such other form of notification acceptable to Us) and submitting it to Our offices no later than within the

next billing cycle immediately following the billing cycle in which the Member or any of the Member's Dependents is terminated from the Group or eligibility for coverage ends (or any other period described in the Schedule of Dental Benefits). The Group will also submit to the Company's Membership & Billing Department evidence of a Member's or his Dependent's election of any applicable COBRA coverage following such termination within three (3) business days of Group's receipt of signed COBRA forms. Company is under no obligation to refund any premium paid by Group or any Member, if payment was made to Company due to Group's failure to timely notify Company of a Member's or his Dependent's termination of coverage.

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

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

The Group warrants the accuracy of the information it transmits to the Company and understands that the Company will rely on this information. The Group agrees to supply or allow inspection of personnel records to verify eligibility as requested by the Company.

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

H. Termination of Your Coverage

1. The Company may choose to rescind coverage or terminate a Member's coverage if a Member performs an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact under the terms of this Benefit Plan. The issuance of this coverage is conditioned on the representations and statements contained at application and enrollment. All representations made are material to the issuance of this coverage. Any information provided on the application or enrollment form or intentionally omitted therefrom, as to any proposed Subscriber or covered Member, shall constitute an intentional misrepresentation of material fact. A Member's coverage may be rescinded retroactively to the Effective Date of coverage or terminated within three (3) years of the Member's Effective Date, for fraud or intentional misrepresentation of material fact. Company will give the Member sixty (60) days advance written notice prior to rescinding or terminating coverage under this section. If Members are enrolled that are not eligible for coverage, it will be considered an act of fraud or intentional misrepresentation of material fact.

2. Unless COBRA or other type of continuation of coverage is available and selected as provided in this Benefit Plan, a Member's coverage terminates as provided below:

    a. The Subscriber's coverage and that of all his Dependents automatically, and without notice, terminates at the end of the period in which the Subscriber ceases to be eligible.

    b. The coverage of the Subscriber's Spouse will terminate automatically, and without notice, at the end of the period for which premiums have been paid at the time of the entry of a final decree of divorce or other legal termination of marriage.

c. The coverage of a Dependent will terminate automatically, and without notice, at the end of the billing cycle in which the Dependent reaches the maximum age for coverage or otherwise ceases to be an eligible Dependent, if premiums have been paid through that period.

d. Upon the death of a Subscriber, the coverage of all of their surviving Dependents will terminate automatically and without notice at the end of the month that death occurred if premiums have been paid through that month. However, a surviving Spouse or Dependent may be able to elect COBRA or other type of continuation of coverage as described elsewhere in this Benefit Plan.

3. In the event the Group cancels this Benefit Plan or Company or SHOP terminates this Benefit Plan for nonpayment of the appropriate payment when due or because the for the Group fails to perform any obligation required by this Benefit Plan, such cancellation or termination alone will operate to end all rights of the Member to Benefits under this Benefit Plan as of the Effective Date of such cancellation or termination. The Group shall have the obligation to notify its Members, participants, and beneficiaries of such cancellation or termination. Company has no such obligation to notify at the Member level.

4. Except as otherwise provided in this Benefit Plan, no Benefits are available to a Member for Covered Services rendered after the date of cancellation or termination of a Member's coverage.

5. When Members on the policy change, Company reserves the right to change Subscriber's class of coverage and bill appropriate premium to reflect the Members covered.

6. Cancellation or termination will be effective at midnight on the last day of the billing cycle.

7. When the Group's coverage ends because the plan ceases to exist or COBRA is exhausted, Members may apply for individual coverage to Company or to the Exchange.

I. Filing of Claims

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

J. Time Limit for Legal Action

1. No lawsuit related to a Claim may be filed any later than twelve (12) months after the Claims are required to be filed.

2. Any and all lawsuits, other than those related to Claims as stated above, must be brought within one (1) year of the end of the Benefit Period.

K. Release of Information

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

L. Assignment

A Member's rights and Benefits under this 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.

M. Member/Provider Relationship

1. The choice of a Provider is solely the Member's.

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

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

N. Applicable Law

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

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

O. Notice

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

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

P. Job-Related Injury or Illness

The Group must report to the appropriate federal or state governmental agency any job-related injury or illness of a Subscriber where so required under the provisions of any federal or state laws and/or related programs. This Benefit Plan excludes Benefits for any services rendered as a result of occupational disease or injury compensable under any federal or state workers compensation laws and/or any 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. In the event Benefits are initially extended by the Company and a compensation carrier, employer, governmental agency or program, insurer, or any other entity makes any type of settlement with the Member, with any person entitled to receive settlement when the Member dies, or if the Member's injury or illness is found to be compensable under federal or state workers' compensation laws or programs, the Group or the Member must reimburse the Company for Benefits extended or direct the compensation carrier, employer, governmental agency, or program, insurer, or any other entity to make such reimbursement. The Company will be entitled to such reimbursement even if the settlement does not mention or excludes payment for dental Benefits expenses.

Q. Subrogation

1. To the extent that Benefits for Covered Services are provided or paid under this Benefit Plan, We will be subrogated and will succeed to the Member's right for the recovery of the amount paid under this Benefit Plan 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 Benefit Plan will constitute subrogation. Our right to recover will be contingent on the Member's 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 the Member in pursuing recovery.

2. The Member 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 a Member who is its insured, to the extent of the Benefits provided or paid under this Benefit Plan. Our right to recover will be contingent on the Member's 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 the Member in pursuing recovery.

3. The Member 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 Benefit Plan. We and Our designees have the right to obtain and review the Member's 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. The Member must notify Us of any Accidental Injury.

R. Right of Recovery

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

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

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

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

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

T. Liability of Plan Affiliates

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Benefit Plan constitutes a contract solely between the Group and Blue Cross and Blue Shield of Louisiana, that Blue Cross and Blue Shield of Louisiana is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the Association permitting Blue Cross and Blue Shield of Louisiana to use the Blue Cross and Blue Shield Service Marks in the State of Louisiana), and that Blue Cross and Blue Shield of Louisiana is not contracting as the agent of the Association. The Group on behalf of itself and its participants further acknowledges and agrees that it has not entered into this Benefit Plan based upon representations by any person other than Blue Cross and Blue Shield of Louisiana and that no person, entity, or organization other than Blue Cross and Blue Shield of Louisiana shall be held accountable or liable to the Group for any of Blue Cross and Blue Shield of Louisiana's obligations to the Group created under this Benefit Plan. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Louisiana other than those obligations created under other provisions of this agreement.

U. Continued Coverage During a Leave of Absence

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

1. Company will continue coverage for Subscriber during any leave of absence the Group is required to provide by applicable federal or state law, including the Family and Medical Leave Act of 1993 (FMLA) and any amendments or successor provisions, as long as all other eligibility criteria under the law continues to be met. If Subscriber's coverage is terminated during a leave under the FMLA, upon return to active full-time employment, Subscriber is entitled to re-enroll for coverage without being subject to otherwise applicable Pre-existing Condition Waiting Periods, so long as the Group maintains coverage with Company. If the Subscriber is not restored to active full-time employment by the end of the leave of absence period, the Subscriber will cease to be eligible and coverage for the Subscriber and any Dependents will terminate at the end of the billing period in which the leave of absence period expires, or as otherwise described in Termination of a Member's Coverage. Subscriber and Dependents may have the right to continue coverage thereafter under the Continuation of Coverage Rights article of this Benefit Plan.

2. When a Subscriber has been granted a documented, approved leave of absence by the employer Group, and the leave of absence is not due to Subscriber's health, Company will maintain coverage for the Subscriber and any Covered Dependents for a period not to exceed ninety (90) days. Premiums must be paid and Subscriber must remain a bona fide employee of Group during the approved leave period. Group will provide Company with proof of the documented leave, upon request. If Group terminates Subscriber's employment, the Subscriber will cease to be eligible and coverage for the Subscriber and any Dependents will terminate as described in Termination of a Member's Coverage. Subscriber and Dependents may have the right to continue coverage thereafter under the Continuation of Coverage Rights article of this Benefit Plan.

V. 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 XIV. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

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

A Member may be dissatisfied about decisions made regarding Covered Services. UCD considers an Appeal as the Member's 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 Our services, access, availability or attitude and those of Participating Providers. A quality of care concern addresses the appropriateness of care given to a Member.

1. To Register a Complaint

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

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

2. To File a Formal Grievance

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

   The Member should send his written Grievance to:

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

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

B. Standard Appeal Procedures

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

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

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

The Member should contact his employer, Plan Administrator, Plan Sponsor, or UCD at 1-866-445-5338 if the Member is unsure whether ERISA is applicable.

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

C. Standard Appeal Process

We will determine if a Member's 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.

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

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

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

All Appeals should be submitted to:

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

1. Administrative Appeals

   Administrative Appeals involve contractual issues, 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 a Member is 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 administrative Appeals. Requests submitted to UCD after one hundred eighty (180) days of receipt the initial Adverse Benefit Determination will not be considered.

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

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

   b. Second Level Administrative Appeals

      If a Member still disagrees with the first level administrative Appeal decision, 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 Member Appeals Committee of persons not involved in previous decisions regarding the initial Adverse Benefit Determination will review the second level administrative Appeals. The Committee's decision is final and binding.

      The Committee's decision will be mailed to the Member, his authorized representative, or a Provider authorized to act on the Member's behalf, within five (5) 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 the Member 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 a Member is 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 the Member's concerns. If the Dental Necessity Appeal is overturned, UCD will reprocess the Member's Claim, if any. If the Dental Necessity Appeal is upheld, UCD will inform the Member of the right to begin the External Appeal process if the Adverse Benefit Determination meets the criteria.

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

b. External Dental Necessity Appeals and Rescission of Coverage

For Dental Necessity Appeals and Rescission of Coverage, 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.

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

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

Requests submitted to Us after four (4) months of receipt of the internal Dental Necessity Appeal decision or Rescission of Coverage 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 the Member, his authorized representative, or a Provider authorized to act on the Member's behalf of its decision.

The IRO decision will be considered a final and binding decision on both the Member 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.

D. Expedited Dental Necessity Appeal

An Expedited Appeal process is available for review of the Adverse Benefit Determination involving a situation where the time frame of the standard Dental Necessity Appeal would seriously jeopardize the Member's life, health or ability to regain maximum function. It includes a situation where, in the opinion of the treating

Provider, the Member may experience pain that cannot be adequately controlled while awaiting a standard Dental Necessity Appeal decision.

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

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

ARTICLE XV. ERISA RIGHTS

TO THE EXTENT THIS IS AN ERISA PLAN, THE MEMBER IS ENTITLED TO CERTAIN RIGHTS AND PROTECTIONS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA). FOR PURPOSES OF THIS PROVISION, THE GROUP IS CONSIDERED THE PLAN ADMINISTRATOR AND WILL BE SUBJECT TO THE PROVISIONS STATED BELOW. ERISA PROVIDES THAT ALL PLAN PARTICIPANTS (MEMBERS) SHALL BE ENTITLED TO:

A. Receive Information About the Plan and Benefits

1. A Member may examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the United States Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. Upon written request to the plan administrator, a Member may obtain copies of documents governing the operation of the plan, including any applicable insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator may make a reasonable charge for the copies.

3. A Member may receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each Member with a copy of this summary annual report.

B. Continue Group Dental Coverage

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

C. Prudent Actions by Plan Fiduciaries

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

D. Enforce Member's Rights

1. If a Member's Claim for a plan Benefit is denied or ignored, in whole or in part, the Member has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules.

2. Under ERISA, there are steps the Member can take to enforce the above rights. A Member must exhaust all Claims and Appeal procedures available to him before filing any suit. For instance, if the Member requests a copy of plan documents or the latest annual report from the plan and does not receive them within thirty (30) days, the Member may file suit in Federal Court. In such a case, the court may require the plan administrator to provide the materials and pay the Member up to one hundred and ten dollars ($110.00) a day until he receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If the Member has a Claim for Benefits, which is denied or ignored, in whole or in part, he may file suit in a state or Federal court. In addition, if he disagrees with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, such Member may file suit in Federal Court. If it should happen that plan fiduciaries misuse the plan's money, or if the Member is discriminated against for asserting his rights, he may seek assistance from the United States Department of Labor, or he may file suit in a Federal Court.

3. The court will decide who should pay court costs and legal fees. If the Member is successful, the court may order the person he has sued to pay these costs and fees. If the Member loses, the court may order him to pay these costs and fees, for example, if it determines that his claim is frivolous.

E. Assistance With Member Questions

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

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

ARTICLE XVI. MAKING PLAN CHANGES AND FILING CLAIMS

ALL OF THE FORMS NECESSARY TO MAKE CHANGES TO THE PLAN CAN BE OBTAINED FROM THE EMPLOYER'S PERSONNEL OFFICE OR OUR HOME OFFICE. IF THE MEMBER NEEDS TO SUBMIT DOCUMENTATION TO US, THE MEMBER MAY FORWARD IT TO OUR HOME OFFICE AT:

Blue Cross and Blue Shield of Louisiana
P. O. Box 98029
Baton Rouge, Louisiana 70898-9029
or to Our street address, 5525 Reitz Avenue, Baton Rouge, LA 70809

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

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

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

A. CHANGING FAMILY MEMBERS ON THE MEMBER'S PLAN

The Schedule of Eligibility lets the You know when You may add additional family members to the Your policy. Please read the Schedule of Eligibility and this section as they contain important information for the Member.

1. If Your coverage was purchased On-Exchange: You will need to make all policy changes directly through the Exchange.

   If Your coverage was purchased Off-Exchange 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. An Employee / Enrollment Change Form is the document that We must receive in order to enroll family members not listed on the Member's original application/enrollment form.

   Because the Member is covered under a Group insurance contract, it is extremely important that the Member follow the timing rules in the Schedule of Eligibility for making these changes to the Member's policy. If the Member does not complete and return a required an Employee / Enrollment Change Form to Us so We receive it within the timeframes set out in the Schedule of Eligibility, it is possible that the Member's insurance coverage will not be expanded to include the additional family members. Completing and returning an Employee / Enrollment Change Form is especially important when the Member's first Dependent becomes eligible for coverage or when the Member no longer has any eligible Dependents.

B. HOW TO FILE INSURANCE CLAIMS FOR BENEFITS

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

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

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

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

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

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

a. an appropriate Claim form is used

b. this contract number (ID #) shown on the form is identical to the number on the ID card

c. the patient's date of birth is listed

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

e. all charges are itemized, whether on the Claim form or on the attached statement

f. the date of service or date of treatment is correct

g. the Provider includes a diagnosis and procedure code for each service/treatment rendered (the diagnosis code pointers must be consistent with the Claim form)

h. the Claim is completed and signed by the Member and the Provider.

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

C. IF A MEMBER HAS A QUESTION ABOUT HIS CLAIM

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

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

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

ARTICLE XVII. GENERAL PROVISIONS – GROUP/POLICYHOLDER ONLY

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

A. Due Date for Group's Premium Payments

1. Premiums are due and payable from Group/policyholder in advance, prior to coverage being rendered. Premiums are due and payable beginning with the Effective Date of this Benefit Plan and on the same date each month thereafter. This is the premium due date.

2. Premiums are owed by Group/policyholder. Premiums may not be paid by third parties, including but not limited to Dentists, Hospitals, Pharmacies, Physicians, automobile insurance carriers, or other insurance carriers. Company will not accept premium payments by third parties unless required by law to do so. The fact that Company may have previously accepted a premium from an unrelated third party does not mean that Company will accept premiums from these parties in the future.

3. If a premium is not paid when due, We may agree to accept a late premium. We are not required to accept a late premium. The fact that We may have previously accepted a late premium does not mean we will accept late premiums in the future. You may not rely on the fact that We may have previously accepted a late premium as indication that We will do so in the future.

4. Premiums must be paid in US dollars. Policyholder will be assessed a twenty-five dollar ($25.00) NSF fee should its premium be paid with a check that is returned by the bank due to insufficient funds. If multiple payments are returned by the bank, Company may at its sole discretion refuse to reinstate coverage.

B. Change in Premium Amount

Premiums for this Benefit Plan may increase after the Group's first twelve (12) months of coverage and every six (6) months thereafter, except when premiums may increase more frequently as described in the following paragraph. Except as provided in the following paragraph, We will give Group forty-five (45) days written notice of any change in premium rates. We will send notice to the Group's latest address shown in Our records. Any increase in premium is effective on the date specified in the rate change notice. Continued payment of premium will constitute acceptance of the change.

We reserve the right to increase the premiums more often than stated above due to a change in the extent or nature of the risk that was not previously considered in the rate determination process at any time during the life of the Benefit Plan. This risk includes, but is not limited to, the right to increase the premium amount because of: (1) the addition of a newly covered person; (2) the addition of a newly covered entity; (3) a change in age or geographic location of any individual insured or policyholder; (4) or a change in the policy Benefit level from that which was in force at the time of the last rate determination. An increase in premium will become effective on the next billing date following the effective date of the change to the risk. Continued payment of premium will constitute acceptance of the change.

C. Group's Right to Cancel the Policy

1. This policy is guaranteed renewable at the option of the Group. Group indicates its desire to continue coverage by its timely payment of each premium as it becomes due.

2. Group may cancel this policy for any reason.

3. To cancel the policy purchased on the SHOP, Group must follow all SHOP processes and timing.

4. To cancel the policy purchased through Company Off-Exchange, Group must give the Company WRITTEN NOTICE of its intent to cancel. GROUP MAY NOT VERBALLY CANCEL THIS COVERAGE. GROUP'S WRITTEN NOTICE OF CANCELLATION MUST BE GIVEN TO COMPANY PRIOR TO OR ON THE EFFECTIVE DATE OF THE CANCELLATION AND MUST BE ACCOMPANIED BY RETURN OF THE BENEFIT PLAN. If Group's written notice to Company of its intent to cancel is not accompanied by the surrendered policy, Group's cancellation notice to the

Company shall be deemed to include Group's declaration that the Group made a good faith attempt to locate its policy and the policy is not returned because it has been lost or destroyed.

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

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

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

3. The Group/policyholder agrees to pay reasonable costs and fees to the Company, including reasonable attorney's fees, for the Company's attempt to collect any amounts owed under this Benefit Plan, including, but not limited to, unpaid premium.

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

1. The Company (or SHOP, as appropriate) may terminate this Benefit Plan if any one of the following occurs:

2. Group commits fraud or makes an intentional misrepresentation.

3. Group fails to comply with a material plan provision, including, but not limited to provisions relating to eligibility, employer contributions or group participation rules. If the sole reason for termination is that Group's participation falls to less than two (2) employees (there is only one (1) employee covered (or owner, if covered)), termination of Group coverage will be effective on the Group's next anniversary date. Otherwise, termination for a reason addressed in this paragraph will be effective after Group receives sixty (60) days written notice as described below.

4. In the case of network plans, there is no longer any enrollee under the Group benefit plan that lives, resides, or works in the service area of the Company or in the area for which the Company is authorized to do business.

5. Group's coverage is provided through a bona fide association and the employer's membership in the association ends.

6. The Company ceases to offer this product or coverage in the market.

7. If the Company terminates this coverage because of prongs a, b, c, or d, We will give Group written notice at least sixty (60) days in advance. The Company will give notice by certified mail and shall include the reason for termination. Notice of termination because of prong e will be sent to the Group by regular mail ninety (90) days in advance of termination.

F. Proxy Votes

Election of Our Board of Directors and certain significant corporate transactions are determined by a majority vote of Our policyholders, unless a different vote is required by law or Our Articles of Incorporation or Bylaws. A policyholder designates, by means of the application for coverage, the members of Our Board of Directors as his proxy to vote on these important matters. Payment of each premium extends the proxy's effectiveness unless revoked by the policyholder. This proxy may be revoked by the policyholder by giving written notice of the revocation. This revocation may be in any form of writing either revoking the proxy or designating a different proxy and must be sent to Us at:

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.

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

1. For purposes of this provision, the following definitions have the same meaning as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA):

   a. Group Health Plan as defined at 45 CFR Part 160, Sec. 160.103.

   b. Protected Health Information (PHI) as defined at 45 CFR Part 164, Sec. 164.501.

   c. Summary Health Information as defined at 45 CFR Part 164, Sec. 164.504(a).

2. Disclosing Information to the Group

   a. Sharing Summary Health Information With the Group:

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

   b. Sharing PHI with the Group:

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

      (1) its plan documents include all of the requirements set forth in 45 CFR Part 164, Sec. 164.504(f)(2)(i), (ii) and (iii);

      (2) it has provided notice to those individuals about whom the PHI relates that meets the requirements of 45 CFR Part 164, Sec. 164.520 (B)(1)(iii)(C); and

      (3) that such PHI will not be used for the purpose of employment-related actions or decisions or in connection with any other Benefits or employee benefits plan of the Group.

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

H. United States Economic Sanctions Laws Compliance

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

subject to trade, export, financial, or transactional sanctions, including the most current version of OFAC's list of Specially Designated Nationals and Blocked Persons, before providing or agreeing to provide coverage to any person.

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

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

LLHIGA NOTICE

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

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

DISCLAIMER

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

LLHIGA
P.O. Drawer 44126
Baton Rouge, Louisiana 70804

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

B. The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law (the law), and is set forth at R.S.22:2081 et seq. The following is a brief summary of this law's coverage, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change any person's rights or obligations under the law or the rights or obligations of LLHIGA.

C. Generally, individuals will be protected by the Louisiana Life and Health Insurance Guaranty Association if they live in this state and hold a direct non-group life, health, health maintenance organization, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons may also be protected as well, even if they live in another state; unless they are afforded coverage by the guaranty association of another state, or other circumstances described under the law are applicable.

D. Exclusion from Coverage

1. A person who holds a direct non-group life, health, health maintenance organization, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract is not protected by LLHIGA if:

   a. he is eligible for protection under the laws of another state;

   b. the insurer was not authorized to do business in this state;

   c. his policy was issued by a profit or nonprofit hospital or medical service organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, an organization that issues charitable gift annuities as is defined by law, or any entity similar to any of these.

2. LLHIGA also does not provide coverage for:

   a. any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

   b. any policy of reinsurance (unless an assumption certificate was issued);

   c. interest rate or crediting rate yields, or similar factors employed in calculating changes in value, that exceed an average rate;

   d. dividends, premium refunds, or similar fees or allowances described under the law;

   e. credits given in connection with the administration of a policy by a group contract holder;

   f. employers', associations' or similar entities' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured;

   g. unallocated annuity contracts (which give rights to group contract holders, not individuals), except if qualified by law

   h. an obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the policy owner or contract owner, including but not limited to, claims described under the law;

   i. a policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to "Medicare Part A coverage", "Medicare Part B coverage", "Medicare Part C coverage", or "Medicare Part D coverage" and any regulations issued pursuant to those parts;

   j. interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer, whichever is earlier.

E. Limits on Amounts of Coverage

1. The Louisiana Life and Health Insurance Guaranty Association Law also limits the amount that LLHIGA is obligated to pay out.

2. The benefits for which LLHIGA may become liable shall in no event exceed the lesser of the following:

   a. LLHIGA cannot pay more than what the insurance company would owe under a policy or contract if it were not an impaired or an insolvent insurer.

   b. For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance.

   c. For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $500,000 in health insurance benefits, and LLHIGA will pay a maximum of $250,000 in present value of annuities, including net cash surrender and net cash withdrawal values.

3. In no event, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverages, LLHIGA shall not be liable to expend more than $500,000 in the aggregate with respect to any one individual.

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

Nondiscrimination Notice

Discrimination Is Against the Law

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana, Inc. and Southern National Life, 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.

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana Inc. and Southern National Life Insurance Company Inc., are independent licensees of the Blue Cross Blue Shield Association.

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)