Group Dental Benefits
For The Employees Of
Louisiana Sheriffs’ Association

Administered by

Louisiana

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

NOTICES

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

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

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

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

Benefits available under this Benefit Plan are described in the Dental Care and Treatment Benefits Article below. Not every Group provides coverage for every service. The services that are available to the Plan Participant under this Benefit Plan are listed in the Schedule of 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 in the Schedule of Benefits. The Group may apply to the Plan Administrator to change the covered services on the Group’s anniversary date. Any special Benefits or limitations are shown in the Schedule of Benefits. Benefits offered may be limited to the least costly treatment.

The Group agrees 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 health care 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 Plan 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.

The AdvantagePlus Network consists of a select group of Providers who have contracted with United Concordia Dental to render services to Plan Participants for discounted fees. All other Providers are considered Non-Participating. Non-Participating Providers may bill you more for their services than Participating Providers.

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

HOW THE PLAN ADMINISTRATOR DETERMINES WHAT IT PAYS FOR COVERED SERVICES

The Plan Administrator bases its payment of Benefits for a Plan Participant’s Covered Services on an amount known as the “Allowable Charge.” If the amount that is billed for Covered Services by the Plan Participant’s Provider is less than the amount that the Plan Administrator has set for the Covered Service, the billed amount is the Allowable Charge and the Plan Administrator’s payment will be based on the billed amount.

NOTICE: THE PLAN PARTICIPANT’S SHARE OF THE PAYMENT FOR COVERED SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN THE PLAN PARTICIPANT’S DENTAL PLAN AND THE PLAN PARTICIPANT’S PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW THE PLAN PARTICIPANT’S PROVIDER TO BILL THE PLAN PARTICIPANT FOR AMOUNTS UP TO THE PROVIDER’S REGULAR BILLED CHARGES.
Louisiana law allows a dental patient to choose any type, form or quality of dental service or procedure, for which dental coverage is not available, as long as the patient approves in advance and in writing the charges for which he will be responsible to the Provider.

When a Plan Participant receives a dental diagnosis from a Participating Provider for a covered benefit under this Benefit Plan, the Plan Participant may choose to have the covered Benefit as designated by this dental Benefit Plan; or an alternate type, form, or quality of dental service which is of equal or greater price, provided the Plan Participant approves the alternate service in advance and in writing. In that case, the Plan Administrator will pay Contract Benefits as if the covered service was actually rendered, and the Plan Participant must pay the difference between the covered Benefit and the amount of the chosen alternative service or procedure.

**When A Plan Participant Uses Participating Providers**

Participating Providers are Providers who have signed contracts to participate in the AdvantagePlus Network to treat Plan Participants for favorable contracted fees. These Providers have agreed to accept the lesser of billed charges or the contracted amount as payment in full for Covered Services provided to the Plan Participant. This amount is the Participating Provider’s Allowable Charge. When a Plan Participant uses a Participating Provider, this Allowable Charge is used to determine the amount the Plan Administrator pays for Covered Services and the amount the Plan Participant pays.

**When A Plan Participant Uses Non-Participating Providers**

Non-Participating Providers are Providers who have not signed a contract to join the AdvantagePlus Network. The Plan Administrator establishes an Allowable Charge for Covered Services provided by Non-Participating Providers that is based on the contracted fee that has been accepted by Participating Providers. When a Plan Participant uses a Non-Participating Provider, this Allowable Charge is used to determine the Plan Administrator’s payment for a Plan Participant’s Covered Services and the amount that the Plan Participant must pay for Covered Services.

The Plan Participant may pay significant costs when he uses a Non-Participating Provider. This is because the amount that some providers charge for a Covered Service may be higher than the contracted fee that has been accepted by most Participating Providers. Also, Participating Providers waive the difference between the actual billed charge for a Covered Service and the Allowable Charge, while Non-Participating Providers will not.

A provider may be contracted with the Plan when providing services at one location, and may be considered out-of-network when rendering services from another location. Please make sure to check your provider directory to verify that the services are in-network from the location where you are seeking care.
ARTICLE II. DEFINITIONS

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

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

B. the Plan Participant's eligibility to participate in the Benefit Plan; or

C. any prospective or retrospective review determination.

Allowable Charge – The lesser of the billed charge or the amount established by the Plan 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 authorized representative to change an Adverse Benefit Determination made by the Claims Administrator.

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

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

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 Plan established by the Group to provide Benefits for eligible Plan Participants.

Benefit Plan Date – The date upon which the Group agrees to begin providing Benefits for Covered Services to Plan Participants on this Benefit Plan.

Claim – A Claim is written or electronic proof, in a form acceptable to the Plan 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 – United Concordia Companies, Inc. is Blue Cross and Blue Shield of Louisiana's claims administrator for this Benefit Plan.

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

Coinsurance – The sharing of Allowable Charges for Covered Services. The sharing is expressed as a 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. The Plan Administrator's percentage will be applied to the Allowable Charge for Covered Services to determine the Benefits provided.
**Common-Law Marriage** – a partnership whereby a man and woman who have lived together for a certain period of time and who hold themselves to be husband and wife may be considered to be married even without a license and a formal ceremony. Plan Administrator will determine eligibility for common law marriages.

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

**Complaint** – An oral expression of dissatisfaction with the Claims Administrator or Provider services.

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

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

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

**Deductible** – The dollar amount that each Plan Participant must pay out of their own pocket for Covered Services within each Benefit Period before any Benefits are paid under this Benefit Plan. The Deductible will be shown in the Schedule of Dental Benefits, which 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 procedure that is determined by Claims Administrator to either establish or maintain a patient’s dental health based on professional diagnostic judgment and the prevailing standards of care in the professional community. The determination will be made by a Dentist in accordance with guidelines established by Claims Administrator.

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

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

**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.
Eligible Person – A person entitled to apply to be an Employee or Dependent as specified in the Schedule of Eligibility.

Employee – An Eligible Person who has satisfied the specifications of this Benefit Plan's Schedule of Eligibility and has enrolled for coverage, and to whom the Plan Administrator has issued a copy of this Benefit Plan.

Employer – Louisiana Sheriffs’ Association.

Endodontic (Pulpal) Therapy – A dental procedure that is performed when the decay in a child's tooth reaches into the pulp (nerve) tissue. The infected part of the nerve tissue within the crown portion of the tooth is removed to prevent further inflammation and spread of disease (caries). During this treatment, the diseased pulp tissue is partially or completely removed from both the crown and the roots of the tooth. The canals are cleansed, disinfected, and filled with a special material.

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

Expedited Appeal – A request for immediate internal review of an Adverse Benefit Determination, which involves any of the following situations:

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

B. In the opinion of the treating physician, the Plan Participant may experience pain that cannot be adequately controlled while awaiting a standard medical Appeal decision.

C. Decision not to Authorize an Admission, availability of care, continued Hospital stay, or health care service for a Plan Participant currently in the emergency room, under observation, or receiving Inpatient care.

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

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

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

Gingivectomy – Surgical removal of gum tissue.

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

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

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

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

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 Group, during which an Employee and any eligible Dependents may enroll for Benefits under this Benefit Plan.

Orthodontics – A dental specialty that treats misalignment of teeth.

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

Plan – Louisiana Sheriffs’ Association dental benefits plan for Employees of Louisiana Sheriffs’ Association 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, the Plan Sponsor is the Plan Administrator.

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

Plan Sponsor – Louisiana Sheriffs’ Association who provides these Benefits on behalf of its eligible Employees 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.

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

A. Active Full-Time Employees

Employee - means a person employed on a full-time (thirty (30) hours per week) permanent basis by the Employer.

B. Part-Time and Reserve/Auxiliary Deputies

Part-time and Reserve/Auxiliary Deputies who are commissioned and who work regularly on a part-time basis (less than thirty (30) hours per week) are eligible for specific coverage as defined herein based on individual Parish option. Dependents of such deputies are not eligible for coverage under the Plan.

C. Retirees

The following Retirees are eligible to participate in the Plan:

1. Retirees currently receiving benefits under the Association Pension Plan who have:
   a.Joined the Plan during the ninety (90) days after their parish joined the Medical Plan;
   b. Exercised their option to continue coverage under the Medical Plan in the thirty (30) days from the date they ceased to be a full-time Employee.

   If such election is not made in the thirty (30) day option period or if the Retiree declines coverage, or drops coverage at any time after retirement, such person will not again be eligible to participate at any time in the future.

2. Employees who have qualified for retirement by years of service, but not by age (Deferred Retirees), who have:
   a. Joined the Plan during the ninety (90) days after their parish joined the Medical Plan; or
   b. Exercised their option to continue coverage under the Plan in the thirty (30) days from the date that they ceased to be an active full-time Employee.

   If such election is not made in the thirty (30) day option period or if the Deferred Retiree declines or drops coverage from the date he or she ceased to be eligible as an active full-time Employee, such person will not again be eligible until the date he or she becomes eligible to draw retirement benefits. On that date, he or she may become eligible to participate in the Medical Plan, but will be required to show evidence of good health before acceptance, and application must be made within thirty (30) days of the date the Retiree becomes eligible.

3. Former Employees who did not qualify for retirement, but had accumulated twelve (12) or more years of full-time service, who have exercised their option to continue coverage under the Plan within thirty (30) days from the date they ceased to be an active full-time Employee.

4. Employees who have qualified for retirement by years, but not by age, who have exercised their right to join the program during the ninety (90) day open enrollment or have exercised their option to continue under the Plan, and their Dependents as defined in ARTICLE II, DEFINITIONS, are eligible to participate in the Plan.

   Dependents covered by the Retiree the day prior to retirement, may be included by Retirees only on the Retirees’ initial effective date of coverage. A Retiree may not add Dependent coverage at a date later than his or her initial date of coverage unless adding a new spouse within 30 days of marriage, or adding a Dependent child within 30 days of eligibility.

5. To comply with House Bill 253, Act 314 of 1999 which provides “the premium costs of group hospital, surgical, medical expenses, and dental insurance and the first ten thousand dollars of life insurance
contracted under the provisions of this Section shall be paid in full from the sheriff’s general fund for all sheriffs and deputy sheriffs retired with a minimum of fifteen years of service and are fifty-five years of age, “effective April 1, 2000 the Plan will open participation to Retirees of Sheriff Offices participating in the Louisiana Sheriffs’ Association Group Benefits Program’s Medical, Dental and Life Plan who were not eligible for coverage upon retirement. Participation is further limited to Retirees of the parishes that are enumerated in Act 314 of 1999. This open enrollment period is from April 1, 2000 through April 30, 2000 for an effective date of April 1, 2000. Coverage into the Plan is for the Retiree only and does not include dependents.

D. Employee - Initial Eligibility Date

1. Each Employee whose employment commenced on or before the effective date of this Plan shall become eligible for coverage on the effective date of this Plan.

2. Each Employee whose employment commences after the effective date of this Plan shall become eligible for coverage on his or her date of employment, provided application for coverage has been made by that date. If application for coverage is made within one (1) month after the date of employment, coverage will become effective on the date application is made.

E. Dependent - Initial Eligibility Date

1. Each eligible Dependent of an Employee or Retiree whose employment commenced on or before the effective date of this Plan shall become eligible for coverage on the effective date of this Plan.

2. Each eligible Dependent of an Employee whose employment commences after the effective date of this Plan shall become eligible for coverage on the Employee’s date of employment, or, if later, the date the Employee makes application for Dependent coverage, provided such application is made within one (1) month after the Dependent’s initial eligibility date.

3. A Dependent Child is a child under age twenty-six (26) who is one of the following:

   (1) born of the Subscriber; or

   (2) legally placed for adoption with the Subscriber; or

   (3) legally adopted by the Subscriber; or

   (4) a child for whom the Subscriber or his legal spouse has been granted legal custody or provisional custody by mandate, or a child for whom the Subscriber or his legal spouse is a court appointed tutor/tutrix; or

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

   (6) a stepchild of the Subscriber; or

   (7) a grandchild residing with the Subscriber, provided the Subscriber has been granted legal custody or provisional custody by mandate of the grandchild; or

   (8) the Subscriber’s child after attaining age twenty-six (26), or grandchild who was in the legal custody of and residing with the Subscriber prior to attaining age twenty-six (26), who is incapable of self-sustaining employment by reason of being mentally or physically disabled prior to attaining age twenty-six (26). The Subscriber must furnish Us with periodic proof of continuing incapacity and dependency within thirty-one (31) days of the child’s twenty-sixth (26th) birthday. We may require subsequent proof once a year after the initial two-year period following the child’s twenty-sixth (26th) birthday.
4. A Dependent Child who is ordered by the court to be covered under the Plan will be eligible for coverage when required by such court or administrative order, to comply with the provisions of the Omnibus Budget Reconciliation Act of 1993 (OBRA ’93). This Plan will automatically be amended to include any change or interpretation to such law.

5. Adding Newborn Children to Coverage

The Employee must notify the Third Party Administrator that the Employee is adding a child and the effective date of coverage. If the Third Party Administrator is notified within thirty (30) days of the date the child becomes eligible, the child’s effective date will be the date the child became eligible. If the Third Party Administrator is not notified within thirty (30) days of the child becoming eligible for coverage, then evidence of good health requirements will apply.

F. In the event an Employer not participating in the Plan on the original effective date of the Plan begins participation subsequent to the effective date, any Participants in that Sponsor’s group insurance plan on the day immediately preceding participation in this Plan shall be eligible for immediate coverage and:

1. There will be no Pre-Existing Conditions exclusion applicable to such participants;

2. Expenses applied toward the Deductible and Out-of-Pocket provisions of the prior plan shall be applied toward the Deductible and Out-of-Pocket provisions of this Plan, provided however,

3. Any benefits otherwise payable under this Plan shall be reduced by any benefits payable under the extended benefits provisions of the prior plan.

G. An Employee not enrolling self or Dependents as defined in ARTICLE II, DEFINITIONS, during their initial period of eligibility will be required to show proof of insurability.

Acceptance or rejection of such application will be made by the Plan at its discretion based on the evidence of good health submitted. The type and form of required proof of good health will be determined by the Plan. The Employee will be required to pay the cost of obtaining such proof.

H. Actively At Work/Non-Confined Requirement

1. The effective date of coverage for an Employee not actively at work on his or her initial eligibility date will be deferred until the date he or she returns to active full-time employment.

2. The effective date of coverage for a Dependent who is confined, because of disease, illness, or injury, at home, in a nursing home, Hospital, or elsewhere on his or her initial eligibility date will be deferred until his or her confinement or disability ends.

This provision will not apply to a newborn Child for whom coverage has previously been applied for or who is the Dependent of an Employee already enrolled for Child or family coverage.

I. Dependents, as defined in ARTICLE II, DEFINITIONS, of an Employee who are covered at the time of the Employee’s death are eligible as follows:

1. If the Employee is killed in the line of duty, eligibility continues as though the Employee had not died.

2. If an Employee with twelve (12) or more years of service dies, his or her Dependents will be eligible to continue coverage as though the Employee had not died.

3. If an Employee with five (5) years, but less than twelve (12) years of service dies other than in the line of duty, his or her Dependents will be eligible to continue participation in the Plan for two (2) years after the Employee’s death.

4. If an Employee with less than five (5) years of service dies other than in the line of duty, his or her Dependents will be eligible to continue participation in the Plan for one (1) year after the Employee’s death.
Dependents have thirty (30) days after the death of an Employee or Retiree to make a decision as to continuation of coverage. After thirty (30) days, Dependents will be dropped from the Plan and will not again be entitled to coverage.

J. If an Employee’s employment terminates for reasons other than (a) retirement, or (b) termination of the Plan, the coverage terminates at midnight on the day employment terminates; however:

1. If the FULL-TIME Employee is granted a leave of absence because of the inability to work due to an on-the-job injury or a disease contracted while on the job, coverage may continue for up to twelve (12) months during such leave.

2. If the FULL-TIME Employee is granted a leave of absence for a work related leave of absence not defined in (1) above, (i.e., law enforcement education, sickness, off-the-job injury, work suspension, etc.), coverage may continue for up to six (6) months during such leave. Exception to the six (6) month extension is that an Employee who takes a leave of absence to run for Sheriff and is elected, can remain on the Plan under this extension for longer than six (6) months, until such time that he takes office or rejoins the department. At such time he or she will be considered an active Employee.

3. If the FULL-TIME Employee is granted a leave of absence for any reason not defined in (1) or (2) above, coverage may continue for up to ninety (90) days.

4. **NOTE:** The following shall apply to Employers who are subject to the Family Medical Leave Act (FMLA) of 1993.
   a. If the Employee qualifies under the Act to take a Family Medical Leave, the twelve (12) week entitlement under the FMLA will apply against any other continuation provision in this Plan.
   b. This Plan will comply with the continuation and reinstatement provision of the said Act.

The continuation of coverage as stated above is in addition to COBRA.

K. Special Transfer Provision

In the event an Employee’s employment with a participating Employer terminates and the Employee begins employment with another participating Employer on the next regularly scheduled work day after termination of coverage with the original Employer, the coverage status for the Employee and any covered Dependents will be transferred in place; i.e., credit will be given for expenses previously applied toward satisfaction of current Deductible and Copayment. Any eligible Dependents who are age nineteen (19) or older who were not covered under the former participating Employer and who apply for coverage under the new participating Employer will be subject to the evidence of good health requirement of Section G of ARTICLE III, ELIGIBILITY AND TERMINATION.

**ARTICLE IV. DENTAL CARE AND TREATMENT BENEFITS**

This Benefit Plan has an Individual Deductible Amount. Benefits will be paid after the Individual Deductible Amount is met. The Individual Deductible Amount does not apply to the Diagnostic and Preventive Services section below.

This Benefit Plan also has a Benefit Period Maximum per Plan Participant. Once this Benefit Plan pays Benefits in that specific amount for a Plan Participant, no more Benefits will be covered for the remaining of the Benefit Period for that Plan Participant. Payments of this Benefit Plan for any of the Orthodontic Services, Treatment and Appliances covered below will not count toward the Benefit Period Maximum. Orthodontic Services, Treatment and Appliances has a separate Orthodontia Maximum per Plan Participant per Lifetime.

Each Benefit will have a Coinsurance amount assigned in the Schedule of Dental Benefits. The Coinsurance represents the percentage of the Allowable Charge that this Benefit Plan will pay for each covered Benefit. Any percentage not covered will be the responsibility of the Plan Participant.
All applicable amounts including Benefit Period Deductible Amount, Benefit Period Maximum, Orthodontia Maximum and Coinsurance percentage for each Benefit will be shown in 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. Initial oral examination and treatment planning limited to one (1) every six (6) months.
   b. Comprehensive and Periodic oral examination limited to one (1) every six (6) months
   c. Detailed problem-focused evaluations are limited to one (1) every 12 months per eligible diagnosis.
   d. Limited problem-focused evaluations are limited to one (1) every 12 months.
   e. Emergency oral examination.
   f. Diagnostic models.
   g. Pulp vitality test.
   h. Biopsy of soft tissue.
   i. Oral Smear.
   j. Bacteriologic culture for determination of oral pathologic agents.
   k. Microscopic examination of pathogens and/or oral tissue.
   l. Intraoral periapical films limited to four (4) every twelve (12) months per Provider if not performed in conjunction with definitive procedures.
   m. Complete intraoral series of periapical x-rays (fourteen (14) or more x-rays) (Limited to once in a two (2) year period)
   n. Bite-wings (Caries Detector) x-rays (Limited to once in a six (6) month period)
   o. Cephalometric x-rays
   p. X-rays of Temporomandibular Joint
   q. Occlusal intraoral films limited for Plan Participants under age 8, and limited to two (2) every twenty four (24) months.
   r. Extraoral - x-rays of T.M.J., lateral head, anteroposterior, postero-anterior
   s. Panographic-type x-rays (Limited to once in a two (2) year period)
   t. Plaque Control Program (Limited to once in a three (3) year period)
   u. Training in oral hygiene (Limited to once in a three (3) year period)
   v. Occlusal Equilibration (Limited to once in a three (3) year period)
   w. Dental Prophylaxis limited to one (1) every six (6) months
x. Topical application of fluoride (Limited to once every 12 months and to persons under nineteen (19) years of age)

y. Dietary prescription and counseling (Limited to once in a three (3) year period)

z. Sealants. Limited to one (1) per tooth every three (3) years for children under 19 years old, and only for permanent first and secondary molars.

B. Basic Dental Services

General Care

1. Simple surgical extractions with local anesthetic, including routine post-operative care
2. Complicated procedures for surgical extractions (e.g. sectioning flaps, residual root recovery, etc.) with local anesthetic, including routine post-operative care
3. Reimplantation following traumatic exfoliation
4. Removal of impacted teeth (soft tissue, partial bony, or complete bony)
5. Root Recovery (surgical removal of residual root)
6. Surgical exposure of impacted or unerupted tooth for orthodontic purposes
7. Alveolectomy of edentulous areas
8. Alveolectomy following the removal of teeth
9. Alveolectomy (surgical preparation of ridge for dentures)
10. Stomatoplasty - including revision of soft tissue, ridge extension, muscle reattachment, and manipulation of other intra-oral tissue.

Surgical Excisions

1. Excision of reactive inflammatory tissue, including hyperplastic/hypertrophic tissue and scar tissue
2. Excision of exostoses
3. Excision of cysts from soft or osseous tissue
4. Excision of benign tumors from soft or osseous tissue
5. Excision or resection of malignant tumors from soft or osseous tissue
6. Radical resection of mandible with bone graft.

Surgical Incisions, Tissue Repair, And Fractures

1. Sialolithotomy (intraoral or extraoral)
2. Incision and drainage of abscess or cellulitis (intraoral or extraoral)
3. Incision and removal of foreign body from soft or osseous tissue
4. Frenulectomy (frenectomy or frenotomy)
5. Suture of soft tissue wound or injury
6. Oral antral fistula closure and/or antral root recovery
7. Injection of trigeminal nerve for destruction closure of salivary fistula
8. Treatment of fractures (simple or compound) of the orofacial structures.

**Temporomandibular Joint Dysfunctions:**

1. Open reduction of dislocation
2. Manipulation under anesthesia
3. Condylectomy
4. Meniscectomy

**Exclusions:**

1. No Benefits will be paid under Temporomandibular Joint Dysfunctions for Congenital Anomalies.
2. No Benefits will be paid for the administration of anesthesia when billed separately by the Dentist or any other

**Space Maintainers:**

1. Limited to Plan Participants under age 14.
2. Covered when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars or deciduous molars and permanent first molars that have not, or will not, develop.
3. Limited to one (1) every three (3) years.

**Simple Restorative:**

1. Basic Restorations (amalgam and posterior resin)
   a. Replacement of restorative services only covered when they are not and cannot be made serviceable.
   b. Basic restorations will not be covered if replaced within 24 months of previous placement of any basic restoration.
2. Cement bases
3. Calcium hydroxide or zinc-oxide-eugenol bases
4. Auto-cured composite resin restorations
5. Light cured composite resin restorations (not for Sealant)

**Endodontics:**

1. Endodontic (Pulpal) Therapy
   a. Eligible teeth limited to primary anterior teeth when there is no permanent tooth to replace it. b. Limited to one per eligible tooth per lifetime.
2. Root Canal
   
a. Limited to one (1) per tooth per lifetime.

**Periodontics**

Non-Surgical Periodontics

1. Periodontal scaling and root planing limited to one (1) every twenty four (24) months for each area of the mouth.

2. Periodontal maintenance following active periodontal therapy limited to two (2) every twelve (12) months in addition to routine Prophylaxis.

Surgical Periodontics

1. Surgical periodontal procedures limited to one (1) every thirty six (36) months for each area of the mouth.

2. Guided tissue regeneration limited to one (1) for each tooth per lifetime.

3. Full mouth debridement limited to one (1) per lifetime.

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

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

6. Clinical crown lengthening;

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

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

9. Pedicle soft tissue graft;

10. Free soft tissue graft;

11. Subepithelial connective tissue graft;

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

Exclusion:

No Benefits will be paid under Periodontics for bone grafts and transplants.

C. **Major Dental Services**

   **Complex Restorative** (when not used as an element of a fixed prosthesis):

   1. Inlays/Onlays

   2. Crowns and jackets

   3. Posts and Copings
Receamentation Of Crowns And Inlays/ONLAYS (Limited to once in a three (3) year period)

Prosthodontics

Prosthodontics-Fixed:

1. Crowns (when used as an element of a bridge)
2. Bridge pontics
3. Recementation of fixed bridge (Limited to once in a three (3) year period)

Prosthodontics-Removable:

1. Complete upper and lower denture, acrylic base
2. Upper or lower partial denture of chrome-cobalt alloy
3. Upper or lower acrylic partial denture
4. Adjustment of dentures (Limited to once in a six (6) month period)
5. Reline of upper or lower complete or partial denture (Limited to once in a three (3) year period)
6. Repairing broken acrylic denture base
7. Replacing missing or broken denture teeth
8. Adding to a partial denture to replace extracted tooth or teeth
9. Replacing clasp with new clasp on partial denture
10. Adding additional clasps and/or teeth

Prosthodontics-Miscellaneous:

1. Management of Temporomandibular problems (Consultant approval required)
2. Occlusal analysis (mounted case) (Consultant approval required)

Prostheses (after termination):

Benefits will be paid under this Endorsement for services rendered after the Benefit Plan is terminated for prostheses which were ordered and fitted before the date of termination, provided they are delivered to the Plan Participant within thirty-one (31) days of the date of termination.

Exclusion:

No Benefits will be paid under this category for replacement of removable bridgework or dentures, unless:

1. at least five (5) years have elapsed since the placement of the bridgework or denture; or
2. the existing appliance is unserviceable; or
3. the existing temporary denture cannot be made permanent and the replacement occurs within twelve (12) months of the initial installation.
D. Orthodontic Services, Treatment and Appliances

Dental Care Provided:

1. Removable or fixed inhibiting appliances to correct oral habits (thumbsucking or tongue thrusting)
2. Orthodontic examinations and diagnostic workups
3. Orthodontic treatment with fixed or removable appliances

Exclusions:

No Benefits will be paid under Orthodontic Services for repair or replacement of any appliances furnished under this category.

Limitations:

The Lifetime Maximum for services rendered for Orthodontics is applicable as shown on the Schedule of Benefits.

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

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

1. Any charges exceeding the Allowable Charges.
2. Dental Care received from a dental or a medical department maintained by or on behalf of a group or employer, a mutual benefit association, labor union, trust, or similar person or group.
3. Services or expenses for which the Plan Participant has no legal obligation to pay, or for which no charge would be made if the Plan Participant had no dental coverage.
4. Services covered or legally required to be covered, in whole or in part, under Worker's Compensation insurance and/or services rendered as a result of occupational disease or injury, except that Employees will be covered for services rendered for illness or injury resulting from the performance of their duties for the Plan.
5. Services for which payment is available under the laws of the United States, any of its states or political subdivisions the Veterans Administration, or Medicare, except where enforcement of this exclusion is prohibited by law.
6. Services in the following categories:
   - those for diseases contracted or injuries sustained as a result of war, declared or undeclared or any act or war;
   - those occurring as a result of taking part in a riot or acts of civil disobedience;
- those occurring as a result of a Plan Participant’s commission or attempted commission of a felony. This exclusion does not apply to the extent inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. Benefits are available to the Plan Participant for illness or bodily injury due to an act of domestic violence or a medical condition (including both physical and mental health conditions) or in case of emergency care, the initial medical screening examination, treatment and stabilization of an emergency condition; or those for intentionally self-inflicted injury or sickness.

7. Dental Care, other than orthodontic services, in progress before the Plan Participant's Effective Date.

8. Dental Care after the termination or cancellation of the Plan, regardless of the cause of termination or cancellation.

9. Transplants, implants, or bone grafts.

10. Services of a Doctor of Medicine (M.D.).

11. Dental Care or supplies other than those specifically listed as covered by this Plan.

12. Services or supplies which are Investigational in nature.

13. Services, supplies, equipment, or charges in connection with Cosmetic Surgery/Treatment.

14. Treatment of any Plan Participant confined in prison, jail, or other penal institution.

15. Dental Care received for any injury resulting from a wrongful act or omission of another party for which that party or some other party is responsible or makes settlement.

16. Sales tax or interest.

17. Care rendered by a Dentist who is the Plan Participant’s spouse, child, stepchild, parent, stepparent or grandparent.

18. Charges for the delivery of health care, diagnosis, consultation, or treatment of a Plan Participant unless the Provider is physically present with the Plan Participant at the time services are rendered are not covered unless approved by Us.

19. Charges for the delivery of health care, diagnosis consultation, or treatment of a Plan Participant using technology, including but not limited to audio and video transmission, telephone or e-mail are not covered unless approved by Us.

20. Charges for failure to keep a scheduled visit, completion of a Claim form, to obtain medical records or information required to adjudicate a Claim, or for access to or enrollment in or with any Provider.

21. Services, supplies, or equipment in connection with bleaching.

22. Anesthesia, when billed separately from the treating Dentist's charges.

23. Services in connection with diagnostic photos (i.e., Polaroid).

24. Services or supplies determined by the Third Party Administrator to be not medically necessary.

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

26. For house or hospital calls for dental services and for hospitalization costs (e.g. facility-use fees).
27. The responsibility of Workers’ Compensation or employer’s liability insurance, or for treatment of any automobile-related injury in which the Plan Participant is entitled to payment under an automobile insurance policy. Our Benefits would be in excess to the third-party benefits and therefore, We would have right of recovery for any benefits paid in excess.

28. For prescription and non-prescription drugs, vitamins or dietary supplements, unless prescribed.

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

30. Cosmetic in nature as determined by Claims Administrator (for example but not limitation, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).

31. Elective procedures (for example but not limitation, the prophylactic extraction of third molars).

32. For congenital mouth malformations or skeletal imbalances (for example, but not limited to, treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment).

33. Dental Implant services will be excluded, even if otherwise covered if such services replace one (1) or more teeth missing prior to Plan Participant’s eligibility under this Benefit Plan.

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

35. For treatment of malignancies or neoplasms.

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

37. For preventative restorations.

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

39. For which in the absence of insurance the Plan Participant would incur no charge.

40. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.

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

42. For any claims submitted to Claims Administrator by the Plan Participant or on behalf of the Plan Participant in excess of twelve (12) months after the date of service.

43. For incomplete treatment (for example but not limitation, patient does not return to complete treatment) and temporary services (for example but not limitation, temporary restorations).

44. For procedures that are:
   - part of a service but are reported as separate services; or
   - reported in a treatment sequence that is not appropriate; or
   - misreported or that represent a procedure other than the one reported.

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

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

ARTICLE VII.   PRE-DETERMINATIONS

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

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

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

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

ARTICLE VIII.  ALTERNATE BENEFITS

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

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

ARTICLE IX.   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 X.   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 XI. CONTINUATION OF COVERAGE RIGHTS

A. COBRA Continuation

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

What is COBRA continuation coverage?

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

Do I have other alternatives to COBRA continuation coverage?

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

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

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

You should consider all Your options in order to choose the one that best fits Your needs and budget.
What if I choose to get COBRA continuation coverage?

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

What are the “qualifying events”?  

A “qualifying event” is any of the following events:

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

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

Do I have to provide notification of any qualifying event?  
The qualified beneficiary must give notice of the following qualifying events to the Group within 60 days of the event:

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

The Group will advise a qualified beneficiary of his rights under COBRA upon the occurrence of any qualifying event or following the timely notice of a qualifying event when such notice is required to be given by the qualified beneficiary.
What do I have to do to get COBRA continuation coverage?

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

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

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

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

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

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

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

- eighteen (18) months after the qualifying event in the case of termination of employment or reduction in work hours. When the Employee became entitled to Medicare benefits less than eighteen (18) months before the termination of employment or reduction of work hours, continuation coverage for qualified beneficiaries other than the Employee will last the longer of thirty-six (36) months from the date of Medicare entitlement or eighteen (18) months from the qualifying event; or
- thirty-six (36) months after the qualifying event when such event is other than termination of employment or reduction of work hours; or
- the date the Employer ceases to maintain any Group health plan for its Employees; or
- the date coverage ceases because of nonpayment of required premiums when due; or
- the date the qualified beneficiary first becomes covered under another group health plan and benefits under that other plan are not excluded or limited with respect to a Pre-Existing Condition (NOTE: There are limitations on plans imposing Pre-Existing condition exclusions and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act); or
- the date the qualified beneficiary becomes entitled to Medicare (under Part A, Part B, or both).

Can I extend my COBRA continuation coverage?

A qualified beneficiary’s right to COBRA continuation coverage will never last longer than thirty-six (36) months from the qualifying event. This maximum duration period cannot be extended, regardless of the circumstances.
Those that are receiving eighteen (18) months of continuation coverage can extend their period, as explained below, if they undergo a second qualifying event during that original eighteen (18) month period, or are declared disabled by the Social Security Administration.

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

- the Employee or former Employee dies;
- the Employee or former Employee and Dependent spouse divorce;
- the Dependent child is no longer eligible under the Benefit Plan as a Dependent.

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

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

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

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

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

Keep Your Plan Informed of Address Changes

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

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

Employees going on a military leave of absence to perform “service in the United States uniformed services” (as that term is defined under USERRA) may elect to continue coverage under this Benefit Plan for up to 24 months from the date that the Employee leaves for service. Only a covered Employee may elect continuation coverage under USERRA for himself/herself and for those eligible Dependents that were covered under the Plan immediately before him/her leaving for military service. Dependents do not have any independent right to elect USERRA continuation coverage.
To claim USERRA continuation coverage, the Employee must properly notify the Employer that he/she is leaving to perform “service in the uniformed services” and apply for continuation coverage as required by the Employer.

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

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

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

USERRA continuation coverage rights may be provided concurrently with COBRA continuation coverage, as allowed by law.

If You wish to elect this coverage or obtain more detailed information, contact the Plan Administrator.

ARTICLE XII.    COORDINATION OF BENEFITS

A. Applicability

1. This Coordination of Benefits (COB) section applies to this Plan when a Plan Participant has health care coverage under more than one plan. “Plan” and “This Plan” are defined below.

2. This Section is intended to describe whether the Benefits of This Plan are determined before or after those of another Plan when this Section applies.

The Benefits of This Plan:

a. will not be reduced when, under the terms of this Section and any applicable laws, This Plan determines its Benefits before another Plan.

b. may be reduced when under the terms of this Section or any applicable laws, another Plan determines its benefits first. That reduction is described in Subsection D of this Section, “When This Plan is Secondary.”

B. Definitions (Applicable only to this Article of this Benefit Plan)

1. “Allowable Expense” means any health care expense, including coinsurance or copayments, and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person.

a. If a Plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan’s deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

b. An expense or a portion of an expense that is not covered by any of the Plans is not an allowable expense.
c. Any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

d. The following are examples of expenses that are not Allowable Expenses.

   i. If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.

   ii. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the Provider in excess of the highest reimbursement amount for a specified benefit is not an Allowable Expense.

   iii. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an Allowable Expense.

   iv. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the primary Plan’s payment arrangement shall be the allowable expense for all plans. However, if the Provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary Plan’s payment arrangement and if the Provider’s contract permits, that negotiated fee or payment shall be the Allowable Expense used by the secondary plan to determine its benefits.

2. “Birthday” refers only to month and day in a calendar year and does not include the year in which the individual is born.

3. “Claim” a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

   a. services (including supplies);

   b. payment for all or a portion of the expenses incurred;

   c. a combination of prongs a and b of this Subparagraph; or

   d. an indemnification.

4. “Claim Determination Period or Plan Year” a period of not less than 12 consecutive months over which Allowable Expenses shall be compared with total benefits payable in the absence of COB to determine whether overinsurance exists and how much each Plan will pay or provide.

   a. The claim determination period is usually a calendar year, but a Plan may use some other period of time that fits the coverage of the group or individual contract. A person is covered by a Plan during a portion of a claim determination period if that person’s coverage starts or ends during the claim determination period.

   b. As each claim is submitted, each Plan determines its liability and pays or provides benefits based upon Allowable Expenses incurred to that point in the claim determination period. That determination is subject to adjustment as later Allowable Expenses are incurred in the same claim determination period.

5. “Closed Panel Plan” a plan that provides health benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the plan, and that
excludes benefits for services provided by other Providers, except in cases of emergency or referral by a panel member.

6. “Consolidated Omnibus Budget Reconciliation Act of 1985 or COBRA” coverage provided under a right of continuation pursuant to federal law.

7. “Coordination of Benefits or COB” a provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total Allowable Expenses.

8. “Custodial Parent”
   a. the parent awarded custody of a child by a court decree; or
   b. in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

9. “Group Insurance Contract” means an insurance policy or coverage that is sold in the group market and that are usually sponsored by a person’s employer union, employer organization or employee organization.

10. “Group-Type Contract” a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. Group-type contract does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the Plan Participant since the Plan Participant would have the right to maintain or renew the policy independently of continued employment with the employer.


12. “Hospital Indemnity Benefits” benefits not related to expenses incurred. Hospital indemnity benefits does not include reimbursement-type benefits even if they are designed or administered to give the Plan Participant the right to elect indemnity-type benefits at the time of claim.

13. “Individual Insurance Contract” means an insurance policy or coverage that is sold to an individual and/or his/her family in the individual market.

14. “Plan” a form of coverage with which coordination is allowed. Separate parts of a plan for Plan Participants of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan. If a plan coordinates benefits, its Benefit Plan shall state the types of coverage that will be considered in applying the COB provision of that contract. Whether the Benefit Plan uses the term “plan” or some other term such as “program,” the contractual definition may be no broader than the definition of “plan” in this Subsection.

   a. Plan includes:
      i. Group Insurance Contracts, Individual Insurance Contracts and Plan Participant contracts;
      ii. uninsured arrangements of group or Group-Type coverage;
      iii. group and non-group coverage through closed panel plans;
      iv. Group-Type Contracts;
      v. the medical care components of long-term care contracts, such as skilled nursing care;
vi. the medical benefits coverage in automobile “no fault” and traditional automobile “fault” type contracts;

vii. Medicare or other governmental benefits, as permitted by law, except as provided in Subparagraph b of this definition. That part of the definition of “Plan” may be limited to the hospital, medical and surgical benefits of the governmental program; and

viii. group and non-group insurance contracts and Plan Participant contracts that pay or reimburse for the cost of dental care.

b. Plan does not include:

i. hospital indemnity coverage benefits

ii. accident only coverage;

iii. specified disease or specified accident coverage;

iv. limited benefit health coverage as defined in La. R.S. 22:47(2)(c), except for group and non-group dental coverage;

v. school accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a “to and from school” basis;

vi. benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

vii. Medicare supplement policies;

viii. a state plan under Medicaid; or

ix. a governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

15. “Policyholder or Plan Participant” means the primary Plan Participant named in an Individual Insurance Contract.

16. “Primary Plan” a plan whose benefits for a person’s health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if:

a. the plan either has no order of benefit determination rules, or its rules differ from those permitted by this regulation; or

b. all plans that cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

17. “Provider” a health care professional or health care facility.

18. “Secondary Plan” a plan that is not a primary plan.

19. “This Plan” means the part of this Benefit Plan and any amendments/endorsements thereto that provides Benefits for health care expenses.
C. Order of Benefit Determination Rules

1. When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

   a. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

      i. Except as provided in Paragraph ii below, a Plan that does not contain a coordination of benefits provision that is consistent with this Section is always primary unless the provisions of both Plans state that the complying plan is primary.

      ii. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that the supplementary coverage shall be excess to any other parts of the Plan provided by the Policyholder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

   b. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

   c. When a person is covered under a group Plan and a non-group (individual) Plan, the non-group Plan is always secondary to any group Plan, disregarding any other provision of this Section.

2. The following rules apply when group Plans coordinate benefits among themselves, and when non-group (“individual”) Plans coordinate benefits among themselves. Each Plan determines its order of benefits using the first of the following rules that applies, and discarding any other successive rules:

   i. Non-Dependent or Dependent Rule. The Plan that covers the person other than as a dependent, for example as an employee, Plan Participant, policyholder or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, Plan Participant, policyholder or retiree is the Secondary plan and the other Plan is the Primary plan.

   ii. Dependent Child Covered Under More Than One Plan Rule. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

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

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

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

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

          (a) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual
knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

(b) If a court decree states that both parents are responsible for the dependent child’s health care expenses or health care coverage, the provisions of Subparagraph (2)(ii)(1) above shall determine the order of benefits;

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (2)(ii)(1) above shall determine the order of benefits; or

(4) If there is no court decree allocating responsibility for the dependent child’s health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) The Plan covering the Custodial parent;

(b) The Plan covering the Spouse of the Custodial parent;

(c) The Plan covering the non-custodial parent; and then

(d) The Plan covering the Spouse of the non-custodial parent.

(5) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraphs (2)(ii)(1) or (2)(ii)(2) above shall determine the order of benefits as if those individuals were the parents of the child.

(6) For a dependent child covered under the Spouse’s plan:

(a) For a dependent child who has coverage under either or both parents’ plans and also has his or her own coverage as a dependent under a Spouse’s plan, the rule in Subparagraph (2)(v) (Longer or Shorter Length in Coverage) applies.

(b) In the event the dependent child’s coverage under the Spouse’s plan began on the same date as the dependent child’s coverage under either or both parents’ plans, the order of benefits shall be determined by applying the birthday rule above in Subparagraph (2)(ii)(1) to the dependent child’s parent(s) and the dependent’s Spouse.

iii. Active Employee or Retired or Laid-off Employee Rule. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule of Subparagraph (2)(i) can determine the order of benefits.

iv. COBRA or State Continuation Coverage Rule. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, Plan Participant or retiree or covering the person as a dependent of an employee, Plan Participant or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule of Subparagraph (2)(i) determine the order of benefits.

v. Longer or Shorter Length of Coverage Rule. The Plan that covered the person as an employee, Plan Participant, policyholder or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
To determine the length of time a person has been covered under a Plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within 24 hours after coverage under the first plan ended.
The start of a new Plan does not include:

1. a change in the amount or scope of a Plan’s benefits;
2. a change in the entity that pays, provides or administers the Plan’s benefits; or
3. a change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

The person’s length of time covered under a plan is measured from the person’s first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a Plan Participant of the group shall be used as the date from which to determine the length of time the person’s coverage under the present plan has been in force.

vi. Fall-Back Rule. If none of the preceding rules determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In any event, This Plan will never pay more than it would have paid had it been the Primary plan.

D. When This Plan is Secondary

Whenever This Plan is secondary to any other Plan, the Benefits of This Plan may be reduced so that no more that the Allowable Expense is ever paid for any given Claim taking into account all the benefits payable to the Plan Participant under all his/her Plans and sum of the Allowable Expenses for any Claim Determination Period. This will apply whether or not a Claim is made. The Benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses. When the Benefits of This Plan are reduced as described above, each Benefit is reduced in proportion. It is then charged against any applicable Benefit limit of This Plan.

E. Right to Receive and Release Needed Information

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

F. Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a Benefit paid under This Plan. To the extent, such payments are made; they discharge Us from further liability. The term “payment made” includes providing benefits in the form of services, in which case the payment made will be deemed to be the reasonable cash value of any benefits provided in the form of services.

G. Right of Recovery

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

1. the persons We have paid or for whom We have paid;
2. insurance companies; or
3. other organizations.
The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services. If the excess amount is not received when requested, any Benefits due under This Plan will be reduced by the amount to be recovered until such amount has been satisfied.

ARTICLE XIII. 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.

   a. To the extent this Benefit Plan may be an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 (“ERISA”), as amended, the Group will be the Plan Administrator of such employee welfare benefit plan and will be solely responsible for meeting any obligations imposed by law or regulation on the administrator of the Plan, except those specifically undertaken by Us herein.

   b. 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.

2. 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.

3. 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.

4. The Plan Administrator 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 the Plan Administrator 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 Subscriber’s rights, and to decide questions of plan interpretation and those of fact relating to the plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

5. The Claims Administrator shall have the right to enter into any contractual agreements with subcontractors, health care 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 intends to maintain this Benefit Plan indefinitely; however, it reserves its right, at any time, to amend, suspend or terminate the plan in whole or in part. This includes amending the Benefits under the plan or the trust agreement, if any.

C. Identification Cards and Benefit Plans

The Claims Administrator will prepare an identification (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 Group, the Claims Administrator will either deliver all materials to the Group for Group’s distribution to the covered Employees, or the Claims
Administrator will deliver the 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. Benefits to Which Plan Participants are Entitled

1. The liability of the Plan Administrator 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 Dentist specified in this Benefit Plan and regularly included in such Dentist's charges.

E. Termination of a Plan Participant's Coverage

1. The Plan 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 Plan. The issuance of this coverage is conditioned on the representations and statements contained in a required application and enrollment. All representations made are material to the issuance of this coverage. Any information intentionally omitted from the enrollment form as to any proposed 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 Plan will give the Plan Participant sixty (60) days advance written notice prior to rescinding or terminating coverage under this section.

2. Unless Continuation of Coverage is available and selected as provided in this Benefit Plan, an Employee's coverage terminates as provided below:

a. The Employee's coverage and that of all his Dependents automatically terminates, without notice, at the end of the last day of employment as a full-time Employee.

b. The coverage of the Employee's spouse will terminate automatically, and without notice at the end of the billing cycle 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 ceases to be an eligible Dependent, if premiums have been paid through that period.

d. Upon the death of an Employee, the coverage of all of his surviving Dependents will terminate automatically and without notice at the end of the billing cycle in which the death occurred if Employee contributions have been paid through that period. However, a surviving Dependent may elect continuation of coverage as described elsewhere in this Benefit Plan.

3. In the event the Group cancels this Benefit Plan, such cancellation or termination alone will operate to terminate all rights of the Plan Participant to Benefits under the terms of this Benefit Plan as of the effective date of such cancellation or termination. Group shall have the obligation to notify its Subscribers, participants, and beneficiaries of such cancellation or termination. The Claims Administrator shall have no such obligation of notification 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 termination of a Plan Participant's coverage.

5. The Claims Administrator reserves the right to automatically change the Plan Participant's class of coverage to reflect when no more Dependents are covered under this Benefit Plan.
F. Filing of Claims

A Claim is a written or electronic proof of charges for Covered Services that have been incurred by a Plan Participant during the time period the Plan Participant was covered under this Benefit Plan. We encourage Providers to file Claims in a form acceptable to the Plan Administrator is filed with the Plan Administrator within ninety (90) days from the date services are rendered, but no later than twelve (12) months after the date of service. Benefits will be denied for Claims filed any later than twelve (12) months from the date of service. Benefit Plan 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.

G. 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 United States of America or the State of Louisiana, the provision is automatically amended to meet the minimum requirements of the statute or regulation.

H. Time Limit for Legal Action

No lawsuit may be filed:
1. any earlier than the first sixty (60) days after notice of Claim has been given; or
2. any later than twelve (12) months after the time proofs of loss are required to be filed.

I. Release of Information

The Claims Administrator may request that the Plan Participant of 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.

J. Plan Participant/Provider Relationship

1. The choice of a Dentist or other Provider is solely the Plan Participant’s.

2. The Claims Administrator and all dental network 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 for which the Plan Participant receives. The Plan and the Claims Administrator will not be held liable for any act or omission of any Dentist or 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 dental network Provider or in any dental network Provider’s facilities. The Plan and the Claims Administrator has no responsibility for a Dentist’s or Provider’s failure or refusal to render Covered Services to a Plan Participant.

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

K. Notice

Any notice required under this 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 his address as the same appears on the Claims Administrator’s records. Any notice that a Plan Participant must give the Group at the address as the same appears in this Benefit Plan. The Group, the Claims Administrator, or a Plan Participant may, by written notice, indicate a new address for giving notice.
L. Job-Related Injury or Illness

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

M. Subrogation

1. To the extent that Benefits for Covered Services are provided or paid under this Benefit Plan, the Group will be subrogated and will succeed to the Plan Participant’s right for the recovery of the amount paid under this Benefit Plan against any person, organization or other carrier even where such carrier provides Benefits directly to a Plan Participant who is its insured. The acceptance of such Benefits hereunder will constitute acknowledgment of such subrogation rights.

2. The Plan Participant will reimburse the Plan all amounts recovered by suit, settlement, or otherwise from any third party or the Plan Participant’s insurer to the extent of the Benefits provided or paid under this Plan. The Plan’s right to reimbursement comes first even if the Plan Participant is not paid for all of the Plan Participant’s Claim for damages against the other person or organization or even if the payment the Plan Participant receives is for, or is described as for, the Plan Participant’s damages other than health care expenses, or if the Plan Participant recovering the money is a minor. All costs that the Plan Participant incurs (including attorney fees) in exercising any right of recovery will be the Plan Participant’s responsibility. Amounts that the Plan paid for which a third party or insurer is responsible will not be reduced by the amount of the Plan Participant’s costs. The Plan Participant shall hold in trust for the account of the Plan all amounts recovered, up to the total amount of Benefits paid. The Group appoints the Plan Participant as its representative for such limited purpose only.

3. The Plan Participant will take such action, furnish such information and assistance, and execute such papers as the Plan may require to facilitate enforcement of the Plan’s rights, and will take no action prejudicing the Plan’s rights and interest under this Plan. The Plan and its designees have the right to obtain and review Plan Participant’s medical and billing records, if the Plan or its designee determines in their sole discretion, that such records would be helpful in pursuing its right of subrogation and/or reimbursement. Nothing contained in this provision will be deemed to change, modify or vary the terms of the Coordination of Benefits Article of this Benefit Plan.

4. The Plan Participant is required to notify the Plan Administrator of any Accidental Injury.

N. Right of Recovery

Whenever any payment for Covered Services has been made by the Plan, in an amount that exceeds the maximum Benefits available for such services under this Benefit Plan or exceeds the Allowable Charge, or whenever payment has been made in error by the Plan for non-covered services, the Plan will have the right to recover such payment from the Plan Participant or, if applicable, the Provider. As an alternative, the Plan reserves the right to deduct from any pending Claim for payment under this Benefit Plan any amounts the Plan Participant, Dentist or Provider owes the Plan.

O. 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 Plan to the extent the veteran would be eligible for Benefits from the Plan if the care or services had not been furnished by a department or agency of the United States.
amount the United States may recover will be reduced by the appropriate Deductible and Coinsurance amount.

The United States will have the right to collect from the Plan Administrator 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 Plan 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 amount.

P. Liability of Plan Affiliates

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

Q. Continued Coverage during a Leave of Absence

1. Family Medical Leave

The Family Medical Leave Act (FMLA) allows eligible Employees to take up to twelve (12) weeks of unpaid FMLA leave in a 12-month period for the following reasons:

a. a serious health condition that makes You unable to perform Your job;

b. to care for a seriously ill dependent child, spouse or parent; or

c. for the birth, placement for adoption or foster care of a child.

A serious health condition is an illness, injury, impairment, or physical/mental condition involving either inpatient care or continuing treatment by a health care Provider. Leave may be taken intermittently or on a reduced schedule only if medically necessary. If leave is taken on an intermittent basis, the arrangement must be agreed to in advance by the Employee and the Group. Certification of a serious health condition must be provided in writing to the Group. To be eligible for FMLA, an Employee must have completed twelve (12) months of employment and have worked at least 1,250 hours during the 12-month period preceding the leave requested.

The Plan will continue coverage for Employee during any leave of absence the Group is required to provide by applicable federal or state law, including FMLA and any amendments or successor provisions, as long as eligibility criteria under the law continues to be met. If the Employee is not restored to active full-time employment by the end of the leave of absence period, the Employee will cease to be eligible and coverage for the Employee 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."
2. Disability Leave

When an Employee is not actively at work due to a health condition, Plan will maintain coverage for the Employee and any Dependents, as long as the Employee remains a bona fide Employee of the Group and required contributions are paid. If Group terminates Employee's employment, the Employee will cease to be eligible and coverage for the Employee and any Dependents will terminate as described in "Termination of a Plan Participant's Coverage."

3. Other Employer-Approved Leave of Absence

When an Employee has been granted a documented, approved leave of absence by the employer Group, the Plan will maintain coverage for the Employee and any Covered Dependents for a period not to exceed ninety (90) days. Employee must remain a bona fide Employee of Group during the approved leave period. Group will provide Company with proof of the documented leave, upon request. If Group terminates Employee's employment, the Employee will cease to be eligible and coverage for the Employee and any Dependents will terminate as described in "Termination of a Plan Participant's Coverage."

R. Compliance with HIPAA Privacy Standards

Certain Plan Participants of the Employer’s workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these Employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards of Privacy of Individually Identifiable Health Information (45 CFR Part 164, the “Privacy Standards”), these Employees are permitted to have such access subject to the following:

1. General

The Plan shall not disclose Protected Health Information to any Plan Participant of the Employer’s workforce unless each of the conditions set out in this HIPAA Privacy section is met. “Protected Health Information” shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

2. Permitted Uses and Disclosures

Protected Health Information disclosed to Plan Participants of the Employer’s workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan’s administrative functions shall include all Plan payment and health care operations. The terms “payment” and “health care operations” shall have the same definitions as set out in the Privacy Standards, the term “payment” generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of Benefits or reimbursement for health care. “Health Care Operations” generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

3. Authorized Employees

The Plan shall disclose Protected Health Information on to Plan Participants of the Employer’s workforce, who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, “Plan Participants of the Employer’s workforce” shall refer to all Employees and other persons under the control of the Employers.
a. Updates Required. The Employer shall amend the plan promptly with respect to any changes in the Plan Participants of its workforce who are authorized to receive Protected Health Information.

b. Use and Disclosure Restricted. An authorized Plan Participant of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his duties with respect to the Plan.

c. Resolution of Issues of Noncompliance. In the event that any Plan Participant of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to a privacy official. The privacy official shall take appropriate action, including:

(1) investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(2) applying appropriate sanctions against the persons causing the breach, which depending upon the nature of the breach, may include oral or written reprimand, additional training or termination of employment;

(3) mitigating any harm caused by the breach, to the extent practicable; and

(4) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

4. Certification of Employer

The Employer must provide certification to the Plan that it agrees to:

a. not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

b. ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

c. not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other Benefit or Employee Benefit Plan of the Employer;

d. report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

e. make available Protected Health Information to individual Plan Participants in accordance with Section 164.524 of the Privacy Standards;

f. make available Protected Health Information for amendment by individual Plan Participants and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

g. make available Protected Health Information required to provide any accounting of disclosures to individual Plan Participants in accordance with Section 164.528 of the Privacy Standards;

h. make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

i. if feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer
needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

j. ensure the adequate separation between the Plan and Plan Participant of the Employer’s workforce, as required by Section 164.504 (f)(2)(iii) of the Privacy Standards.

The following Plan Participants of the Louisiana Sheriffs’ Association workforce are designated as authorized to receive Protected Health Information from the Louisiana Sheriffs’ Association Employee Dental Benefit Plan (“the Plan”) in order to perform their duties with respect to the Plan:

Michael Williams, Senior Benefits Consultant; Annette Dowdle, Senior Vice-President; Brenda Smith, Benefits Consultant; Kaelin Telschow, Marketing Analyst; Roxanne Valenti, Benefit Analyst; Jennifer Taffaro, Benefit Consultant; Valerie Cowart, Group Benefits Specialist; Roxie Lea, LSA Group Benefit Program Secretary; Ret. Sheriff Gary Bennett, Asst. Executive Director/Insurance Committee; Sheriff Mike Waguespack, Ch. Insurance Committee; Sheriff Mike Stone, Insurance Committee; Janelle Millet, Insurance Committee; Skip McGee, Insurance Committee; Ricky Edwards, Insurance Committee; Renee Brinkley, Insurance Committee; Mike Ranatza, Executive Director; James Bustillo, Regional Director/BCBSLA.

S. Compliance with HIPAA Electronic Security Standards

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the “Security Standards”), the Employer agrees to the following:

1. The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. “Electronic Protected Health Information” shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

2. The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

3. The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance with HIPAA Privacy Standards sections (3) Authorized Employees and (4) Certification of Employers described above in this Article.

ARTICLE XIV. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

The Claims Administrator wants to know when a Plan Participant is unhappy about the care or services they receive from the Claims Administrator or one of its Providers. Plan Participants may register a Complaint, or file a formal written Grievance about the Claims Administrator or a Provider by following the procedures outlined below.

The Plan considers a written Appeal as the Plan Participant’s request to change an Adverse Benefit Determination made by the Claims Administrator. An Appeal is defined as a request from a Plan Participant or their authorized representative to change a previous decision made by the Claims Administrator about Covered Services. Examples of issues that qualify as Appeals include denied Authorizations, Claims denied based on adverse determinations of Dental Necessity, or other adverse Benefit determinations. Adverse Benefit determinations include denials of and reductions in Benefit payments.
We have expedited Appeals processes for situations where the time frame of the standard Dental Necessity Appeal would seriously jeopardize the life or health of a Plan Participant or would jeopardize the Plan Participant’s ability to regain maximum function.

Appeal rights for Plan Participants are outlined below, after the Complaint and Grievance Procedures.

A. Complaint and Grievance Procedures

A quality of service concern addresses the Claims Administrator’s services, access, availability or attitude and those of the Claims Administrator’s Network 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 Claims Administrator or with Provider services.

Call the Claims Administrator’s customer service department at 1-866-445-5338. The Claims Administrator will attempt to resolve a Plan Participant’s Complaint at the time of their call.

2. To File a Formal Grievance

A Grievance is a written expression of dissatisfaction with the Claims Administrator or with Provider services. If a 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. For assistance, the Plan Participant may call the Claims Administrator’s customer service department. 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.

If the Plan Participant has questions or needs assistance putting the Appeal in writing, the Plan Participant may call the Claims Administrator’s customer service department at 1-800-599-2583 or 1-225-291-5370.

The Plan Administrator has full discretionary authority to determine eligibility for Benefits and/or construe the terms of this Plan.

The Claims Administrator will distinguish the Plan Participant’s Appeal as an administrative Appeal or Dental Necessity Appeal. There are two (2) levels of each Appeal, the first by the Claims Administrator or its designee, and the second by the Plan Administrator, Louisiana Sheriffs’ Association Group Benefits Program.

Plan Participants are encouraged to provide the Claims Administrator 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. The Claims Administrator will provide the Plan Participant, upon request by the Plan Participant and free of charge, the Claims Administrator will provide reasonable access to and copies of all documents records, and other information relevant to the Adverse Benefit Determination.
The Plan Participant has the right to appoint an authorized representative to represent the Plan Participant in their 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.

1. Administrative Appeals

Administrative Appeals involve contractual issues, Rescissions of Coverage, and Adverse Benefit Determinations which are not related to Dental Necessity, appropriateness, health care setting, level of care, effectiveness or treatment is determined to be experimental or investigational.

a. First Level Administrative Appeal

If the Plan Participant is not satisfied with the Claims Administrator’s decision, a written request to Appeal must be submitted within one hundred eighty (180) days of the initial Adverse Benefit Determination for first level administrative Appeals. Requests submitted to the Claims Administrator after one hundred eighty (180) days of the initial Adverse Benefit Determination will not be considered.

The Claims Administrator will investigate the Plan Participant’s concerns. If the administrative Appeal is overturned, the Claims Administrator will reprocess the Plan Participant’s Claim, if any. If the administrative Appeal is upheld, the Claims Administrator will inform the Plan Participant of the right to begin the second level Appeal process.

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

Administrative Appeals should be submitted in writing to:

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

b. Second Level Administrative Appeal

If the Claims Administrator does not reverse the decision, the Plan Participant may further Appeal the denial of Benefits to the Plan Administrator. Requests submitted after sixty (60) calendar days of the denial will not be considered. Send a written request for further review and any additional information to:

Insurance Advisory Committee
Louisiana Sheriffs’ Association Group Benefits Program
1175 Nicholson Dr.
Baton Rouge, LA 70802

Requests submitted to the Claims Administrator will be forwarded to the Louisiana Sheriffs’ Association Group Benefits Program.

2. Medical Appeals

Medical Appeals involve Adverse Benefit Determinations for Dental Necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and any related prospective or retrospective review determination.
a. First Level Medical Appeals

If the Plan Participant is not satisfied with the Claims Administrator’s decision, a written request to Appeal must be submitted within one hundred eighty (180) days of the initial Adverse Benefit Determination for internal Medical Appeals.

Medical Appeals should be submitted in writing to:

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

Requests submitted to the Claims Administrator after one hundred eighty (180) days of the initial Adverse Benefit Determination will not be considered.

A Physician or other health care professional in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment will review the Adverse Benefit Determination.

If the internal Medical Appeal is overturned, the Claims Administrator will reprocess the Plan Participant’s Claim, if any. If the internal Medical Appeal is upheld, the Claims Administrator will inform the Plan Participant of the right to begin the second level Appeal process.

The internal Medial Appeal decision will be mailed to the Plan Participant, the authorized representative, or a Provider authorized to act on the Plan Participant’s behalf, within thirty (30) calendar days of the Plan Participant’s request; unless the Claims Administrator mutually agrees that an extension of the time is warranted.

b. Second Level Medical or Rescission Appeal

If the Plan Participant disagrees with the first level medical Appeal determination, the Plan Participant or their authorized representative may request a second level medical Appeal. Within sixty (60) days of receipt of the first level decision, the Plan Participant must send his written request to:

Insurance Advisory Committee
Louisiana Sheriffs’ Association Group Benefits Program
1175 Nicholson Dr.
Baton Rouge, LA 70802

Requests submitted to the Plan Administrator after sixty (60) days of receipt of the first level Appeal decision will not be considered.

Requests submitted to the Claims Administrator will be forwarded to the Group. The Plan Administrator has full discretionary authority to determine eligibility for Benefits and/or construe the terms of this Plan.

c. Expedited Appeals

The expedited Appeal process is available for review of the Adverse Benefit Determination involving a situation where the time frame of the standard medical 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 physician, the Plan Participant may experience pain that cannot be adequately controlled while awaiting a standard Medical Appeal decision.
An Expedited Appeal also includes requests concerning an Admission, availability of care, continued stay, or health care service for a Plan Participant currently in the emergency room, under observation, or receiving Inpatient care.

An Expedited External Appeal is also available if the Adverse Benefit Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is deemed experimental or Investigational; and the covered person's treating Physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the Adverse Benefit Determination would be significantly less effective if not promptly initiated.

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, his 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 or written Expedited Appeals send to:
United Concordia Dental
Appeals Division
P.O. Box 69420
Harrisburg, PA 17106-9420
1-866-445-5338

You may contact the Commissioner of Insurance directly for assistance.
Commissioner of Insurance
P. O. Box 94214
Baton Rouge, LA 70804-9214
1-225-342-5900 or 1-800-259-5300

ARTICLE XV. 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 his Employer or call the Claims Administrator's customer service department at the telephone number shown on his 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.

Group may require the Employee to use the Group Enrollment Change Form to enroll family members not listed on the Employee's original enrollment form. If the Plan Participant does not complete and return a required Group 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 Employee's health benefits coverage will not be expanded to include the additional family members. Completing and returning a Group Enrollment Change Form is especially important when the Employee's first Dependent becomes eligible for coverage or when the Employee no longer has any eligible Dependents.
The Schedule of Eligibility explains when coverage becomes effective for new family members. Generally, a Group Enrollment Change Form is used to add newborn children, newborn adopted children, a spouse, or other Dependents not listed on the Employee’s original enrollment form. The Plan should receive the Employee’s completed form within thirty (30) days of the child’s birth or placement, or the Employee’s marriage.

B. How to File Insurance Claims for Benefits

The Claims Administrator and most 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. 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. If You need to file a paper Claim, send it to:

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

The Plan Participant’s 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 shown on the enrollment information the Plan received.) 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 to the Claims Administrator each time a Claim is filed.

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. this 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, procedure code, and total minutes (anesthesia professional fee) 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. This contract number (ID #) must be correct. It is important that the Plan Participant keep a copy of all bills and Claims submitted.

C. If a Plan Participant has a Question about His 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 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 ID number, patient's name and date of service.
ARTICLE XVI. RESPONSIBILITIES OF A PLAN ADMINISTRATOR

A. Plan Administrator

The Louisiana Sheriffs’ Association Group Benefit Plan is the Benefit Plan of Louisiana Sheriffs’ Association, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan. An individual may be appointed by Louisiana Sheriff’s Association to be the Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Louisiana Sheriffs’ Association shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this Benefit Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any Benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.

Any interpretation, determination or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any Benefits or making any claim for Benefits under this Benefit Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion and further constitutes agreement to the limited standard and scope of review described by this section.

Service of legal process may be made upon the Plan Administrator.

B. Duties of the Plan Administrator

1. to administer the Plan in accordance with its terms;
2. to interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions;
3. to decide disputes that may arise relative to a plan participant’s rights;
4. to prescribe procedures for filing a Claim for Benefits and to review Claim denials;
5. to keep and maintain the Plan documents and all other records pertaining to the Plan;
6. to appoint a Claims Administrator to pay Claims;
7. to establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609; and
8. to delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.
C. **Plan Administrator Compensation**

The Plan Administrator serves without compensation; however, all expenses for Plan administration, including compensation for hired services, will be paid by the Plan.

D. **Fiduciary**

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

1. **Fiduciary Duties**

   A fiduciary must carry out his duties and responsibilities for the purpose of providing Benefits to the employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

   a. with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

   b. by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

   c. in accordance with the Plan documents.

2. **The Named Fiduciary**

   A “named fiduciary” is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

   a. the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

   b. the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

E. **The Claims Administrator is not a Fiduciary**

A Claims Administrator is NOT a fiduciary under the Plan by virtue of paying Claims in accordance with the Plan’s rules as established by the Plan Administrator.
### General Plan Information

<table>
<thead>
<tr>
<th>Name of Plan:</th>
<th>Louisiana Sheriffs’ Association Dental Benefit Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name and Address of Plan Sponsor:</td>
<td>Louisiana Sheriffs’ Association Group Benefits Program  1175 Nicolson Drive  Baton Rouge, LA 70802  1-225-343-8402</td>
</tr>
<tr>
<td>Employer Identification Number (EIN):</td>
<td>37-6485374</td>
</tr>
<tr>
<td>Plan Number (PN):</td>
<td>501(C)(9)</td>
</tr>
<tr>
<td>Type of Plan:</td>
<td>Dental Benefit Plan</td>
</tr>
<tr>
<td>Funding Medium and Type of Administration:</td>
<td>The Plan is a self-funded Group Dental Plan. Benefits are on behalf of the Plan Administrator, by Blue Cross and Blue Shield of Louisiana, pursuant to the terms of the Administrative Services Agreement and the terms and conditions of the Benefit Plan. The funding for the Benefits is derived from the general assets of the Employer and contributions made by covered Employees. Employee contributions are at a rate determined by the Plan Sponsor. The Plan is not insured.</td>
</tr>
<tr>
<td>Name and Address of Plan Administrator:</td>
<td>Louisiana Sheriffs’ Association Group Benefits Program  1175 Nicolson Drive  Baton Rouge, LA 70802  1-225-343-8402</td>
</tr>
<tr>
<td>Agent for Service of Legal Process:</td>
<td>Usry, Weeks and Matthews, APLC  1615 Poydras Street, Suite 1250  New Orleans, LA 70112  1-504-592-4600</td>
</tr>
<tr>
<td>Plan Year:</td>
<td>The financial records of the Plan are kept on a Plan Year basis. The Plan Year ends on each June 30th (midnight).</td>
</tr>
<tr>
<td>Plan Details:</td>
<td>The eligibility requirements, termination provisions and a description of the circumstances which may result in disqualification, ineligibility, denial, or loss of any benefits are described in the Benefit Plan.</td>
</tr>
<tr>
<td>Future of the Plan:</td>
<td>Although the Plan Sponsor expects and intends to continue the Benefit Plan indefinitely, the Group reserves the right to modify, amend, suspend, or terminate the Benefit Plan at any time.</td>
</tr>
<tr>
<td>Source of Contributions and Funding:</td>
<td>The cost of all coverage is shared by the Plan Participant and the Plan Sponsor. The Participant’s contributions to the Benefit Plan are at a rate determined by the Plan Sponsor.</td>
</tr>
</tbody>
</table>
Nondiscrimination Notice
Discrimination is Against the Law

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

Blue Cross and Blue Shield of Louisiana and its subsidiaries:

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

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

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

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

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

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

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

   U.S. Department of Health and Human Services
   200 Independence Avenue, SW
   Room 509F, HHH Building
   Washington, D.C. 20201
   1-800-368-1019, 800-537-7697 (TDD)

Or

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

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


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

Oferencemos servicios lingüísticos gratuitos. Caso necesaria, ligue para o numero de Atendimento ao Cliente indicado no verso de seu cartão de identificação. Caso tenha uma deficiência auditiva, ligue para 1-800-711-5519 (TTY 711).

免費的語言服務請您使用。如果您ID卡背面有客服電話，請拨打。聽障人士請撥1-800-711-5519 (TTY 711).


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

Oferencemos servicios lingüísticos gratuitos. Caso necesario, ligue para o número de Atendimento ao Cliente indicado no verso de seu cartão de identificação. Caso tenha uma deficiência auditiva, ligue para 1-800-711-5519 (TTY 711).