



Dental Care and Treatment Contract

For The Employees Of



Caddo Parish School Board

Administered by



5525 Reitz Avenue • Baton Rouge, Louisiana • 70809-3802
www.bcbsla.com



**CADDO PARISH SCHOOL BOARD
DENTAL BENEFIT PLAN**

NOTICES

If you need help, call the customer service number on the ID card.

Para obtener asistencia en español, comuníquese con el Servicio de Atención al Cliente al número que figura en su tarjeta de identificación.

Upang makakuha ng tulong sa Tagalog, tumawag sa numero ng telepono ng serbisyong pang-kustomer na nakalista sa iyong card ng pagkikilalan.

對於在中國的幫助，請致電客戶服務上您的身份證列出的電話號碼。

T'áá Diné k'ehjí shiká 'adoowol nínízingo, ninaaltsoos bee ééhózíngíí béesh bee hane'é bikáá' bee bik'e'ashchinigíí bich'l' hodílnih.

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 ON 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.**

A handwritten signature in black ink, appearing to read "B R Camerlinck".

Bryan R. Camerlinck
President and Chief Executive Officer
Louisiana Health Service & Indemnity Company

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

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ARTICLE I.

UNDERSTANDING THE BASICS

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

Benefits available under this Benefit Plan are described in the Dental Care and Treatment Benefits Article below. The services that are available to the Plan Participant under this Benefit Plan are listed on the Schedule of Dental Benefits. A Plan Participant must meet the Employer's Eligibility Waiting Period before coverage is effective on this dental plan. Once effective, each service may be subject to a different Dental Waiting Period, Deductible, Coinsurance, Benefit Period Maximum and/or Lifetime Maximum as shown on the Schedule of Dental Benefits. The Group may apply to the Claims Administrator to change the Covered Services on the Group's anniversary date. Any special Benefits or limitations are shown on the Schedule of Dental Benefits. Benefits offered may be limited to the least costly treatment.

As of the later of the Original Effective Date or the Amended Effective Date of the Benefit Plan shown on the Group's Schedule of Dental Benefits, We agree to provide the dental Benefits specified herein for Employees of the Group and their enrolled Dependents. This Benefit Plan replaces any others previously issued to the Group/policyholder. A word used in the masculine gender applies also in the feminine gender, except where otherwise stated. Reference to dental healthcare may be applied to dental services provided under this Benefit Plan.

Except for necessary technical terms, We use common words to describe the Benefits provided under this Benefit Plan. The Plan, We, Us and Our means the Claims Administrator 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. You, Your, and Yourself means the Plan Participant and/or enrolled Dependent. Capitalized words are defined terms in the Definitions Article.

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 Benefit Plan, and is in charge of managing the dental network, handling and paying claims, and providing customer services to the Plan Participants eligible to receive these Benefits and their legal representatives.

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

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

SERVICES RENDERED BY NON-PARTICIPATING PROVIDERS

You should know that care received from a Non-Participating Provider could mean a higher cost to you. This amount you could be subject to pay could be significant. We recommend that you ask the Non-Participating Provider about their billed charges before you receive care. Reimbursements for services rendered by a Non-Participating Provider will be based on Our Allowable Charge and will be paid under the same limits, rules and policies that We would have applied to Claims for services rendered by a Participating Provider.

ARTICLE II.

DEFINITIONS

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.

Accidental Injury – A condition occurring as a direct result of a traumatic bodily injury sustained solely through accidental means from an external force. If Benefits are available for the treatment of a particular injury, Benefits will be provided for an injury that results from an act of domestic violence or a medical condition.

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 Plan Participant's eligibility for coverage under the Benefit Plan;
- C. any prospective or retrospective review determination; or
- D. a Rescission.

Allowable Charge – The lesser of the billed charge or the amount established by the Claims Administrator as the maximum amount allowed for all Provider services covered under the terms of this Benefit Plan.

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

Appeal – A written request from a Plan Participant or a Plan Participant's authorized representative to change an Adverse Benefit Determination made by the Claims Administrator.

Authorization (Authorized) – A determination by the Claims Administrator regarding an admission, continued hospital stay, or other 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 Plan Participant's choice of Provider.

Benefit Period – A calendar year, January 1 through December 31. For new Plan Participants, the Benefit Period begins on the Effective Date and ends on December 31 of the same year.

Benefit Period Maximum – The maximum amount the Plan Administrator will pay per Plan Participant during a Benefit Period, according to the Group's service(s) of Dental Care and Treatment.

Benefit Plan – The program established by the Group to provide dental Benefits for eligible Plan Participants.

Benefits – Coverage for dental services, treatment, procedures, equipment, drugs, devices, items or supplies provided under this Benefit Plan. Benefits covered by the plan are based on the Allowable Charge for Covered Services.

Child or Children – includes:

- A. the issue of a marriage of the Employee/Retiree;
- B. a natural Child of the Employee/Retiree;
- C. a legally adopted Child of the Employee/Retiree or a Child placed for adoption with the Employee/Retiree;
- D. the Child of a male Employee/Retiree, if a court of competent jurisdiction has issued an order of filiation declaring the paternity of the Employee/Retiree for the Child or the Employee/Retiree has formally acknowledged the Child;

- E. the issue of a previous marriage or a natural or legally adopted Child of the Employee's/Retiree's legal Spouse, hereinafter stepchild, which stepchild has not been adopted by the Employee/Retiree and for whom the Employee/Retiree does not have court-ordered legal custody;
- F. a grandchild in the court ordered legal custody of and residing with the grandparent Employee/Retiree, until the end of the month the grandchild attains the age of twenty-six (26);
- G. a dependent for whom the Employee/Retiree has court-ordered legal custody or court-ordered legal guardianship but who is not a Child or grandchild of the Employee/Retiree, until the end of the month the custody or guardianship order expires or the end of the month the dependent attains the age of eighteen (18), whichever is earlier; or
- H. a grandchild or dependent of a Dependent of the Employee/Retiree whose parent is covered under the Plan as a Dependent, or a child for whom the Employee/Retiree has current provisional custody, which grandchild/child has not been adopted by the Employee/Retiree and for whom the Employee/Retiree has not obtained court-order legal guardianship/tutorship or court-ordered custody, provided the grandchild/child was enrolled as a Plan Participant and met the eligibility requirements of a Child as of December 31, 2015.

Claim – A Claim is written or electronic proof, in a form acceptable to the Claims Administrator, of charges for Covered Services that have been incurred by a Plan Participant during the time period the Plan Participant 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 – The entity with whom Caddo Parish School Board has contracted to handle the Claims payment functions of its Plan. For purposes of this Plan, the Claims Administrator is 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.

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

Code – The Internal Revenue Code of 1986, as amended, and the regulations promulgated thereunder.

Coinsurance – The sharing of Allowable Charges for Covered Services. The sharing is expressed as a pair of percentages, a percentage that We pay, and a Plan Participant percentage that You pay. Once the Plan Participant has met any applicable Deductible, the Plan Participant's percentage will be applied to the Allowable Charges for Covered Services to determine the Plan Participant's financial responsibility.

Company – Blue Cross and Blue Shield of Louisiana (incorporated as Louisiana Health Service & Indemnity Company) 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 Claims Administrator or Provider services.

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

Covered Service – A service or supply specified in this 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.

Date Acquired – The date a Dependent of a covered Employee/Retiree is acquired in the following instance and on the following dates only:

- A. Spouse – the date of marriage.
- B. Child or Children
 - 1. Natural Children – the date of birth.
 - 2. Children placed for adoption with the Employee/Retiree
 - a. Agency adoption – the date the adoption contract was executed between the Employee/Retiree and the adoption agency.
 - b. Private adoption – the date the Act of Voluntary Surrender is executed in favor of the Employee/Retiree. The Plan Administrator must be furnished with certification by the appropriate clerk of court setting forth the date of execution of the Act and the date the Act became irrevocable, or the date of the first court order granting legal custody, whichever occurs first.
 - 3. Child for whom the Employee/Retiree has court-ordered custody or court-ordered legal guardianship – the date of the court order granting legal custody or guardianship.
 - 4. From the date of the court order of filiation declaring paternity or the date of formal acknowledgement of the Child.
 - 5. Stepchild – the date of the marriage of the Employee/Retiree to his/her Spouse.

Deductible – The dollar amount, shown on the Schedule of Dental Benefits, of Allowable Charges for Covered Services that each Plan Participant must pay within a Benefit Period before payments are made under this Benefit Plan. If shown on the Schedule of Benefits, the Deductible may be waived for certain services.

Dental Care and Treatment – All services, 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 the Claims Administrator to either establish or maintain a patient's dental health based on professional diagnostic judgment and the prevailing standards of care in the professional community. The determination will be made by a Dentist in accordance with guidelines established by the Claims Administrator.

Dentist – A Doctor of Dental Surgery or a Doctor of Dental Medicine who is legally qualified and licensed to practice dentistry at the time and place Dental Care and Treatment is performed.

Dependent – Any of the following persons who (a) are enrolled for coverage as Dependents by completing appropriate enrollment documents, if they are not also covered as an Employee/Retiree; and, (b) whose relationship to the Employee/Retiree has been documented, as defined herein:

A. The covered Employee's/Retiree's Spouse;

B. A Child from the Date Acquired until the end of the month of attainment of age twenty-six (26); except for the following:

1. A grandchild or dependent of a Dependent of the Employee/Retiree whose parent is covered under the Plan as a Dependent and for whom the Employee/Retiree has not obtained court-ordered legal guardianship/tutorship or court-ordered custody and has not adopted, which grandchild or dependent of a Dependent was covered under the Plan and met the definition of a Child as of December 31, 2015, from the Date Acquired until the end of month the parent Dependent Child is no longer enrolled on or eligible to participate in the Plan, the end of the month the grandchild or dependent of a Dependent turns twenty-six (26), or the grandchild or dependent of a Dependent no longer meets the eligibility requirements under this Plan, whichever is earlier;
2. A child for whom the Employee/Retiree has current provisional custody and for whom the Employee/Retiree has not obtained court-ordered legal guardianship/tutorship or court-ordered custody and has not adopted, which child was covered under the Plan and met the definition of a Child as of December 31, 2015, from the Date Acquired until the end of the month of the 2016 anniversary date of the existing provisional custody document, the end of the month the Child reaches the age of eighteen (18), or December 31, 2016, whichever is earlier;
3. A child, who is not the Child or grandchild or the Employee/Retiree, for whom the Employee/Retiree has court-ordered custody or court-ordered legal guardianship but who has not been adopted by the Employee/Retiree, from the Date Acquired until the end of the month the custody/guardianship order expires or the end of the month the Child reaches the age of eighteen (18), whichever is earlier.
4. A stepchild of the Employee/Retiree, which stepchild has not been adopted by the Employee/Retiree and for whom the Employee/Retiree does not have court-ordered legal custody, until the earliest of:
 - a. The end of the month the Employee/Retiree is no longer married to the stepchild's parent;
 - b. The end of the month of the death of the Employee's/Retiree's Spouse who is the stepchild's parent;
or
 - c. The end of the month the stepchild attains the age of twenty-six (26).

C. A Child of any age who meets the criteria set forth in the Eligibility Article of this Benefit Plan.

Effective Date – The date when the Plan Participant'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.

Eligibility Waiting Period – The period that must pass before an individual is eligible to receive Benefits under this Benefit Plan. A Plan Participant must satisfy any Eligibility Waiting Periods established by the Group before dental coverage is effective and prior to satisfying the Dental Waiting Period.

Eligible Person – See Employee.

Employee – An active Employee is defined as (1) any Caddo Parish School Board employee whose membership in either the Louisiana School Employees' Retirement System (LSERS) or the teachers' Retirement System of Louisiana (TRSL) is mandatory, (2) any Caddo Parish School Board employee who elects to participate in another qualified state retirement system in lieu of the LSERS/TRSL, or (3) an elected Caddo Parish School Board Member.

Employer – Caddo Parish School Board.

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

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

Expedited Appeal – A request for immediate internal 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 Dental Necessity Appeal would seriously jeopardize the life or health of the Plan Participant or jeopardize the Plan Participant's ability to regain maximum function, or decision not to Authorize continued services for Plan Participants currently in the emergency room, under observation, or receiving Inpatient care.
- B. In the opinion of the treating Dentist, the Plan Participant 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 dental health care service for which a Plan Participant 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 Plan Participant or jeopardize the Plan Participant's ability to regain maximum function,
- B. A decision to not Authorize continued services for Plan Participants 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 healthcare service or treatment is experimental or Investigational and the treating Physician certifies that any delay may pose an imminent threat to the Plan Participant'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 Plan Participant.

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 Plan Participant or the Plan Participant'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.

Full Time Equivalent (FTE) – A Full-Time Equivalent Employee who is employed on average thirty (30) or more hours per week, as defined under Code Section 4980H and determined pursuant to the regulations issued thereunder.

Gingivectomy – Surgical removal of gum tissue.

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

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

Group – Caddo Parish School Board or other legal entity of Caddo Parish School Board who is the Plan Administrator of this Benefit Plan and for whom Blue Cross and Blue Shield of Louisiana provides claims administration services.

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

Informal Reconsideration – A request by telephone for additional review of a utilization management determination not to authorize. Informal Reconsideration is available only for initial or Concurrent Review determinations that are requested within ten (10) days of denial.

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.

Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination the Claims Administrator makes that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

- A. whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
- B. whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
 1. consultation with the Blue Cross and Blue Shield Association technology assessment program (TEC) or other non-affiliated technology evaluation center(s);
 2. credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
 3. reference to federal regulations.

Lifetime Maximum – The maximum amount the Plan Administrator will pay on behalf of the covered Plan Participant during their lifetime. The Covered Services to which a Lifetime Maximum applies are shown on the Schedule of Benefits.

Medically Necessary (or Medical Necessity) – Dental healthcare services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- A. in accordance with nationally accepted standards of medical practice;
- B. clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
- C. not primarily for the personal comfort or convenience of the patient, or Provider, and not more costly than alternative services, treatment, procedures, equipment, drugs, devices, items or supplies or sequence thereof and that are as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or procedure of that patient's illness, injury or disease.

For these purposes, nationally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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

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

Open Enrollment – A period of time, designated by the Plan, during which an eligible Employee, Retiree and any eligible Dependents may enroll for Benefits under this Plan.

Orthodontia Maximum – The maximum amount the Plan Administrator will pay per Lifetime for each Plan Participant, according to the Group's services of Orthodontic Services, Treatment and Appliances.

Orthodontics – A dental specialty that treats misalignment of teeth.

Over-Age Dependent – A Dependent Child (or grandchild) who is age twenty-six (26) or older, reliant on the Plan Participant for support, and is incapable of sustaining employment because of an intellectual or physical disability that began prior to age twenty-six (26). Coverage of the Over-Age Dependent may continue after age twenty-six (26) for the duration of incapacity if, prior to or within thirty-one (31) days of the Dependent Child reaching age twenty-six (26), an application for continued coverage with current medical information from the Dependent Child's attending Physician is submitted to the Company. The 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 twenty-sixth (26th) birthday. The Company may terminate coverage of the Over-Age Dependent if the Company determines the Dependent Child is no longer reliant on the Plan Participant for support or is no longer intellectually or physically disabled to the extent, he or she 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.

Pharmacy Benefit Manager (PBM) – A third-party administrator of Prescription Drug programs.

Plan – Caddo Parish School Board's Dental Benefit Plan for certain Employees of Caddo Parish School Board and is described in this document.

Plan Administrator – The person or entity designated by the Plan Sponsor to administer this group Plan. If no one is designated, Plan Sponsor is Plan Administrator.

Plan Participant – Any Employee, Retiree or Dependent who is covered under this Plan.

Plan Sponsor – Caddo Parish School Board, who provides these Benefits on behalf of its eligible Employees, Retirees and their eligible Dependents.

Plan Year – A period of time beginning with the effective date of this Benefit Plan or the anniversary of this date and ending on the day before the next anniversary of the effective date of this Benefit Plan.

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

- A. Participating Provider – A Provider that has a Provider Agreement with the United Concordia Dental pertaining to payment for Covered Services rendered to a Plan Participant.
- B. Non-Participating Provider – A Provider that does not have a Provider Agreement with the United Concordia Dental pertaining to payment for Covered Services rendered to a Plan Participant.

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

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

Retiree – An individual who was a covered Employee immediately prior to the date of retirement and who, upon retirement, satisfied one of the following categories:

- A. Immediately received a retirement plan distribution from an approved state or governmental agency defined benefit plan;
- B. Was not eligible for participation in such a plan or who had legally opted not to participate in such a plan, and either:
 - 1. Began employment prior to September 16, 1979, has ten (10) years of continuous state service, and has reached the age of sixty-five (65); or
 - 2. Began employment after September 16, 1979, has ten (10) years of continuous state service, and has reached the age of seventy (70); or
 - 3. Began employment after July 8, 1992, has ten (10) years of continuous state service, has a credit for a minimum of forty (40) quarters in the Social Security system at the time of employment, and has reached the age of sixty-five (65); or
 - 4. Maintained continuous coverage with the Plan as an eligible Dependent until he/she became eligible to receive a retirement benefit from an approved state governmental agency defined benefit plan as a former state Employee.

- C. Immediately received a retirement plan distribution from a state-approved or state governmental agency-approved defined contribution plan and has accumulated the total number of years of creditable service which would have entitled him/her to receive a retirement allowance from the defined benefit plan of the retirement system for which the Employee would have otherwise been eligible. The appropriate state governmental agency or retirement system responsible for administration of the defined contribution plan shall be responsible for certification of eligibility to the Plan Administrator.
- D. Retiree also means an individual who was a covered Employee and continued the coverage through the provisions of COBRA immediately prior to the date of retirement and who, upon retirement, qualified for any items A., B., or C. above.

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

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

Spouse – The Employee's Spouse pursuant to a marriage recognized under state law where the marriage was entered.

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

Waiting Period – See Eligibility Waiting Period.

ARTICLE III.

SCHEDULE OF ELIGIBILITY

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 PLAN, NOR MAY A DEPENDENT BE COVERED BY MORE THAN ONE EMPLOYEE.

A. Persons to be covered

1. Employees

- a. Employee, as defined in this Benefit Plan.
- b. Spouse, as defined in this Benefit Plan.

If a covered Spouse is eligible for coverage as an Employee and chooses at a later date to be covered separately, that person will be a covered Employee effective the first day of the month after the election of separate coverage. The change in coverage will not increase the Benefits.

c. Re-enrollment; Previous Employment

Full-time Employees returning to full time or part-time status with less than thirteen (13) weeks (less than twenty-six (26) weeks for educational institutions) since separation or termination may resume coverage if application is made within thirty (30) days following return to work. Coverage will resume on the first of the month following return to work. If an Employee acquires an additional Dependent during the termination period, that Dependent may be covered if added within thirty (30) days of re-employment.

d. Board and Commission Members

Members of school boards, state boards, or commissions, defined by the Group as full-time Employees, are eligible to participate in this Benefit Plan.

2. Retirees

A person meeting the definition of Retiree shall be eligible for coverage under this Benefit Plan. Retirees may not be covered as an Employee.

3. Documented Dependents

- a. A documented Dependent of an eligible Employee or Retiree will be eligible for Dependent coverage on the latest of the following dates:

- (1) The date the Employee or Retiree becomes eligible, or
- (2) The Effective Date following Open Enrollment.

- b. The following written proof of relationship to the Employee or Retiree must be presented to the Plan Administrator, or representative designated by the Plan Administrator, for inspection and copying:

- (1) Spouse – A certified copy of the certificate of marriage, indicating date and place of marriage.
- (2) Child or Children:

- (a) Naturally or legally adopted Child or Children of Plan Participant – Certified copy of birth certificate listing Plan Participant as parent or certified copy of legal acknowledgment of paternity signed by the Plan Participant or certified copy of adoption decree naming Plan Participant as adoptive parent.
- (b) Stepchild – Certified copy of certificate of marriage to Spouse and birth certificate or adoption decree listing Spouse as natural or adoptive parent.
- (c) Child placed with Your family for adoption by agency adoption or irrevocable act of voluntary surrender for private adoption – Certified copy of adoption placement order showing date of placement or copy of signed and dated irrevocable act of surrender.
- (d) Child for whom You have been granted court-ordered legal guardianship or court-ordered custody – Certified copy of the signed court order granting legal guardianship or custody.
- (e) The Employee's Child, or grandchild who is in the legal custody of and residing with the Employee, who is covered on the Plan before turning age twenty-six (26) and is able to remain covered on the Plan once turning age twenty-six (26) because he meets the definition and requirements of an Over-Age Dependent.
- (f) Medical Child Support Orders

A Dependent Child shall be enrolled for coverage under the Plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN). An Employee who is not currently enrolled in the Plan may enroll to effect coverage for his Dependent(s) who are the subject of the QMCSO. A QMCSO is a state court order or judgment, including approval of a settlement agreement that:

- i. Provides for support of a covered Plan Participant's Dependent Child;
- ii. Provides for dental healthcare coverage for that Dependent Child;
- iii. Is made under state domestic relations law (including a community property law);
- iv. Relates to Benefits under the Plan; and
- v. Is qualified in that it meets the technical requirements of applicable state law.

QMCSO also means a state court order or judgment that enforces a state Medicaid law regarding medical child support required by Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSN is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO that requires coverage under the Plan for the Dependent Child of a non-custodial parent who is (or will become) a Plan Participant by a domestic relations order that provides for dental healthcare coverage.

- (3) Such other written proof of relationship to the Employee/Retiree deemed sufficient by the Plan Administrator.

B. Available Classes of Coverage

- 1. Employee only coverage means coverage for the Employee only.
- 2. Employee and Spouse coverage means coverage for the Employee and his/her Spouse.
- 3. Employee and Child(ren) coverage means coverage for the Employee and one or more Dependents.

4. Family coverage means coverage for the Employee, his/her Spouse, and one or more Dependents.

C. Change of Classification

1. Adding or Deleting Dependents

When a Dependent is added to the Employee's/Retiree's coverage as a result of a HIPPA special enrollment event or deleted from the Employee's/Retiree's coverage consistent with a change in the Dependent's status, application made by an active Employee or Retiree shall be provided to the Plan Administrator. Application is required to be made within thirty (30) days of the HIPPA special enrollment event or change in status unless otherwise specified in this Plan document or unless a longer application period is required by federal or state law. When a Dependent is added to or deleted from coverage during a designed enrollment period, application is required to be made as directed by the Plan Administrator for the designed enrollment period.

2. Change in Coverage

When the addition of a Dependent as a result of a HIPPA special enrollment event results in a change in classification, the change in classification will be effective on the date of the HIPPA special enrollment event.

3. Notification of Change

It is the Employee's/Retiree's responsibility to make application for any change in classification of coverage during Open Enrollment.

D. Effective Date of Coverage

1. New Employee, Transferring Employee, FTE and Documented Dependents of Employees

Coverage for an Employee who completes the applicable enrollment form and agrees to make the required Employee contribution is effective as follows:

- a. For new full-time Employees, if employment begins on the first day of the month, coverage is effective the first day of the following month, for example, if hired on July 1st, coverage will begin on August 1st.
- b. For new full-time Employees, if employment begins on or after the second day of the month, coverage is effective the first day of the second month following employment (for example, if hired on July 15th, coverage will begin on September 1st).
- c. Employee coverage will not become effective unless the Employee completes an enrollment form within thirty (30) days following the date of employment. If completed after thirty (30) days following the date of employment, the Employee will have to wait to enroll until the next open enrollment period.
- d. An Employee who transfers employment to this Employer from another Participant Employer must complete a transfer form within thirty (30) days following the date of transfer in order to maintain coverage without interruption. If the Employee does not timely complete an enrollment form, the Employee will have to wait to enroll until the next open enrollment period.
- e. An Employee who is determined to be an FTE shall be allowed to enroll in this Benefit Plan with coverage effective as required under Code Section 4980H, which is the first day of the Plan Year for those Employees determined to be FTEs during the standard determination period and which is no later than the thirteenth month of employment for those Employees determined to be FTEs during their initial measurement period.

2. Retiree and Documented Dependents of Retirees

Active members upon retirement will be moved to the Retiree class on their first date of retirement, if the Retiree and his or her Dependents were covered immediately prior to retirement. There is no coverage available for Dependents of Retirees following the date of retirement.

E. HIPPA Special Enrollment Events

Certain eligible persons may enroll in the Plan if they experience a HIPPA special enrollment event as provided by federal law. HIPPA special enrollment events include but are not limited to birth, adoption, placement for adoption, marriage, eligibility for premium assistance subsidy under Medicaid or State Children's Health Insurance Program (SCHIP) coverage, loss of other health coverage through divorce, legal separation, or annulment, and loss of eligibility based on termination of Medicaid or SCHIP coverage. Application to the Plan Administrator must be made within thirty (30) days of the HIPPA special enrollment event unless a longer period is provided by federal law or by the Group.

1. Retirees Special Enrollment

Retirees will not be eligible for special enrollment, except under the following conditions:

- a. Retirement began on or after July 1, 1997;
- b. The Retiree can document that credible coverage was in force at the time of the election not to participate or continue participation in the Plan;
- c. The Retiree can demonstrate that credible coverage was maintained continuously from the time of the election until the time of requesting special enrollment;
- d. The Retiree has exhausted all COBRA and/or other continuation rights and has made a formal request to enroll within thirty (30) days of the loss of other coverage; and
- e. The Retiree has lost eligibility to maintain other coverage through no fault of his or her own and has no other creditable coverage in effect.

2. Effective Date of Coverage of Special Enrollees

The Effective Date of coverage for special enrollees who timely enroll shall be:

- a. For loss of other coverage or marriage, the first of the month following the date the Plan Administrator receives all required forms for enrollment;
- b. For birth of a Dependent, the date of birth;
- c. For adoption, the date of adoption or placement for adoption.
- d. Medicare Advantage Option for Retirees

Retirees who are eligible to participate in a Medicare Advantage plan who cancel coverage with the Benefit Plan upon enrollment in a Medicare Advantage plan may re-enroll in the Benefit Plan upon withdrawal from or termination of coverage in the Medicare Advantage plan, at the earlier of the following:

- (1) during the month of November, for coverage effective January 1; or
- (2) during the next annual enrollment, for coverage effective at the beginning of the next Plan Year.

Retirees who elect to participate in a Medicare Advantage plan not sponsored by the Group will not be allowed to re-enroll in this Plan upon withdrawal from or termination of coverage in the Medicare Advantage plan. If the Group does not sponsor a Medicare Advantage plan when the eligible Retiree elects to participate in a Medicare Advantage plan, this restriction will not apply should the Retiree later wish to re-enroll in this Plan.

e. TRICARE for Life Option for Military Retirees

Retirees eligible to participate in the TRICARE for Life (TFL) option on and after October 1, 2001, who cancel coverage with the Benefit Plan upon enrollment in TFL may re-enroll in the Benefit Plan in the event that the TFL option is discontinued, or its benefits significantly reduced.

ARTICLE IV. DENTAL CARE AND TREATMENT BENEFITS

Dental Care and Treatment Benefits have a Benefit Period Deductible per Plan Participant. Benefits will be paid after the corresponding Benefit Period Deductible has been met. The Benefit Period Deductible is not applicable to Preventive and Diagnostic Dental Services listed below.

This Benefit Plan has a Benefit Period Maximum per Plan Participant. Once this Benefit Plan pays Benefits in that amount for a Plan Participant, no more Benefits will be covered for the remainder of the Benefit Period for that Plan Participant. The Benefit Period Maximum includes Diagnostic and Preventive, Basic and Major Dental Services. Orthodontic Services, Procedure and Appliances listed below do not accrue to the Benefit Period Maximum per Plan Participant.

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

All applicable Deductibles, Maximums, and Coinsurances for each Benefit will be disclosed on the Schedule of Dental Benefits.

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

A. Preventive and Diagnostic Dental Services

1. Routine Oral Exams and Consultations
 - a. Comprehensive evaluation.
 - b. Periodic oral evaluation. Limited to one (1) every six (6) months each Benefit Period.
 - c. Limited problem-focused and evaluations.
 - d. Detailed problem-focused evaluations.
 - e. Consultations or diagnostic services provided by a dentist or Provider other than the practitioner providing the dental treatment.
 - f. Emergency oral examination.
 - g. Diagnostic models.
 - h. Pulp vitality test.
 - i. Oral smear.
 - j. Bacteriologic culture for determination of oral pathologic agents.

- k. Microscopic examination of pathogens and/or oral tissue.
2. Oral Radiographs (x-rays)
 - a. Complete series of intraoral x-rays or panoramic film x-rays (14 or more x-rays). Limited to one (1) series or one (1) film every two (2) years.
 - b. Bitewing x-rays, limited to one (1) set every six (6) months.
 - c. Periapical intraoral films.
 - d. Occlusal intraoral films.
 - e. Cephalometric x-rays.
 - f. X-rays of Temporomandibular Joint.
 - g. Extraoral films: x-rays of T.M.J.
 3. Plaque Control Program. Limited to one (1) every three (3) years.
 4. Training in oral hygiene. Limited to one (1) every three (3) years.
 5. Occlusal Equilibration. Limited to one (1) every three (3) years.
 6. Oral Cleanings (Prophylaxis). Limited to one (1) every six (6) months.
 7. One (1) fluoride treatment per covered person under age nineteen (19) each Benefit Period.
 8. Space maintainers are limited to replacement of the same space maintainer. One (1) every three (3) years.
 9. Dietary prescription and counseling. Limited to one (1) every three (3) years.
 10. Drugs and medication dispensed by a practitioner for home or office includes prescription and non-prescription drugs, vitamins or dietary supplements.
 11. Sealants are limited to covered persons up to age nineteen (19). Limited to permanent teeth only.

B. Basic Dental Services

1. Simple surgical extractions with local anesthetic, including routine post-operative care.
 - a. Oral Surgery
 - Surgical removal of erupted tooth with elevation of mucoperiosteal flap and removal of bone and/or section of tooth.
 - b. Transplantation or re-implantation and/or stabilization of accidentally avulsed or displaced tooth.
 - c. Removal of impacted teeth (soft tissue, partial bony, or complete bony).
 - d. Surgical removal of residual tooth roots.
 - e. Apicoectomy.
 - f. Root recovery (surgical removal of residual root)

- g. Surgical exposure of impacted or unerupted tooth for orthodontic purposes.
- h. Coronectomy – intentional partial tooth removal.
- i. Excision of pericoronal gingival.
- j. Surgical access to an unerupted tooth.
- k. Alveolectomy of edentulous areas.
- l. Alveolectomy following the removal of teeth.
- m. Alveoloplasty (surgical preparation of ridge for dentures) in conjunction with extraction.
- n. Removal of exostosis.
- o. Stomatoplasty – including revision of soft tissue, ridge extension, muscle reattachment, and manipulation of other intraoral tissue.
- p. Medical evaluation and management services associated with major oral surgical procedures.
- q. Biopsy of hard or soft tissue.
- r. Excision of reactive inflammatory tissue, including hyperplastic/hypertrophic tissue and scar tissue.
- s. Excision of pericoronal gingival.
- t. Excision of cysts from soft or osseous tissue.
- u. Excision of benign tumors from soft or osseous tissue.
- v. Excision or resection of malignant tumors from soft or osseous tissue.
- w. Radical resection of mandible with bone graft.
- x. Sialolithotomy (intraoral or extraoral).
- y. Incision and drainage of abscess or cellulitis (intraoral or extraoral).
- z. Incision and removal of foreign body from soft or osseous tissue.
- aa. Frenulectomy (frenectomy or frenotomy).
- bb. Suture of soft tissue wound or injury.
- cc. Oral antral fistula closure and/or antral root recovery.
- dd. Injection of trigeminal nerve for destruction closure of salivary fistula.
- ee. Treatment of fractures (simple or compound) of the orofacial structures.
- ff. Bone grafts when performed with certain eligible oral surgery services.

3. Anesthesia/Sedation

- a. Anesthesia, (including IV conscious sedation and deep sedation and general anesthesia)
- b. Other dental anesthesia, such as local anesthetic, nitrous oxide and orally administered sedation

when included in global charges for dental procedures.

4. Temporomandibular Joint Dysfunctions
 - a. Open reduction of dislocation.
 - b. Manipulation under anesthesia.
 - c. Condylectomy.
 - d. Meniscectomy.
5. Basic Restorations
 - a. Amalgam and composite resin restorations for permanent and primary teeth.
 - b. Cement bases.
 - c. Calcium hydroxide or zinc-oxide-eugenol bases.
 - d. Auto-cured composite resin restorations.
 - e. Pins for reinforced pin restorations.
 - f. Light cured composite resin restorations (not for Sealants).
6. Endodontic Services
 - a. Pulp cap (excluding restorations).
 - b. Recalcification (treatment restoration).
 - c. Therapeutic apical closure (apical calcification technique).
 - d. Pulpotomies (excluding restoration).
 - e. Root Canal (excluding restoration).
 - f. Endodontic (Pulpal) Therapy.
7. Non-Surgical Periodontal Services
 - a. Periodontal scaling and root planning.
 - b. Periodontal maintenance following active periodontal therapy.
 - c. Occlusal guards.
 - d. Minor occlusal adjustments.
 - e. Treatment of hypersensitive teeth or periodontal prophylaxis.
 - f. Occlusal analysis.

8. Surgical Periodontics
 - a. Periodontal scaling and root planing with subgingival curettage.
 - b. Full mouth debridement to enable comprehensive evaluation and diagnosis.
 - c. Subgingival curettage.
 - d. Gingivectomy or gingivoplasty.
 - e. Gingival flap procedure.
 - f. Clinical crown lengthening.
 - g. Osseous surgery.
 - h. Mucogingivoplastic surgery.
 - i. Provisional splinting.
 - j. Guided tissue regeneration.
 - k. Pedicle soft tissue graft.
 - l. Free soft tissue graft.
 - m. Subepithelial connective tissue graft.
9. Chairside Resin laminate veneers

C. Major Dental Services

1. Prosthetic Dentures and Bridges
 - a. Complete, Fixed or Removable Partial Dentures. Limited to one (1) every three (3) years.
2. Other Prosthetic Services
 - a. Adjustment of dentures is limited to one (1) every six (6) months.
 - b. Denture relining is limited to one (1) every three (3) years.
 - c. Abutment Crowns (when used as an element of a bridge).
 - d. Bridges
 - (1) Limited to one (1) replacement every three (3) years.
 - (2) Recementation of fixed bridge. Limited to one (1) every three (3) years.
 - e. Repairing broken acrylic denture base.
 - f. Replacing missing or broken denture teeth.
 - g. Adding to a partial denture to replace extracted tooth or teeth.
 - h. Replacing clasp with new clasp on partial denture.

- i. Adding additional clasps and/or teeth.
 - j. Denture rebasing.
3. Inlays, Onlays and Crowns
- a. Crowns and jackets, Inlays, Onlays, post and copings.
 - b. Recementation of Crowns and Inlays/Onlays. Limited to one (1) in a three (3) year period.
4. Management of Temporomandibular problems.
- a. This is a procedure to move teeth by means of appliances to correct a handicapping malocclusion of the mouth.
5. Laboratory created resin laminate veneers and porcelain veneers.

Orthodontic Services, Treatment and Appliances

1. This Benefit Plan covers Orthodontic Services. There is no age limit for Plan Participants for Orthodontic Services. Orthodontic Services are subject to the Orthodontics Lifetime Maximum Benefit stated on the Schedule of Dental Benefits. Once this Benefit Plan has paid Benefits up to the Lifetime Maximum for a Plan Participant, no more Orthodontic Services will be payable for the life of the Plan Participant. The Orthodontic Lifetime Maximum does not accrue to the Benefit Period Maximum.

Removable or fixed inhibiting appliances to correct oral habits (thumb sucking or tongue thrusting).

ARTICLE V. TRANSFER OF CARE LIMITATIONS

If a Plan Participant transfers from the care of one Dentist to another Dentist during the course of treatment, or if more than one Dentist renders Dental Care and Treatment for the same procedure, the Plan Administrator will not pay more than the amount for which it would have been liable had one Dentist rendered the care.

ARTICLE VI. LIMITATIONS AND EXCLUSIONS

Any of the limitations and exclusions in this Benefit Plan may be revised, deleted or limited as shown on the Schedule of Benefits.

Unless shown as covered on the Schedule of Benefits, no Benefits will be provided for the following services:

- 1. Before coverage. Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.
- 2. For house or hospital calls for dental services and for hospitalization costs (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, 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 Plan Participant 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 court of competent jurisdiction, or a judgment following a trial.

4. Administrative costs. Administrative costs of completing Claim forms or reports or for providing dental records.
5. Broken appointments. Charges for broken or missed dental appointments.
6. Excess charge. The part of an expense for care and treatment of an injury or sickness that is in excess of the usual and reasonable charge.
7. Felonious behavior. Charges for services received as a result of injury or sickness caused or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, assault or other felonious behavior, or by participating in a riot or public disturbance.
8. Government. Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
9. Implants. Implants, including any appliances and the surgical insertion or removal of implants.
10. No charge. Care and treatment for which there would not have been a charge if no coverage had been in force.
11. No listing. Services which are not included in the list of covered dental services.
12. No obligation to pay. Charges incurred for which the Plan has no legal obligation to pay.
13. Not Medically or Dentally Necessary. Care and treatment that is not Medically or Dentally Necessary.
14. Which are Cosmetic in nature as determined by the Company (for example but not limited to, bleaching, personalization or characterization of Crowns, bridges and/or dentures).
15. Replacement or repair of lost, stolen or damaged prosthetic or Orthodontic appliances.
16. Preventive restorations.
17. For duplicate dentures, prosthetic devices or any other duplicative device.
18. Incomplete treatment (for example but not limited to, patient does not return to complete treatment) and temporary services (for example but not limitation, temporary restorations).
19. 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.
20. Specialized procedures and techniques (for example but not limited to, precision attachments, and intentional root canal treatment).
21. Those specifically listed on the Schedule of Benefits as Not Covered or Plan Pays 0%.
22. No Benefits will be paid under Periodontal and Endodontics Services for bone grafts and transplants.
23. No Benefits will be paid under Orthodontic Services for repair or replacement of any Orthodontic appliances.
24. Sealants, except on permanent teeth of Plan Participants up to age nineteen (19).
25. Anesthesia other than IV conscious sedation, deep sedation and general anesthesia is excluded when billed separately from global charges for dental procedures.

26. Services for treatment of any Plan Participant detained in a correctional facility who has been adjudicated or convicted of the criminal offense causing the detention.
27. 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.
28. 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 VII. PRE-DETERMINATIONS

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

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

Please note that pre-determinations are not designed to be used for emergency treatments or routine preventive services such as exams, x-rays or cleanings. A pre-determination is not an Authorization. When a covered Benefit needs to be Authorized, a formal Authorization request prior to service will have to be submitted.

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

If a Plan Participant 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 Plan Participant may have.

ARTICLE IX. BENEFIT EXTENSION PERIOD AFTER TERMINATION OF COVERAGE

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

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

A covered Benefit expense will be deemed incurred as follows:

1. For appliances or changes to appliances – on the date the appliance or prosthesis is permanently placed;
2. For Crowns, dentures or bridgework – on the date the impression is taken;
3. For Root Canal therapy -- on the date the pulp chamber is opened; or
4. For all other dental expenses -- on the date the service is rendered, or the supply is furnished.

ARTICLE X.

CONTINUATION OF COVERAGE RIGHTS

A. Leave of Absence

1. Leave of Absence without Pay, Employer Contributions to Premiums

- a. An Employee who is granted leave of absence without pay due to a service-related injury may continue coverage and the Employer shall continue to pay its portion of premiums for up to twelve (12) months if the Employee continues his/her coverage. Failure of the Employee to pay the premium will result in cancellation of coverage.
- b. An Employee who suffers a service-related injury that meets the definition of a total and permanent disability under the workers' compensation laws of Louisiana may continue coverage and the Employer shall continue to pay its portion of the premium until the Employee becomes gainfully employed or is placed on state disability retirement.
- c. An Employee who is granted leave of absence without pay in accordance with the federal Family and Medical Leave Act (FMLA) may continue coverage during the time of such leave and the Employer may continue to pay its portion of premiums if the Employee continues his/her coverage. Failure of the Employee to pay the premium will result in cancellation of coverage.

2. Leave of Absence without Pay – No Employer Contributions to Premiums

An Employee granted leave of absence without pay for reasons other than those stated above in paragraph a, may continue to participate in this Benefit Plan for a period up to twelve (12) months upon the Employee's payment of the full premiums due.

B. Dependents Continuation

1. Benefits under the Plan for covered Dependents of a deceased covered Employee or Retiree will terminate on the last day of the month in which the Employee's or Retiree's death occurred unless the surviving covered Dependents elect to continue coverage.
 - a. The surviving Dependent child of an Employee or Retiree may continue coverage unless or until such Dependent child is or becomes eligible for coverage under a group health plan other than Medicare, or until end of the month of the attainment of the termination age for that specific Dependent Child, whichever occurs first.
 - b. Surviving Dependents will be entitled to receive the same Group premium contributions as Employees and Retirees, subject to the provisions of La. R.S. 42:851 and rules promulgated pursuant thereto by the Office of Group Benefits.
 - c. Coverage provided by the Civilian Health and Medical Program of the Uniform Services (CHAMPUS/TRICARE) or its successor will not be sufficient to terminate the coverage of an otherwise eligible Dependent child.
 - d. A Dependent child cannot add new Dependents to continued coverage other than a child of the deceased Employee or Retiree born after the Employee's or Retiree's death.

2. Employee and Dependent Responsibilities

- a. It is the responsibility of the surviving covered Dependent to notify the Plan Administrator within thirty (30) days of the death of the Employee or Retiree.
 - b. The Plan Administrator will notify the surviving Dependents of their right to continue coverage.
 - c. Application for continued coverage must be made in writing to the Plan Administrator within sixty (60) days of receipt of notification, and premium payment must be made within forty-five (45) days of the date continued coverage is elected for coverage retroactive to the date coverage would have otherwise terminated.
3. Coverage for a surviving Dependent child under this section will continue until the earliest of the following events:
- a. Failure to pay the applicable premium timely.
 - b. Eligibility of the surviving Dependent child for coverage under any group health plan other than Medicare.
 - c. The end of the month of the attainment of the termination age for that specific Dependent child.
4. The provisions of section B above are applicable to surviving Dependents who, on or after July 1, 1999, elect to continue coverage following the death of an Employee or Retiree. Continued coverage for surviving Dependents that made such election before July 1, 1999, shall be governed by the rules in effect at the time of the election.

C. Over-Age Dependents

1. If a Dependent child is incapable (and became incapable prior to attainment of age twenty-six (26) of self-sustaining employment) by reason of physical or mental disability, the coverage for the Dependent child may be continued for the duration of incapacity.
 - a. No earlier than six (6) months prior to the Dependent child reaching age twenty-six (26), an application for continued coverage must be filed with the Plan Administrator or a form designated by the Plan Administrator, with current medical information from the Dependent Child's attending Physician along with the Child's attending Physician's attestation of the Child's incapacity to perform self-sustaining employment, must be submitted to the Plan Administrator to establish eligibility for continued coverage as set forth above.
 - b. After the initial approval, the Plan Administrator may require the submission of additional medical or other supporting documentation substantiating the continuance of the disability, but not more frequently than annually, as a precondition to continued coverage.

D. Military Leave

1. Employees in the National Guard or in the United States military reserves who are called to active military duty and their covered eligible Dependents will have access to continued coverage under this Benefit Plan subject to submittal of appropriate documentation to the Plan Administrator.
2. When an Employee is called to active military duty, the Employee and their covered eligible Dependents may:
 - a. continue participation in the Plan during the period of active military service, in which case the Employer may continue to pay its portion of premiums; or

- b. cancel participation in the Plan during the period of active military service, in which case the Employee may apply for reinstatement of coverage within thirty (30) days of:
 - (1) the date of the Employee's re-employment with the Employer; or
 - (2) the date of termination of extended health coverage provided as a benefit of active military duty, such as TRICARE Reserve Select. For Employees who elect this option and timely apply for reinstatement coverage, the lapse in coverage during active military duty or extended military coverage will not result in any adverse consequences with respect to the participation schedule set forth in La. R.S. 42:851E and the corresponding rules promulgated by the Office of Group Benefits.

E. COBRA Continuation

During the period of continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Benefits will be identical to those provided to others enrolled in this Plan under its standard eligibility provisions for Employees, Retirees and their Dependents.

1. Employees

- a. Coverage under this Plan for a covered Employee will terminate on the last day of the calendar month during which employment is terminated (voluntarily or involuntarily) or significantly reduced, the Employee no longer meets the definition of an Employee, or coverage under a Leave of Absence expires unless the covered Employee elects to continue coverage at the Employee's own expense. Employees terminated for gross misconduct are not eligible for COBRA coverage.
- b. Application for continued coverage must be made in writing to the Plan Administrator within sixty (60) days of the date of the election notification, and premium payment must be made within forty-five (45) days of the date the Employee elects continued coverage. Coverage will be retroactive to the date it would have otherwise terminated.
- c. If employment for a covered Employee is terminated (voluntarily or involuntarily) or significantly reduced, the Employee no longer meets the definition of an Employee, or Leave of Absence has expired, and the Employee has not elected to continue coverage, the covered Spouse and/or covered Dependent children may elect to continue coverage at his own expense. The elected coverage will be subject to the above stated notification provisions.

2. Surviving Dependents

- a. Coverage under this Plan for covered surviving Dependents of an Employee or Retiree will terminate on the last day of the month in which the Employee's or Retiree's death occurs, unless the surviving covered Dependents elect to continue coverage at their own expense.
- b. It is the responsibility of the surviving covered Dependent to notify the Plan Administrator within thirty (30) days of the death of the Employee or Retiree. The Plan Administrator will notify the surviving Dependents of their right to continue coverage. Application for continued coverage must be made in writing to the Plan Administrator within sixty (60) days of the date of the election notification.
- c. Payment of premiums, contributions and surcharges must be made within forty-five (45) days of the date the continued coverage was elected, retroactive to the date coverage would have terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

3. Ex-Spouse/Ex-Stepchildren – Divorce, Annulment, or Legal Separation or Death

- a. Coverage under this Plan for an Employee's or Retiree's Spouse (and any stepchildren enrolled in the Plan) will terminate on the last day of the month during which dissolution of the marriage occurs by virtue of a legal decree of divorce, annulment, or legal separation from the Employee or Retiree, unless the covered ex-Spouse elects to continue coverage at his/her own expense.
- b. Coverage under this Plan for an Employee's/Retiree's stepchild will terminate on the last day of the month of the death of the Employee's/Retiree's Spouse who is the stepchild's parent.
- c. It is the responsibility of the Employee / Retiree to notify the Plan Administrator of the divorce, annulment, legal separation or death within sixty (60) days from the date of the divorce, annulment, legal separation or death. The Plan Administrator will notify the ex-Spouse (and any ex-stepchildren of the Employee/Retiree who were enrolled on the Plan) within fourteen (14) days of his/her right to continue coverage. Application for continued coverage must be made in writing to the Plan Administrator within sixty (60) days of the election notification.
- d. Payment of premiums, contributions and surcharges must be made within forty-five (45) days of the date continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

4. Dependent Children

- a. Coverage under this Plan for a covered Dependent child will terminate on the last day of the month during which the Dependent child no longer meets the definition of an eligible covered Dependent, unless the Dependent child elects to continue coverage at his/her own expense.
- b. It is the responsibility of the Dependent child to notify the Plan Administrator within sixty (60) days of the date coverage would have terminated. The Plan Administrator will notify the Dependent child within fourteen (14) days of his/her right to continue coverage. Application for continued coverage must be made in writing to the Plan Administrator within sixty (60) days of receipt of the election notification.
- c. Payment of premiums, contributions and surcharges must be made within forty-five (45) days of the date the continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

5. Dependents of COBRA Participants

- a. If a covered terminated Employee has elected to continue coverage and if during the period of continued coverage, the covered Spouse or a covered Dependent child becomes ineligible for coverage due to:
 - (1) Death of the Employee,
 - (2) Divorce, Annulment, or Legal Separation from the Employee, or
 - (3) A Dependent child no longer meets the definition of an eligible covered Dependent,then, the Spouse and/or Dependent child may elect to continue COBRA coverage at his/her own expense. Coverage will not be continued beyond thirty-six (36) months from the date coverage would have otherwise terminated.

- b. It is the responsibility of the Spouse and/or the Dependent child to notify the Plan Administrator within sixty (60) days of the date COBRA coverage would have terminated.
- c. Monthly payments for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

6. Disability COBRA

- a. If a Plan Participant is determined by the Social Security Administration or by the Plan Administrator staff (in the case of a person who is ineligible for Social Security Disability benefits due to insufficient quarters of employment) to have been totally disabled on the date the Plan Participant became eligible for continued coverage or within the initial eighteen (18) months of continued coverage, coverage under this Plan may be extended at his own expense up to a maximum of twenty-nine (29) months from the date coverage would have otherwise terminated.
- b. To qualify for disability COBRA, the Plan Participant must:
 - (1) Submit a copy of his Social Security Administration's disability determination to the Plan Administrator before the initial eighteen (18) month continued coverage period expires and within sixty (60) days after the latest of:
 - (a) The date of issuance of the Social Security Administration's disability determination; or
 - (b) The date on which the qualified beneficiary loses (or would lose) coverage under terms of the Plan as a result of the covered Employee's termination or reduction of hours.
 - (2) In the case of a person who is ineligible for Social Security disability benefits due to insufficient quarters of employment, submit proof of total disability to the Plan Administrator before the initial eighteen (18) month continued coverage period expires. The staff and medical director of the Plan Administrator will make the determination of total disability based upon medical evidence, not conclusions, presented by the applicant's physicians, work history and other relevant evidence presented by the applicant.
- c. For purposes of eligibility for extended continued coverage under this section, total disability means the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to last for a continuous period of twelve (12) months. To meet this definition, one must have a severe impairment which makes one unable to do his previous work or any other substantial gainful activity which exists in the national economy, based upon a person's residual functional capacity, age, education, and work experience.
- d. Monthly payments for each month of extended disability COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

7. Medicare COBRA

- a. If an Employee becomes entitled to Medicare less than eighteen (18) months before the date the Employee's eligibility for Benefits under this Plan terminates, coverage under this Plan may be extended at his/her own expense up to a maximum of thirty-six (36) months.
- b. Monthly payments for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

8. COBRA continuation coverage will continue until the earliest of the following:

- a. Employees
 - (1) Failure to pay the applicable premiums, contributions and surcharges timely;
 - (2) Eighteen (18) months beyond the date coverage would have otherwise terminated;
 - (3) Entitlement to Medicare;
 - (4) Coverage under a group health plan; or
 - (5) The Employer ceases to provide any group health plan for its Employees or Retirees.
- b. Surviving Dependents, Divorced Spouse, Dependent Children and Dependents of COBRA Participants.
 - (1) Failure to pay the applicable premiums, contributions and surcharges timely;
 - (2) Thirty-six (36) months beyond the date coverage would have otherwise terminated;
 - (3) Entitlement to Medicare;
 - (4) Coverage under a group health plan; or
 - (5) The Employer ceases to provide any group health plan for its Employees or Retirees.
- c. Disability COBRA
 - (1) Failure to pay the applicable premiums, contributions and surcharges timely;
 - (2) Twenty-nine (29) months from the date coverage would have otherwise terminated;
 - (3) Entitlement to Medicare;
 - (4) Coverage under a group health plan; or
 - (5) The Employer ceases to provide any group health plan for its Employees or Retirees.
 - (6) Thirty (30) days after the month in which the Social Security Administration determines that the Covered Person is no longer disabled. (The Covered Person must report the determination to the Plan Administrator within thirty (30) days after the date of issuance by the Social Security Administration.) In the case of a person who is ineligible for Social Security disability benefits due to insufficient quarters of an employment, thirty (30) days after the month in which the Plan Administrator determines that the Covered Person is no longer disabled.
- d. Medicare COBRA
 - (1) Failure to pay the applicable premiums, contributions and surcharges timely;
 - (2) Thirty-six (36) months from the date of the Employee's Medicare entitlement;
 - (3) Entitlement to Medicare;
 - (4) Coverage under a group health plan; or
 - (5) The Employer ceases to provide any group health plan for its Employees or Retirees.

XARTICLE XI. GENERAL PROVISIONS – GROUP AND PLAN PARTICIPANTS

A. The Benefit Plan

1. Except as specifically provided herein, this Benefit Plan will not make the Claims Administrator liable or responsible for any duty or obligation imposed on the Employer by federal or state law or regulations.
2. 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 Caddo Parish School Board of such employee welfare benefit plan and will be solely responsible for meeting any obligations imposed by law or regulation on the administrator of the Plan, except those specifically undertaken by the Claims Administrator 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 Plan Participants for illness or bodily injury otherwise covered under this 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 Claims Administrator harmless in the event the Claims Administrator incurs any liability as a result of the Group's failure to do so.
3. The Claims Administrator will not be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance or malpractice on the part of any Hospital or other institution, or any agent or employee thereof, or on the part of any Physician, Allied Provider, nurse, technician or other person participating in or having to do with a Plan Participant care or treatment.
4. The Benefit Plan will not impose eligibility rules or variations in Employee contributions or fees based on a Plan Participant's health status or a health status-related factor.
5. Caddo Parish School Board shall administer the Benefit Plan in accordance with its terms and established policies, interpretations, practices and procedures. It is the express intent of this Benefit Plan that Caddo Parish School Board shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the plan, to make determinations regarding issues which relate to eligibility for Benefits, to make determinations on the termination of coverage for its Employees and Dependents, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of plan interpretation and those of fact relating to the plan. The decisions of Caddo Parish School Board will be final and binding on all interested parties.
6. The Claims Administrator shall have the right to enter into any contractual agreements with subcontractors, dental healthcare Providers, or other third-parties relative to this Benefit Plan. Any of the functions to be performed by the Claims Administrator under this Plan may be performed by the Claims Administrator or any of their subsidiaries, affiliates, subcontractors, or designees.

B. Amending and Terminating the Benefit Plan

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

C. Identification Cards and Benefit Plans

The Claims Administrator will prepare an ID card for each covered Employee. The Claims Administrator will issue a Benefit Plan to the Group and print a sufficient number of copies of this Benefit Plan for the Group's covered Employees. At the direction of the Group, the Claims Administrator will either deliver all materials to the Group for the Group's distribution to the covered Employees, or the Claims Administrator will either deliver

all materials directly to each covered Employee. Unless otherwise agreed between the Group and the Claims Administrator, the Group has the sole responsibility for distributing all such documents to covered Employees.

D. 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 regarding any change in rates. Such increase in premiums will become effective on the date specified in the notice and continued payment of premiums will constitute acceptance of the change. We reserve the right to increase the premiums more often than stated above due to the Group's addition of a newly covered person or entity not previously considered in the rate determination process at any time during the life of the Benefit Plan. Additionally, the Company reserves the right to increase the premium amount because of: (1) any change in age or geographic location of any individual insured or policyholder; (2) a change in the extent or nature of the risk of the Group; or (3) any change in the Benefit level from that which was in force at the time of the last rate determination. Such increase of premiums will become effective on the next billing date following the effective date of the change. Continued payment of premiums will constitute acceptance of the change.
2. Premiums are due and payable beginning with the Effective Date of this Benefit Plan and on the same date each month thereafter. The Group is considered delinquent if premiums are not paid as of the due date.
3. If the Group does not make payment to the Company's 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.

E. Benefits to Which Members are Entitled

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

F. Retroactive Cancellation of Coverage

1. The Plan Administrator may retroactively cancel coverage in the following instances:
 - a. To the extent the cancellation of coverage is attributable to failure of the Plan Participant to timely pay required premiums, contributions and surcharges toward the cost of the coverage; or
 - b. The cancellation of coverage is initiated by the Plan Participant
2. When the Plan Administrator retroactively cancels coverage, the Plan Participant shall be liable to the Plan Administrator for all Benefits paid on behalf of the Plan Participants after the effective date of Rescission or cancellation of coverage.

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

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

2. All notification of membership or coverage changes must be on forms approved by the Company and include all information required by the Company to effect changes.
3. The Group must notify the Company's membership and billing department of a Plan Participant'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 Plan Participant or any of the Dependents is terminated from the Group or eligibility for coverage ends (or any other period described on the Schedule of Dental Benefits). The Group will also submit to the Company's membership and billing department evidence of a Plan Participant's or his/her Dependent's election of any applicable COBRA coverage following such termination within three (3) business days of Group's receipt of signed COBRA forms. The Company is under no obligation to refund any premium paid by the Group or any Plan Participant, if payment was made to the Company due to the Group's failure to timely notify the Company of a Plan Participant's or his/her Dependent's termination of coverage.
4. Requests for termination of coverage that are submitted after the period provided above will only be honored prospectively after the date of receipt and the Group will be responsible to pay all corresponding premiums until the effective date of termination. All requests for termination of coverage, whether timely or not, will be subject to any other terms, conditions and legal requirements that may apply.

Whenever the Group submits a request to the Company to terminate a Plan Participant's coverage or that of any Dependents, the Group will be deemed to be making a representation that neither the Plan Participant nor his/her 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 Plan Participant or 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 the Company for such purpose, and to submit any election from the individual to continuation coverage in a separate process.

5. The Group warrants the accuracy of the information it transmits to the Company and understands that the Company will rely on this information. The Group agrees to supply or allow inspection of personnel records to verify eligibility as requested by the Company.
6. The Group also agrees to indemnify Us for all expenses We may incur if the Group does not send correct information when required. Indemnification includes, but is not limited to, Claims payments made on behalf of people who are not eligible for Benefits. Alternatively, We may, at Our sole option, hold the Group responsible for all premium payments for Plan Participants who are not cancelled from coverage on time because the Group did not notify Us of terminations or changes in eligibility.

H. Termination of Your Coverage

1. The Company may choose to rescind coverage or terminate a Plan Participant's coverage if a Plan Participant 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 Plan Participant or covered Plan Participant, shall constitute an intentional misrepresentation of material fact. A Plan Participant's coverage may be rescinded retroactively to the Effective Date of coverage or terminated within three (3) years of the Plan Participant's Effective Date, for fraud or intentional misrepresentation of material fact. The Company will give the Plan Participant sixty (60) days advance written notice prior to rescinding or terminating coverage under this section. If Plan Participants 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 Plan Participant's coverage terminates as provided below:
 - a. The Plan Participant's coverage and that of all Dependents automatically, and without notice, terminates at the end of the period in which the Plan Participant ceases to be eligible.
 - b. The coverage of the Plan Participant'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 Plan Participant, the coverage of all 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 the Company terminates this Benefit Plan for nonpayment of the appropriate payment when due or because 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 Plan Participant 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 Plan Participants and beneficiaries of such cancellation or termination. The Company has no such obligation to notify at the Plan Participant level.
4. Except as otherwise provided in this Benefit Plan, no Benefits are available to a Plan Participant for Covered Services rendered after the date of cancellation or termination of a Plan Participant's coverage.
5. When covered Plan Participants on the Benefit Plan change, the Company reserves the right to change the Plan Participant's class of coverage and bill appropriate premium to reflect the Plan Participants 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, Plan Participants may apply for individual coverage to the Company or to the Exchange.

I. Filing of Claims

All Claims must be filed 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.

When a Plan Participant has coverage under more than one dental plan or a health plan that may provide dental benefits, it is necessary for the Plan Participant to file a Claim under each plan. If Claims are filed by the Provider, it is the responsibility of the Plan Participant to verify that the Provider has filed Claims with each plan. Benefits will only be paid on a plan if a Claim is filed for that specific plan.

J. Applicable Law

This 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 Plan is not subject to regulation by any state other than the State of Louisiana. If any provision of this Benefit Plan is in conflict with any applicable statutes or regulations of the United States of America or the State of Louisiana, the provision is automatically amended to meet the minimum requirements of the statute or regulation. Any legal action filed against the Plan must be filed in the appropriate court in the State of Louisiana.

K. 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.

L. Release of Information

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

M. Assignment

A Plan Participant's rights, and Benefits under this Benefit Plan are personal to the Plan Participant and may not be assigned in whole or in part by the Plan Participant. The Claims Administrator will not recognize assignments or attempted assignments of Benefits. Nothing contained in this written description of dental coverage shall be construed to make the Group or the Claims Administrator liable to any third-party to whom a Plan Participant may be liable for the cost of dental care, treatment or services.

N. Plan Participant /Provider Relationship

1. The choice of a Provider is solely the Plan Participant's.
2. The Claims Administrator 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. The Claims Administrator does not render Covered Services, but only makes payment for Covered Services that the Plan Participant receives. Neither the Plan nor the Claims Administrator will 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 Plan Participant while receiving care from any Network Provider or in any Network Provider's facilities. The Plan and the Claims Administrator have no responsibility for a Provider's failure or refusal to render Covered Services to a Plan Participant.
3. The use or non-use of an adjective such as Preferred Network, Participating and Non-Participating in referring to any Provider is not a statement as to the ability of the Provider.

O. 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.

P. Notice

Any notice required under this Benefit Plan must be in writing. Any notice required to be given to a Plan Participant will be considered delivered when deposited in the United States Mail, postage prepaid, addressed to the Plan Participant at the address as the same appears on the Claims Administrator's records. Any notice that a Plan Participant must give at the address as the same appears on this Benefit Plan. The Group, the Claims Administrator, or a Plan Participant, by written notice, may indicate a new address for giving notice.

Q. Job-Related Injury or Illness

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

R. Subrogation

1. To the extent that Benefits for Covered Services are provided or paid under this Benefit Plan, the Company will be subrogated and will succeed to the right of the Plan Participant 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 a Plan Participant who is its insured. The acceptance of such Benefits under this Benefit Plan will constitute subrogation. The Company's right to recover will be contingent on the Plan Participant'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 court of competent jurisdiction, or a judgment following a trial. The Company will be responsible for its proportionate share of the reasonable attorney fees and costs actually paid by the Plan Participant in pursuing recovery.
2. The Plan Participant will reimburse the Company 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 the Plan Participant who is its insured, to the extent of the Benefits provided or paid under this Plan. The Company's right to recover will be contingent on the Plan Participant'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.
3. The Plan Participant will take such action, furnish such information and assistance, and execute such papers as the Company may be required to facilitate enforcement of its rights, and will take no action prejudicing the rights and interest of the Company under this Benefit Plan. The Company and its designees have the right to review medical and billing records if the Company determines, in its sole discretion, that such records would be helpful in pursuing the Company's right of subrogation and reimbursement.
4. The Plan Participant must notify the Plan of any Accidental Injury.

S. Right of Recovery

Whenever any 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 for non-Covered Services, the Company will have the right to recover such payment from the Plan Participant 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 Plan Participant or Provider owes the Company.

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

In any case in which a veteran is furnished care or services by the Department of Veterans Affairs for a non-service-connected disability, the United States will have the right to recover or collect the reasonable cost of such care or services from 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.

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 and Coinsurance.

U. Liability of Plan Affiliates

The Plan Administrator, 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.

V. Continued Coverage During a Leave of Absence

As stated in the Schedule of Eligibility, an Employee must be actively working for the 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 a Plan Participant and Dependents to be entitled to continued coverage under this Plan.

1. The Company will continue coverage for the Plan Participant 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 the Plan Participant's coverage is terminated during a leave under the FMLA, upon return to active full-time employment, the Plan Participant 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 the Company. If the Plan Participant is not restored to active full-time employment by the end of the leave of absence period, the Plan Participant will cease to be eligible and coverage for the Plan Participant 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 Plan Participant's Coverage. The Plan Participant and Dependents may have the right to continue coverage thereafter under the Continuation of Coverage Rights Article of this Benefit Plan.
2. When a Plan Participant is not actively at work due to a health condition, the Company will maintain coverage for the Plan Participant and any Dependents, as long as the Plan Participant remains a bona fide Employee of the Group and premiums are paid. If the Group terminates the Plan Participant's employment, the Plan Participant will cease to be eligible and coverage for the Plan Participant and any Dependents will terminate as described in Termination of a Plan Participant's Coverage. The Plan Participant and Dependents may have the right to continue coverage thereafter under the Continuation of Coverage Rights Article of this Benefit Plan.
3. When a Plan Participant has been granted a documented, approved leave of absence by the Employer Group, and the leave of absence is not due to Plan Participant's health, the Company will maintain coverage for the Plan Participant and any covered Dependents for a period not to exceed ninety (90) days. Premiums must be paid, and the Plan Participant must remain a bona fide Employee of Group during the approved leave period. The Group will provide the Company with proof of the documented

leave, upon request. If the Group terminates the Plan Participant's employment, the Plan Participant will cease to be eligible and coverage for the Plan Participant and any Dependents will terminate as described in Termination of a Plan Participant's Coverage. Plan Participants and Dependents may have the right to continue coverage thereafter under the Continuation of Coverage Rights Article of this Benefit Plan.

ARTICLE XII. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

We want to know when a Plan Participant is dissatisfied with the care or services they receive from Blue Cross Blue Shield of Louisiana, United Concordia Dental (UCD) or Participating Providers. If a Plan Participant wants to register a Complaint or file a formal written Grievance about the Company, UCD or a Provider, please refer to the procedures below.

A Plan Participant may be dissatisfied about the decisions made regarding Covered Services. UCD considers an Appeal as the Plan Participant'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 Appeal process for situations where the time frame of the standard Dental Necessity Appeal would seriously jeopardize the life or health of a covered person, or would jeopardize the covered person's ability to regain maximum function.

A. Complaint and Grievance Procedures

A quality-of-service concern addresses the services, access, availability or attitude of the Company and those of Participating Providers. A quality-of-care concern addresses the appropriateness of care given to a Plan Participant.

1. To Register a Complaint

A Complaint is an oral expression of dissatisfaction with the Company, UCD or with Provider services. Plan Participants may call UCD at 1-866-445-5338 to register a Complaint. UCD will attempt to resolve the Plan Participant's Complaint at the time of the call.

2. To File a Formal Grievance

A Grievance is a written expression of dissatisfaction with the Company, UCD or with Provider services. If the Plan Participant does not feel their Complaint was adequately resolved or the Plan Participant 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's customer service department will assist the Plan Participant if necessary.

The Plan Participant should send written Grievances to:

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

A response will be mailed to the Plan Participant within thirty (30) business days of receipt of the Plan Participant'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.

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

C. Standard Appeal Process

UCD will distinguish if the Plan Participant'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 of an administrative Appeal and a review by an external Independent Review Organization (IRO) on a Dental Necessity Appeal.

The Plan Participant 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 Plan Participant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to Adverse Benefit Determination.

The Plan Participant has the right to appoint an authorized representative to represent the Plan Participant in Appeals. An authorized representative is a person to whom the Plan Participant has given written consent to represent the Plan Participant in a review of an Adverse Benefit Determination. The authorized representative may be the Plan Participant's treating Provider, if the Plan Participant 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. 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 Plan Participant 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. Request 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 Plan Participant's concerns. If the administrative Appeal is overturned, UCD will reprocess the Plan Participant's Claim, if any. If the administrative Appeal is upheld, UCD will inform the Plan Participant of the right to begin the second level of administrative Appeal process.

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

b. Second Level Administrative Appeals

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

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

2. Dental Necessity Appeals

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

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

a. Internal Dental Necessity Appeals

If a Plan Participant 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. Request 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 Plan Participant's concerns. If the Dental Necessity Appeal is overturned, UCD will reprocess the Plan Participant's Claim if any. If the Dental Necessity is upheld, UCD will inform the Plan Participant 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 Plan Participant, the Plan Participant's authorized representative, or a Provider authorized to act on the Plan Participant's behalf, within thirty (30) days of receipt of the Plan Participant's request; unless its mutually agreed that an extension of time is warranted.

b. External Dental Necessity Appeals and Rescissions

For Dental Necessity Appeals and Rescissions, 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 Plan Participant must exhaust all internal Appeal opportunities prior to requesting an External Appeal conducted by an Independent Review Organization.

If a Plan Participant still disagrees with the internal Dental Necessity Appeal decision or Rescission, 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.

Requests submitted to UCD after four (4) months of receipt of the internal Dental Necessity Appeal decision or Rescission 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 within forty-five (45) days of receipt of the External Appeal. The IRO will notify the Plan Participant, the Plan Participant's authorized representative, or a Provider authorized to act on the Plan Participant's behalf of its decision.

The IRO decision will be considered a final and binding decision on both the Plan Participant 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 Plan Participant's life, health or ability to regain maximum function. It includes a situation where, in the opinion of the treating Provider, the Plan Participant 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 Plan Participant, the Plan Participant's authorized representative, or a Provider authorized to act on the Plan Participant'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 Expedited Appeal request that meets the criteria for Expedited Appeal.

In any case where the internal Expedited Appeal process does not resolve the difference of opinion between UCD and the Plan Participant or the Provider acting on behalf of the Plan Participant, 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
PO Box 94214
Baton Rouge, LA 70804-9214
1-225-342-5900 or 1-800-259-5300

ARTICLE XIII.

MAKING PLAN CHANGES AND FILING CLAIMS

All of the forms mentioned in this section can be obtained from the Employer's personnel office, from one of the Claims Administrator's local service offices, or from the home office of Blue Cross and Blue Shield of Louisiana. If the Plan Participant needs to submit documentation, the Plan Participant may forward it to Blue Cross and Blue Shield of Louisiana at P.O. Box 98029, Baton Rouge, LA 70898-9029, or to 5525 Reitz Avenue, Baton Rouge, LA 70809.

If the Plan Participant has any questions about any of the information in this section, the Plan Participant may speak to the Employer or call the Claims Administrator's customer service department at the telephone number shown on the ID card.

A. Adding or Changing the Plan Participant's Family Members on the Plan

The Schedule of Eligibility lets the Plan Participant know when it is necessary to enroll additional family members for Dependent coverage under the Plan. Please read the Schedule of Eligibility Article and this section as they contain important information for the Plan Participant.

The Group may require the Employee to use the Employee Enrollment / Change Form to enroll family members not listed on the Plan Participant's original enrollment form. If the Plan Participant does not complete and return a required Employee Enrollment/Change Form to the Plan so the Claims Administrator receives it within the timeframes set out in the Schedule of Eligibility, it is possible that the Plan Participant's dental Benefits coverage will not be expanded to include the additional family members. Completing and returning an Employee Enrollment / Change Form is especially important when the Plan Participant's first Dependent becomes eligible for coverage or when the Plan Participant no longer has any eligible Dependents.

The Schedule of Eligibility explains when coverage becomes effective for new family members. Generally, an Employee Enrollment / Change Form is used to add newborn children, newborn adopted children, a Spouse, or other Dependents not listed on the Plan Participant's original application for coverage. The Plan should receive the Plan Participant's completed form within thirty (30) days of the child's birth or placement, or the Plan Participant's marriage.

B. How to File Insurance Claims for Benefits

The Claims Administrator and Participating Providers have entered into agreements that eliminate the need for a Plan Participant to personally file a Claim for Benefits. Participating Providers will file Claims for Plan Participants either by mail or electronically and the Participating Provider normally will be reimbursed directly. In certain situations, the Provider may request the Plan Participant to file the Claim. If the Plan Participant's Provider does request the Plan Participant to file directly with the Claims Administrator, the following information will help the Plan Participant in correctly completing the Claim form.

In certain situations, and only when permitted by the Company, a Plan Participant may consent to allow a Non-Participating Provider to be reimbursed directly.

The ID card shows the way the name of the Employee (Plan Participant of the Group) appears on the Claims Administrator's records. If the Plan Participant has Dependent coverage, the name(s) are recorded as the Plan Participant wrote them on the enrollment form. The ID card also lists the Plan Participant's contract number (ID #). This number is the identification to the Plan Participant's membership records and should be provided each time a Claim is filed.

If the Plan Participant completes the Claim form and this is a Group plan, remember the Plan Participant is the Employee Member. If the Plan Participant is the patient, the relationship is SELF. If the Plan Participant's wife or husband is the patient, the relationship is SPOUSE.

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

1. an appropriate Claim form is used
2. the contract number (ID #) shown on the form is identical to the number on the ID card

3. the patient's name and date of birth is listed
4. the patient's relationship to the Employee is correctly stated
5. all charges are itemized, whether on the Claim form or on the attached statement
6. the date of service or date of treatment is correct
7. the Provider includes a diagnosis and a procedure code for each service/treatment rendered (the diagnosis code pointers must be consistent with the Claim form)
8. the Provider's name, address and tax ID number
9. the Claim is completed and signed by the Plan Participant and the Provider.

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

If You need to submit documentation, please send it to:

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

C. If a Plan Participant has a Question about a Claim

If a Plan Participant has a question about the processing or payment of a Claim, the Plan Participant can write to the Claims Administrator at the below address or the Plan Participant may call UCD's customer service department at 1-866-445-5338. If the Plan Participant calls for information about a Claim, We can help the Plan Participant better if the Plan Participant 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 Plan Participant must ALWAYS refer to the contract number in all correspondence and recheck it against the contract number on the ID card to be sure it is correct.

ARTICLE XIV. GENERAL PROVISIONS – GROUP/POLICYHOLDER ONLY

IN ADDITION TO THE GENERAL PROVISIONS FOR GROUP/POLICYHOLDER AND PLAN PARTICIPANTS, 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 the 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 the 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. The Company will not accept premium payments by third parties unless required by law to do so. The fact that the Company may have previously accepted a premium from an unrelated third-party does not mean that the 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. The Group/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, the Company may in its sole discretion refuse to reinstate coverage.

B. Change in Premium Amount

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

C. The Group's Right to Cancel the Benefit Plan

1. This Benefit Plan is guaranteed renewable at the option of the Group. The Group indicates its desire to continue coverage by its timely payment of each premium as it becomes due.
2. The Group may cancel this plan for any reason.
3. To cancel the plan the Group must give the Company WRITTEN NOTICE of its intent to cancel. THE GROUP MAY NOT VERBALLY CANCEL THIS COVERAGE. THE GROUP'S WRITTEN NOTICE OF CANCELLATION MUST BE GIVEN TO THE COMPANY PRIOR TO OR ON THE EFFECTIVE DATE OF THE CANCELLATION AND MUST BE ACCOMPANIED BY RETURN OF THE INSURANCE POLICY. If the Group's written notice to the Company of its intent to cancel is not accompanied by the surrendered policy, the Group's cancellation notice to the Company shall be deemed to include the 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. The Company's Right to Terminate the Plan for Reasons Other Than Nonpayment of Premium

The Company may terminate this Benefit Plan within sixty (60) days advance written notice to the Group, providing the reason for termination, if any one of the following occurs:

1. The Group commits fraud or makes an intentional misrepresentation.
2. The 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 the Group's participation falls to less than one (1) Employee (only the owner left on the plan), termination of the 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 the Group receives sixty (60) days written notice.
3. 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.
4. The Group's coverage is provided through a bona fide association and the employer's membership in the association ends.
5. The Company ceases to offer this product or coverage in the market (ninety (90) days advance written notice will be given to the Group, Plan Participants, and beneficiaries).
6. Advance written notice will be given to the Group in accordance with the timeframe required by law.

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:

Blue Cross and Blue Shield of Louisiana
P.O. Box 98029
Baton Rouge, Louisiana 70898-9029

In lieu of giving his proxy in the application for coverage, the policyholder may designate any other policyholder as his proxy by any form of writing which includes the policyholder's name and policy number, sent to Us as indicated above. Notice of meetings to the proxy constitutes notice to the policyholders giving their proxies. Further, notice is hereby given that Our annual meeting is held in the month of February with notice of the date of that meeting between 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. U.S. 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 U.S. 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 Plan

Participants and their covered Dependents, against all relevant U.S. 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.

I. Our Right to Offer Premium Incentives

The Claims Administrator 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:

1. Encouraging Plan Participants and/or Groups to participate in quality programs;
2. Ensuring Plan Participants and/or Groups are better able to afford benefits packages;
3. Reducing and alleviating social determinants of health;
4. Reducing transition costs for Plan Participants and/or Groups who have changed insurers or have ended self-insured coverage and purchased fully insured coverage;
5. Rewarding Plan Participants and/or Groups for choosing lower cost, quality healthcare providers;
6. Rewarding Plan Participants and/or Groups for select lower cost, quality healthcare goods and products;
7. Rewarding Plan Participants and/or Groups 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 Plan Participants and/or Groups when such costs are related to effectuating and/or maintaining coverage.



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

Nondiscrimination Notice

Discrimination Is Against the Law

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana, Inc. and Southern National Life, comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. Louisiana Blue does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

Louisiana Blue and its subsidiaries:

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

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

If you believe that Louisiana Blue or one of its subsidiaries failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you have the right to take the following steps:

1. **If you are fully insured through Louisiana Blue or one of its subsidiaries, file a grievance in person or by mail, fax or email.**

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

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

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

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

This notice is available at www.lablue.com.

NOTICE

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

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

Des services d'assistance linguistique gratuits et des aides auxiliares 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 ເຄື່ອງຊ່ວຍເສີມພຣີ. ຖ້າຕ້ອງການ, ກະລຸນາໂທຫາບໍລິການລູກຄ້າ ທີ່ເບີ 1-800-495-2583. ລູກຄ້າທີ່ມີການຫຼຸ 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)

