

GROUP DENTAL BENEFITS

FOR THE EMPLOYEES
OF



LOUISIANA SHERIFFS' ASSOCIATION

ADMINISTERED BY



**BlueCross BlueShield
of Louisiana**

An independent licensee of the Blue Cross and Blue Shield Association.

Blue Cross and Blue Shield of Louisiana
Incorporated as Louisiana Health Service & Indemnity Company

SCHEDULE OF BENEFITS

DEDUCTIBLES:

First Year Deductible: \$100

Subsequent Year Deductible: \$50.00

Deductible Carryover: Dental Expenses incurred during the last three months (October, November, December) of a Benefit Period will be allowed as a credit, in whole or in part, toward satisfying the Deductible for the following Benefit Period, even if the Deductible was met and expenses paid.

COINSURANCE:

Endorsement A: 100%
Endorsement B: 80%
Endorsement C: 80%
Endorsement D: 80%
Endorsement E: 80%

Replacement of Dentures or Bridgework installed five (5) or more years before replacement is limited to 50% of the Allowable Charge. Replacement required due to extraction of one (1) or more teeth while covered under this Plan is covered at 80% of the Allowable Charge.

Endorsement F: 80%
Endorsement G: 50% up to the \$1,000.00 Lifetime Maximum

MAXIMUMS:

Benefit Period Maximum: \$1,000.00

Lifetime Maximum for Orthodontics: \$1,000.00 (Does not accrue to the Benefit Period maximum)

WAITING PERIOD

No Waiting Periods are applicable.

ELIGIBILITY

The eligibility date is the date of employment if the application is received within thirty (30) days of the date of employment.

Newborns are effective on the date of birth if the application is received within thirty (30) days of the date of birth.

A spouse is effective on the date of marriage if the application is received within ninety (90) days of the date of marriage.

If the application is not received within the time limits stated above, Employees and/or Dependents may not enroll until the next January 1.

Retirees:

Coverage will continue without interruption for Retirees currently receiving Benefits from the Sheriff's Pension Fund who exercise their option to continue coverage under the Plan within thirty (30) days from the date they cease to be a full-time Employee.

If such election is not made as stated above, or if the Retiree declines coverage or drops coverage at any time after retirement, he/she will not again be eligible to enroll at any time in the future.

Please Note:

Blue Cross and Blue Shield of Louisiana provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims liability.

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ARTICLE I.

DEFINITIONS

Administrator - means the person responsible for the daily management of the Plan. For purposes of this Plan, the Administrator is the Insurance Advisory Committee of the Louisiana Sheriffs' Association Group Benefits Plan.

Accidental Injury - A condition occurring as a direct result of a traumatic bodily injury sustained solely through accidental means from an external force. With respect to injuries to teeth, the act of chewing does not constitute an injury caused by external force.

Allied Health Facility - An institution, other than a Hospital, licensed by the appropriate state agency where required, and/or approved by Us to render Covered Services.

Allied Health Professional - A person or entity other than a Hospital, Doctor of Medicine, or Doctor of Osteopathy who is licensed by the appropriate state agency, where required, and/or approved by Us to render Covered Services. For coverage purposes under this Benefit Plan, Allied Health Professional includes: dentists, psychologists, certified nurse practitioners, optometrists, pharmacists, chiropractors, podiatrists, Physician's assistant, registered nurse first assistant, advanced practice registered nurse, certified registered nurse anesthetists, licensed professional counselor, and any other health professional as mandated by state law for specified services, if approved by Us to render Covered Services. Licensed clinical social workers are considered Allied Health Professionals when they work in collaboration and continuing Consultation with a Physician that is licensed by the appropriate/applicable licensing authority. Social workers may be required to submit written documentation to Us to support the collaboration and continuing Consultation.

Allied Provider - Any Allied Health Facility or Allied Health Professional.

Allowable Charge - The lesser of the submitted charge or the amount established by the Third Party Administrator as the maximum amount allowed for all Provider services covered under the terms of this Benefit Plan.

Benefits - Amounts provided under this Benefit Plan for Covered Services, based on the Allowable Charge.

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

Benefit Period Maximum - The maximum amount this Benefit Plan will provide for Covered Services per Member during a Benefit Period, according to the Plan's endorsement(s) of Dental Care.

Benefit Plan - This agreement, including the Schedule of Benefits and amendments or endorsements, if any, entitling the Subscriber and covered Dependents to specified Dental Care.

Benefit Plan Date - The date upon which the Third Party Administrator begins to administer Benefits for Covered Services to Members under this Benefit Plan.

Certificate - The recitation of coverage under this Plan that is furnished to an Employee, including the original and/or amended Schedule of Benefits, the Employee's individual enrollment form, change of status form and any amendments to the Certificate.

Child - means a stepchild, foster child, and any other child natural or adopted who:

- A. Lives with the Covered Person in a normal parent-child relationship and depends upon the Covered Person for principal support and maintenance; or
- B. Is of a previous marriage for which child support payments are being made by the Covered Person.

The Plan reserves the right to require proof that the Child was filed as a Dependent on the Covered Person's Federal Income Tax return.

Claim - A claim is written or electronic proof, in a form acceptable to the Third Party Administrator, of charges for Covered Services that have been incurred by a Member during the time period the Member was insured under this 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.

Coinsurance - The sharing of eligible charges for Covered Services between the Member and the Plan. The sharing is expressed as a percentage. Once the Member has met any applicable Deductible Amount, their percentage will be applied to the Allowable Charges for Covered Services to determine the Member's financial responsibility. The Plan's percentage will be applied to the Allowable Charges for Covered Services to determine the Benefits provided.

Congenital Anomaly - A condition existing at or from birth which significantly interferes with normal bodily function. For the purposes of this Plan, the Third Party Administrator will determine what conditions will be covered as Congenital Anomalies.

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

Covered Service - A service or supply specified in this Plan for which Benefits are available when rendered by a Provider. A charge for a Covered Service is considered to have been incurred on the date the service or supply was provided to the Member.

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

Dental Care - Dental services provided for under this Benefit Plan.

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

Dependent - means the legal spouse of an Employee/Retiree, and any unmarried Child who meets the following conditions:

- A. Is a natural Child; or

- B. Is a legally adopted Child (Note: an adopted Child who is awaiting final order of adoption is an eligible Dependent from the date the Child is placed in the Employee's home), foster child, stepchild, grandchild, or other child who both (i) lives with the Employee in a regular parent-child relationship and (ii) is dependent upon the Employee for principal financial support. Any natural or adopted Child of a previous marriage for which child support payments are being made is considered as an eligible Dependent.
- C. Is less than twenty-one (21) years of age. However, a Child who is principally dependent upon the Employee for support (depends on the Employee for more than half of the Child's support) and who is enrolled on a full-time basis in an accredited college or university, or a vocational, technical, vocational-technical, or trade school or institute, or secondary school, shall be considered a Dependent until attainment of twenty-five (25) years of age. For coverage to be continued during vacation periods, the covered Dependent must be scheduled to enter school on the next enrollment date.
- D. Any mentally retarded or physically handicapped Child shall remain covered beyond the maximum age provided the unmarried Child satisfied the requirements of (a) and (b) above; became mentally or physically disabled before age twenty-one (21) or twenty-five (25) if a covered student; and is incapable of self-sustaining employment and is chiefly dependent upon the Employee for support and maintenance. Proof of incapacity must be furnished and additional proof may be required from time to time. "Disabled" means any medically determinable physical or mental condition which prevents the Child from engaging in self-sustaining employment; provided that the disability commences prior to such Child's attainment of the limiting age and that satisfactory proof of such disability and dependency is submitted by the Employee within thirty-one (31) days following the Child's attainment of the limiting age.

Note: No coverage will be made effective for a Child other than a natural Child until the Employee has submitted documentation which satisfies the Committee that both (a) a parent-child relationship exists, and (b) the Employee provides principal financial support for that Child.

Effective Date - The date when the Member's coverage begins under this 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 a Subscriber or Dependent as specified in the Schedule of Eligibility.

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

Employer - means each Parish Sheriffs' Department, the Louisiana Sheriffs' Association Executive Office, and the Louisiana Sheriffs' Association Pension & Relief Fund Office, when such groups have been accepted by the Plan for participation.

Investigational - A medical treatment or procedure, a drug, device, or biological product, is investigational if the efficacy has not been clearly tested or which has not been incorporated into standard medical practice. Any determination that a medical treatment or procedure, a drug, device, or biological product, is investigational will be made by the Third Party Administrator. Such determinations may be made based on the determination that the medical treatment or procedure, drug, device, or biological product:

- A. Cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and which has not been approved for marketing at the time the drug or device is sought to be furnished; or

- B. Needs further studies or clinical trials to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis, according to the consensus of opinion among experts as shown by reliable evidence, including:
1. consultation with the Blue Cross and Blue Shield Association technology assessment program (TEC) or other non-affiliated technology evaluation center(s);
 2. published reports and articles in authoritative medical and scientific literature;
 3. reference to federal regulations; or
 4. consultation with provider organizations or committees.

Lifetime Maximum - The maximum amount provided by the Plan on behalf of a Member for Covered Services. The Covered Services to which a Lifetime Maximum applies are shown on the Schedule of Benefits.

Member – An Employee or an enrolled Dependent.

Plan - means the Louisiana Sheriffs' Association Group Benefits Plan, effective as of May 1, 1983.

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 Third Party Administrator.

- A. Participating Provider - A Provider that has a Provider Agreement with the Company pertaining to payment for Covered Services rendered to a Member.
- B. Nonparticipating Provider - A Provider that does not have a Provider Agreement with the Company pertaining to payment of Covered Services rendered to a Member.

Provider Agreement - An agreement for payment negotiated by the Company 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 negotiated between the Company and the Participating Provider.

Retiree - means a former Employee who meets the retirement criteria specified by the Employer.

Third Party Administrator - means the firm with whom the Administrator has contracted to handle the claims and billing function of the Plan. For purposes of this Benefit Plan, the Claims Administrator is Blue Cross and Blue Shield of Louisiana.

Waiting Period - The period that must pass before an individual is eligible to receive Benefits for Dental Care, except for an Accidental Injury, subject to review by the Third Party Administrator.

ARTICLE II.

ELIGIBILITY AND TERMINATION

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. Retiree

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 I, 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 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 Sheriff's Association'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 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.

4. 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. Once approved, the effective date will then be the first of the month following the date the change card was notarized.

- 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 Employer's group insurance plan on the day immediately preceding participation in this Plan shall be eligible for immediate coverage and:
1. 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,
 2. 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 I, DEFINITIONS, during their initial period of eligibility will be required to show proof of insurability. The effective date of coverage will be the first day of the month following the date the application or change card is notarized.

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 I, 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 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 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 Employee is granted a leave of absence for a work related leave of absence not defined in (2) 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 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.

ARTICLE III.

INSURING AGREEMENT

After the Member's payment of any applicable Deductible, shown on the Schedule of Benefits, this Plan will provide Benefits at the Coinsurance percentage for the Endorsements shown on the Schedule of Benefits, for Covered Services rendered by a Dentist, not to exceed the Allowable Charge, up to the Benefit Period maximum, if any, as shown on the Schedule of Benefits.

If shown on the Schedule of Benefits, Benefits under Endorsement G - Orthodontics may be limited to the Lifetime Maximum per Member in the amount shown. Unless otherwise noted on the Schedule of Benefits, payments made under this Endorsement during a Benefit Period are included in the Benefit Period Maximum for Dental Care.

ARTICLE IV.

DENTAL CARE BENEFITS

Dental Care Benefits available under this Plan are described in the Endorsements listed below. The Coinsurance percentages for each selected Endorsement and any special Benefits are shown on the Schedule of Benefits.

- Endorsement A - Oral Surgery
- Endorsement B - Diagnostic and Preventive
- Endorsement C - Simple Restorative
- Endorsement D - Complex Restorative
- Endorsement E - Prosthodontics
- Endorsement F - Periodontics
- Endorsement G - Orthodontics

ENDORSEMENT A

ORAL SURGERY

After the Deductible (if applicable) has been met, Benefits will be provided at the Coinsurance percentage of Allowable Charges, as shown on the Schedule of Benefits, for Dental Care listed herein.

I. DENTAL CARE PROVIDED:

A. 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. Apicoectomy
6. Root Recovery (surgical removal of residual root)

7. Surgical exposure of impacted or unerupted tooth for orthodontic purposes
8. Alveolectomy of edentulous areas
9. Alveolectomy following the removal of teeth
10. Alveoloplasty (surgical preparation of ridge for dentures)
11. Stomatoplasty - including revision of soft tissue, ridge extension, muscle reattachment, and manipulation of other intra-oral tissue.

B. 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.

C. 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.

D. TEMPOROMANDIBULAR JOINT DYSFUNCTIONS:

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

II. EXCLUSIONS:

- A. No Benefits will be paid under this Endorsement for Congenital Anomalies, except for those of Dependents born Members.
- B. No Benefits will be paid for the administration of anesthesia when billed separately by the Dentist or any other person.

ENDORSEMENT B DIAGNOSTIC AND PREVENTIVE

After the Deductible (if applicable) has been met, Benefits will be provided at the Coinsurance percentage of Allowable Charges, as shown on the Schedule of Benefits, for Dental Care listed herein.

I. DENTAL CARE PROVIDED:

A. DIAGNOSTIC:

1. Initial oral examination and treatment planning
2. Periodic oral examination
3. Emergency oral examination
4. Special consultation fee by specialist for case presentation when diagnostic procedures have been performed by a general Dentist
5. Diagnostic models
6. Pulp vitality test
7. Biopsy of soft tissue
8. Oral Smear
9. Bacteriologic culture for determination of oral pathologic agents
10. Microscopic examination of pathogens and/or oral tissue

B. RADIOGRAPHIC:

1. Intraoral periapical X-Rays
2. Complete intraoral series of periapical X-Rays (fourteen (14) or more X-Rays) (Limited to once in a two (2) year period)
3. Bite-wings (Caries Detector) X-Rays (Limited to once in a six (6) month period)
4. Cephalometric X-Rays
5. X-Rays of Temporomandibular Joint
6. Intraoral-occlusal X-Rays
7. Extraoral - X-Rays of T.M.J., lateral head, anteroposterior, postero-anterior
8. Panographic-type X-Rays (Limited to once in a two (2) year period)

C. PREVENTIVE:

1. Plaque Control Program (Limited to once in a three (3) year period)
2. Training in oral hygiene (Limited to once in a three (3) year period)
3. Occlusal Equilibration (Limited to once in a three (3) year period)
4. Dental Prophylaxis
5. Topical application of fluoride (Limited to once yearly and to persons under nineteen (19) years of age)
6. Space maintainers (Limited to replacement of same maintainer once in a three (3) year period)
7. Dietary prescription and counseling (Limited to once in a three (3) year period)

II. EXCLUSION:

No Benefits will be paid under this Endorsement for Fissure Sealants, except on permanent teeth only, for Members up to age nineteen (19).

ENDORSEMENT C

SIMPLE RESTORATIVE

After the Deductible (if applicable) has been met, Benefits will be provided at the Coinsurance percentage of Allowable Charges, as shown on the Schedule of Benefits, for Dental Care listed herein.

I. DENTAL CARE PROVIDED:

A. SIMPLE RESTORATIVE:

1. Amalgam restorations for permanent and primary teeth
2. Cement bases
3. Calcium hydroxide or zinc-oxide-eugenol bases
4. Silicate cement (synthetic porcelain) restorations
5. Auto-cured composite resin restorations
6. Pins for reinforced pin restorations (maximum three (3) pins)
7. Light cured composite resin restorations (not for Fissure Sealant)

B. ENDODONTICS:

1. Pulp cap (excluding restorations)
2. Recalcification (treatment restoration)
3. Therapeutic apical closure (apical calcification technique)
4. Pulpotomies (excluding restoration)
5. Extirpation of pulp and root canal fillings (excluding restoration)

ENDORSEMENT D

COMPLEX RESTORATIVE

After the Deductible (if applicable) has been met, Benefits will be provided at the Coinsurance percentage of Allowable Charges, as shown on the Schedule of Benefits, for Dental Care listed herein.

I. DENTAL CARE PROVIDED:

A. RESTORATIONS (when not used as an element of a fixed prosthesis):

1. Inlays/Onlays
2. Crowns and jackets
3. Posts and Copings

B. RECEMENTATION OF CROWNS AND INLAYS/ONLAYS (Limited to once in a three (3) year period)

ENDORSEMENT E

PROSTHODONTICS

After the Deductible (if applicable) has been met, Benefits will be provided at the Coinsurance percentage of Allowable Charges, as shown on the Schedule of Benefits, for Dental Care listed herein.

I. DENTAL CARE PROVIDED:

A. 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)

B. 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

C. PROSTHODONTICS-MISCELLANEOUS:

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

D. 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 Member within thirty-one (31) days of the date of termination.

II. EXCLUSION:

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

- A. at least five (5) years have elapsed since the placement of the bridgework or denture; or
- B. the existing appliance is unserviceable; or
- C. the existing temporary denture cannot be made permanent and the replacement occurs within twelve (12) months of the initial installation.

ENDORSEMENT F

PERIODONTICS

After the Deductible (if applicable) has been met, Benefits will be provided at the Coinsurance percentage of Allowable Charges, as shown on the Schedule of Benefits, for Dental Care listed herein.

I. DENTAL CARE PROVIDED:

- A. Emergency palliative treatment
- B. Subgingival curettage
- C. Gingivectomy and/or gingivoplasty
- D. Osseous surgery - including flap entry and closure
- E. Mucogingivoplastic surgery
- F. Periodontal scaling and root planing

ARTICLE VI.

LIMITATIONS AND EXCLUSIONS

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

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 Member has no legal obligation to pay, or for which no charge would be made if the Member 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:
 - a. those for diseases contracted or injuries sustained as a result of war, declared or undeclared or any act of war;
 - b. those occurring as a result of taking part in a riot or acts of civil disobedience;
 - c. those occurring as a result of a Member's commission or attempted commission of a felony; or
 - d. those for intentionally self-inflicted injury or sickness.
7. Dental Care, other than orthodontic services, in progress before the Member'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. Fissure Sealants, except on permanent teeth only, for Members up to age nineteen (19).
12. Dental Care or supplies other than those specifically listed as covered by this Plan.
13. Services or supplies which are Investigational in nature.
14. Services, supplies, equipment, or charges in connection with Cosmetic Surgery/Treatment.

15. Treatment of any Member confined in prison, jail, or other penal institution.
16. 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.
17. Sales tax or interest.
18. Care rendered by a Dentist who is related to the Member by blood, marriage or adoption or who regularly resides in the Member's household.
19. Charges for telephone or e-mail consultations, failure to keep a scheduled visit, completion of a claim form, or to obtain medical records or information required to adjudicate a claim, or for access to or enrollment in or with any provider.
20. Services, supplies, or equipment in connection with bleaching.
21. Anesthesia, when billed separately from the treating Dentist's charges.
22. Services in connection with diagnostic photos (i.e., Polaroid).
23. Services or supplies determined by the Third Party Administrator to be not medically necessary.
24. Unless shown as waived on the Schedule of Benefits, the Member is not eligible for Dental Care Benefits under any Dental Care endorsement for ninety (90) days after the Effective Date, except for an Accidental Injury determined to be such by the Third Party Administrator.

ARTICLE VII. DIRECT PAYMENT OF BENEFITS TO A MEMBER

1. All Benefits payable under this Benefit Plan and any amendment hereto are personal to the Member and are not assignable in whole or in part by the Member. The Third Party Administrator has the right to make payment on behalf of the Plan to a Dentist, or other Provider (instead of to the Member) for Covered Services while there is in effect between the Third Party Administrator and any such Dentist or other Provider an agreement calling for the Third Party Administrator to make payment directly to them. In the absence of such an agreement for direct payment, the Third Party Administrator will pay to the Member and only the Member those Benefits called for herein and the Third Party Administrator will not recognize a Member's attempted assignment to, or direction to pay, another, except as required by law. Nothing contained in the written description of dental coverage shall be construed to make the Plan or the Third Party Administrator liable to any third party to whom a Member may be liable for dental care, treatment or services.
2. Dentists and other Providers which have agreed with this Third Party Administrator or another Blue Cross and Blue Shield Company for such direct payment are, by reason of such agreements, "Participating other Providers," respectively, and are referred to collectively as "Participating Providers." Those Dentists and other Providers which do not have such agreements for direct payment are "Nonparticipating Dentists," and "Nonparticipating other Providers," respectively, and are referred to collectively as "Nonparticipating Providers."

3. If the Third Party Administrator has offered a Dentist or other Provider an agreement for direct payment by the Third Party Administrator, but there is no such agreement in effect when Covered Services are rendered to a Member by such Dentist or other Provider, the Third Party Administrator will not recognize a Member's attempted assignment to, or direction to pay, such Dentist or other Provider. The Third Party Administrator will pay on behalf of the Plan to the Member and only the Member those Benefits called for in this Benefit Plan and any amendment thereto.
4. The Third Party Administrator reserves the right to select the Dentists and other Providers with which it will make agreements for direct payment by the Third Party Administrator for Covered Services rendered to Members, based on criteria which include the Third Party Administrator's need in the locality, Utilization Management practices of the Dentist or other Provider, quality of services, and the like.

ARTICLE VIII. COBRA CONTINUATION OF COVERAGE

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and any amendments thereto, certain covered Employees and Dependents who would otherwise lose coverage as a result of a qualifying event, will have the option of continuation of that coverage without evidence of insurability.

These Employees and Dependents ("qualified beneficiaries") are those who are covered under this Benefit Plan on the day before a qualifying event occurs. In addition, a child who is born or placed for adoption with the covered Employee during a period of COBRA coverage will be eligible to become a qualified beneficiary if notification of such birth or adoption is made within thirty (30) days of birth or adoption.

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 covered employee;
- Death of a covered Employee;
- A Dependent spouse's divorce or legal separation from a covered Employee;
- The covered Employee becomes entitled to Medicare benefits resulting in the loss of coverage for Dependents; or
- A Dependent child ceases to be an Eligible Dependent under the terms of this Benefit Plan.
- The employer's Title 11 bankruptcy proceeding, with respect to covered employees who retired from the employer at any time.

The qualified beneficiary must notify the plan administrator if the qualifying event is a divorce or legal separation or if a Dependent child loses eligibility for coverage, within sixty (60) days of the occurrence of the qualifying event.

The employer will advise a qualified beneficiary of his or her rights under COBRA upon the occurrence of any other qualifying event and following notice or occurrence of a qualifying event when such notice is required to be given by the qualified beneficiary.

A Member may be required to pay the applicable premium for continued coverage plus an amount to cover administrative expenses. The option to elect continuation coverage will be offered during a period which:

- begins no later than the date on which a Member otherwise would lose coverage under the group health plan (the termination date); and
- ends no earlier than sixty (60) days after the termination date or if timely notice by a Member must be given, sixty (60) days after the Member is notified of their right to continue coverage.

If continuation of coverage is elected, the qualified beneficiary then has forty-five (45) days within which to make the first premium payment.

Continuation of coverage begins on the termination date and ends no earlier than:

- eighteen (18) months after the termination date in the case of termination of employment or reduction in work hours. If a second qualifying event, other than bankruptcy occurs during this eighteen (18) month period, the eighteen (18) month period may be extended to thirty-six (36) months. Where the qualifying event is entitlement of a covered Employee to Medicare during the eighteen (18) month period preceding the termination of employment or reduction in hours of employment, the period of coverage for Dependents of that Employee shall terminate on the later of thirty-six (36) months from the date the Employee becomes entitled to Medicare or eighteen (18) months from the termination of employment or reduction in hours of employment.

Note: The eighteen (18) months may be extended to twenty-nine (29) months if a qualified beneficiary who is determined to be disabled (as determined under Title II, or XVI of the Social Security Act) before the first day of COBRA coverage or becomes 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 due to a termination or reduction in hours of employment. The qualified beneficiary must notify the plan administrator of the disability determination no later than sixty (60) days from the date of the Social Security Administration determination and before the end of the original eighteen (18) month period. The qualified beneficiary must also notify the employer within thirty (30) days of any final determination 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 (as determined under the Social Security Act) subject to the original eighteen (18) months of COBRA coverage; or

- thirty-six (36) months after the date of termination due to any other qualifying event; or
- the date the employer ceases to maintain any group health plan; or
- the date coverage ceases because of non-payment of required premiums; or
- the date the Employee or Dependent first becomes covered after the date of the COBRA election under another group health plan and benefits under that plan are not excluded or limited with respect to a pre-existing condition; or
- the date the Employee or Dependent becomes entitled to Medicare after the date he or she elects COBRA coverage.

Note: Special rules apply for the duration of coverage under COBRA for certain retirees and their Dependents who lose coverage as a result of an employer's bankruptcy, which is a "qualifying event." In this event, affected retirees may elect lifetime COBRA coverage as of the date of the bankruptcy proceeding. Dependents of retirees may continue COBRA coverage until the retiree's death. When the retiree dies, Dependents of retirees 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: 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.

Note: Special Second Election Period for Certain Trade-Displaced Individuals Who Did Not Elect COBRA Coverage: Special COBRA rights apply to employees who lost health coverage as a result of a termination or reduction of hours and who qualify for a “trade adjustment assistance (TAA)” or “alternative trade adjustment (ATAA)” under a federal law called the Trade Act of 2002. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) during a special second election period. This special second election period lasts for sixty (60) days or less. The sixty (60) day period begins on the first day of the month in which an eligible employee becomes a TAA or ATAA eligible individual, but only if the election is made within six (6) months immediately after the eligible employee’s group health plan coverage ended. If the Member qualifies or may qualify for assistance under the Trade Act of 2002, the Member should contact his Plan’s Human Resources Manager for additional information. **THE MEMBER MUST CONTACT THE PLAN’S HUMAN RESOURCES MANAGER PROMPTLY AFTER QUALIFYING FOR ASSISTANCE UNDER THE TRADE ACT OF 2002 OR THE MEMBER WILL LOSE HIS SPECIAL COBRA RIGHTS.**

ARTICLE IX. GENERAL PROVISIONS

In the event of a conflict between this Benefit Plan and the Certificates or booklets, the terms of this Benefit Plan will prevail.

Blue Cross and Blue Shield of Louisiana provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

A. The Plan

1. To the extent that this Plan may not comply with any federal or state law enacted after its drafting, provisions necessary for such compliance shall be deemed incorporated and the Plan shall be administered accordingly.
2. Except as specifically provided herein, this Plan will not make the Third Party Administrator liable or responsible for any duty or obligation which is imposed on the Plan by federal or state law or regulations.
3. To the extent that this Benefit Plan may be part of an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 ("ERISA"), the Plan will be the administrator of such employee welfare benefit plan and will be solely responsible for meeting any obligations imposed by law or regulation on the administrator (including establishment of written procedures for determining qualification of medical child support of Dependents and related required notifications), except those specifically undertaken by the Third Party Administrator herein. The Plan will also be the administrator for the purposes of COBRA.
4. Neither the Plan nor the Third Party Administrator will be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance or malpractice on the part of any Dentist, his/her agent or employee or other person participating in, or having to do with, the care or treatment of a Member.

B. Benefit Plan Changes

The Administrator reserves the right to modify the terms of this Benefit Plan upon not less than thirty (30) days notice to the Member. No change or waiver of any Benefit Plan provision will be effective until approved by the the insurance advisory committee who is authorized to make such changes.

C. Identification Cards and Certificates or Booklets

Employees will be issued identification cards and certificates or booklets which describe Benefits and the procedures for obtaining Benefits. The Administrator has the sole responsibility for distributing all such documents and material to Employees.

D. Benefits to Which Members are Entitled

1. The liability of the Plan 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 Member's Effective Date by a Dentist specified in this Benefit Plan and regularly included in such Dentist's charges.

E. Filing of Claims

A claim is a written or electronic proof of charges for Covered Services that have been incurred by a Member during the time period the Member was insured under this Benefit Plan. Benefits will not be paid under this Plan unless a claim in a form acceptable to the Third Party Administrator is filed with the Third Party Administrator within ninety (90) days from the date services are rendered. If it is not reasonably possible to file the claim within this time, the Third Party Administrator will allow more time. The claim must then be filed as soon as possible, but not more than fifteen (15) months after the claim is incurred. Benefits will be denied for claims filed any later than fifteen (15) months from the date of service. The claim must contain the data necessary for the Third Party Administrator to determine Benefits. A claim will be considered incurred on the date services or supplies are provided. 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.

F. Review of Claims Denied in Whole or in Part

A Member has sixty (60) days, from the date of receipt of notification of the Third Party Administrator's action on his or her claim, to request a review of any Benefits denied in whole or in part. To request a review, the Member must write to Blue Cross and Blue Shield of Louisiana, Claims Review Department (Customer Service Center), Post Office Box 98029, Baton Rouge, LA 70898-9029, stating the issue to be reviewed and attaching pertinent medical records or other information that the Member offers in support of his or her claims. The Member may also request a description of any pertinent records that the Third Party Administrator relied on in making its original decision to deny the claim in whole or in part.

A disposition of the claim will not be deemed final until such time as a written decision is rendered. The decision will be rendered within sixty (60) days after the request for review is received, unless medical records are requested. In such case the decision will be rendered no later than one hundred twenty (120)

days after the request for review is received. **The Plan has full discretionary authority to determine eligibility for Benefits and/or to construe the terms of this Benefit Plan.** The Member will receive a written decision stating the specific reasons for the final decision with specific references to pertinent Benefit Plan provisions.

A Member may request that the Insurance Advisory Committee review a denied Claim (along with any written or oral comments the Member or his representative may wish to make) within sixty (60) days after receipt of the denial of the Claim.

The Insurance Advisory Committee will explain in writing the basis for its decision. This will ordinarily be done within (60) days, but in special circumstances, the Insurance Advisory Committee may extend this period by up to (60) additional days if the Member is given written notice of the extension during the initial 60-day period.

G. 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 fifteen (15) months after the date services are rendered.

H. Release of Information

Each Member receiving care under this Plan authorizes and directs any Dentist to furnish to the Third Party Administrator, upon its request, all information, records, copies of records or testimony relating to attendance, diagnosis, examination, or treatment. Such authorization and compliance therewith by each Dentist affected will be a condition precedent to rights to Benefits to each Member hereunder, and no Benefits will be provided in any case where such authorization is not given full effect. The Third Party Administrator will hold such information, records, or copies of records, as confidential except where in its discretion the same should be disclosed.

I. Member/Dentist Relationship

1. The choice of a Dentist is solely the Member's.
2. Neither the Third Party Administrator nor the Plan renders Covered Services but only makes payment for Covered Services received by Members. Neither the Third Party Administrator nor the Plan is liable for any act or omission of any Dentist. The Third Party Administrator nor the Plan has responsibility for a Dentist's failure or refusal to render Covered Services to a Member.

J. Applicable Law

This Benefit Plan will be governed and construed in accordance with the laws and regulations of the State of Louisiana, except when preempted by federal law.

K. Coordination of Benefits

1. Applicability

- a. This Coordination of Benefits ("COB") section applies to This Plan when the Member has Dental Care coverage under more than one plan. "Plan" and "This Plan" are defined below.
- b. If this COB section applies, the Order of Benefit Determination Rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:
 - (1) will not be reduced when, under the Order of Benefit Determination Rules, This Plan determines its benefits before another plan.
 - (2) may be reduced when under the Order of Benefit Determination Rules, another plan determines its benefits first. That reduction is described in Paragraph 4 of this COB section, "Effect on the Benefits of This Plan."

2. Definitions (Applicable only to this Section of the Plan)

- a. "Plan" means any group or blanket health or dental plan which provides benefits for services, supplies, or equipment for hospital, surgical, medical, or dental care or treatment, including but not limited to coverage under:
 - (1) insurance policies, non-profit health service plans, health maintenance organizations, subscriber contracts, self-insured plans, pre-payment plans, automobile or homeowners medical payments plans;
 - (2) government programs, including compulsory no-fault automobile insurance, unless an applicable law forbids coordinating benefits with this type of program;
 - (3) labor-management trustee plans, union welfare plans, employer organization plans, employee benefit organization plans, and professional association plans;
 - (4) any other employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended;
 - (5) Medicare as permitted by federal law;
 - (6) group-type plans or policies which can be obtained only because of employment with or membership in a particular organization, corporation, or other business entity.

This does not include school accident insurance, Medicaid, hospital daily indemnity plans, specified diseases only policies, or limited occurrence policies which provide only for intensive care or coronary care in the hospital.

Each plan or other arrangement for coverage is a separate plan. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

- b. "This Plan" means the part of the Plan and any amendments/endorsements thereto that provides benefits for Dental Care expenses.
- c. "Primary Plan" / "Secondary Plan." The Order of Benefit Determination Rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

- d. "Allowable Expense" means a necessary, reasonable, and customary item of expense for Dental Care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When benefits are reduced under a Primary Plan because a covered person does not comply with the Primary Plan's provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements.

- e. "Claim Determination Period" means that part of the calendar year during which a person covered by This Plan is eligible to receive benefits under the provisions of This Plan.

3. Order of Benefit Determination Rules

- a. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:

(1) the other plan has rules coordinating its benefits with those of This Plan; and,

(2) both those rules and This Plan's rules, in subparagraph b. below, require that This Plan's benefits be determined before those of the other plan.

- b. This Plan determines its order of benefits using the first of the following rules which applies:

(1) Non-dependent/Dependent: The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is

- (a) Secondary to the plan covering the person as a dependent, and
- (b) Primary to the plan covering the person as other than a dependent (e.g., a retired employee),

then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent.

- (2) Dependent Child/Parents Not Separated or Divorced: Except as stated in subparagraph b.(3) below, when This Plan and another plan cover the same child as a dependent of different persons, called “parents”:

- (a) the benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in the calendar year; but
- (b) if both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in (a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

- (3) Dependent Child/Separated or Divorced Parents: If two or more plans cover a person who is a dependent child of divorced or separated parents, benefits for the child are determined in this order:

- (a) first, the plan of the parent with custody of the child;
- (b) then, the plan of the spouse of the parent with custody of the child;
- (c) finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the Dental Care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan.

This paragraph does not apply when any benefits are actually paid or provided before the entity has that actual knowledge.

- (4) Joint Custody: If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the Dental Care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in Paragraph 3.b.(2).

- (5) Active/Inactive Employee: The benefits of a plan which covers a person as an employee who is not terminated, laid off, or retired (or as that employee's dependent) are determined before those of a plan which covers that person as a terminated, laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (6) Continuation Coverage: If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination:
- (a) First, the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent);
 - (b) Second, the benefits under the continuation coverage.
- If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (7) Longer/Shorter Length of Coverage: If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter time.

4. Effect on the Benefits of This Plan

- a. This Paragraph 4 applies when, in accordance with Paragraph 3, "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event the benefits of This Plan may be reduced, as described in this paragraph. Such other plan or plans are referred to as "the other plans" in b. immediately below.

- b. Reduction in This Plan's Benefits

The benefits of This Plan will be reduced when the sum of:

- (1) the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB section, and
- (2) the benefits that would be payable for the Allowable Expenses under the other plans in the absence of provisions with a purpose like that of this COB section, whether or not claims are made,

would be more than those Allowable Expenses in a Claim Determination Period. In that case, 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.

5. Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. Blue Cross and Blue Shield of Louisiana has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Blue Cross and Blue Shield of Louisiana need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Blue Cross and Blue Shield of Louisiana any facts it needs to pay the claim.

6. Facility of Payment

A payment made under another plan may include an amount which should have been paid under This Plan. Blue Cross and Blue Shield of Louisiana may pay that amount to the organization which 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 Blue Cross and Blue Shield of Louisiana and the Plan 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.

7. Right of Recovery

If the amount of payments made by the Third Party Administrator and the Plan is more than it should have paid under this COB section, it may recover the excess. It may get such recovery or payment from one or more of:

- a. The persons it has paid or for whom it has paid;
- b. Insurance companies; or
- c. Other organizations.

The "amount of payments made" includes reasonable cash value of benefits provided in the form of services. If the excess amount is not received when requested, benefits due under this Plan will be reduced by the amount to be recovered until such amount has been satisfied.

L. Job-Related Injury or Illness

This Benefit Plan 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 unless incurred while the Employee is on active duty with the Plan. In the event Benefits are initially extended and a compensation carrier or employer makes any type 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 Employee must reimburse the Plan for Benefits extended or direct the compensation carrier to make such reimbursement. The Plan will be entitled to such reimbursement even if the settlement does not mention or excludes payment for Dental Care expenses.

M. Subrogation

1. To the extent that Benefits for Covered Services are provided or paid under the Benefit Plan, the Plan will be subrogated and will succeed to the Member's right for the recovery of the amount paid under the Plan against any person, organization or other carrier even where such carrier provides Benefits directly to a Member who is its insured. The acceptance of such Benefits hereunder will constitute acknowledgment of such subrogation rights. The Plan's right to subrogation comes first even if the Member is not paid for all of the Member's Claim for damages or even if the payment the Member receives is for, or is described as for, the Member's damages other than health care expenses, or if the Member recovering the money is a minor. All costs that the Member incurs (including attorney fees) in exercising any right of recovery will be the Member's responsibility. Amounts that the Third Party Administrator paid on behalf of the Plan for which a third party or insurer is responsible will not be reduced by the amount of the Member's costs. The Plan may recover attorney fees in accordance with La. Revised Statute 33:1448.
2. The Member will reimburse the Plan all amounts recovered by suit, settlement, or otherwise from any third party or the Member's insurer to the extent of the Benefits provided or paid under the Plan. The Plan's right to reimbursement comes first even if the Member is not paid for all of the Member's Claim for damages or even if the payment the Member receives is for, or is described as for, the Member's damages other than health care expenses, or if the Member recovering the money is a minor. All costs that the Member incurs (including attorney fees) in exercising any right of recovery will be the Member's responsibility. Amounts that We paid on behalf of the Plan for which a third party or insurer is responsible will not be reduced by the amount of the Member's costs. The Member shall hold in trust for the account of the Plan all amounts recovered, up to the total amount of Benefits paid. The Plan appoints the Member as its representative for such limited purpose only. The Plan may recover attorney fees in accordance with La. Revised Statute 33:1448.
3. The Member will take such action, furnish such information and assistance, and execute such papers as We may require to facilitate enforcement of the Plan's rights, and will take no action prejudicing the Plan's rights and interest. Nothing contained in this provision will be deemed to change, modify or vary the terms of the Coordination of Benefits section of this Plan.
4. The Member will notify Us of any Accidental Injury.
5. If any portion of the provision above is contrary to applicable law, the entire provision shall not be invalid but shall be considered to be modified to the minimum extent necessary to comply with law.

N. Right of Recovery

When payment for Covered Services has been made by the Third Party Administrator or the Plan in an amount that exceeds the maximum Benefits available for such services under this Benefit Plan, or when payment has been made in error by the Third Party Administrator or the Plan for non-Covered Services, the Third Party Administrator or the Plan will have the right to recover such payment from the Member or, if applicable, the Dentist. As an alternative, the Third Party Administrator and the Plan reserves the right to deduct from any pending claim for payment under this Benefit Plan any amounts the Member or Dentist 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 to the extent the veteran would be eligible for Benefits under this Benefit Plan if the care or services had not been furnished by a department or agency of the United States. The amount the United States may recover will be reduced by the appropriate Deductible and Coinsurance amount. The United States will have the right to collect from the Third Party 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 Third Party Administrator 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.

ARTICLE X. DETERMINATION OF ALLOWABLE CHARGE SCHEDULE

Each year, Blue Cross and Blue Shield of Louisiana establishes Allowable Charge Schedules based on a nationally recognized dental relative value scale times a conversion factor developed from charges submitted by Dentists for services during the previous year.

The Dental Allowable Charge Schedule is determined annually utilizing the following steps:

1. The percentile to be used for development of the Dental Allowable Charge Schedule is determined. This percentile is called the reimbursable percentile. The charges for each dental procedure with thirty (30) or more cases are arrayed to determine the reimbursable percentile charge for each procedure.
2. The reimbursable percentile charge for each procedure is multiplied by the number of cases for that procedure. The resultant products for all procedures are summed to arrive at the total charges if all procedures had been billed at the reimbursable percentile value.
3. The corresponding relative value units for each procedure are multiplied by the cases for that procedure. The resultant products for all procedures are summed to arrive at the total units corresponding to the total charges determined in the previous step.
4. The sum of the products of the percentile charges times the cases (step 2) is divided by the sum of the products of the relative value units times the cases (step 3) to determine the conversion factor value per unit.
5. The conversion factor value per unit is then multiplied by the relative value units for each procedure to establish a maximum fee allowance for each procedure.

**LOUISIANA SHERIFF'S ASSOCIATION
EMPLOYEE BENEFIT PLAN**

SUMMARY PLAN DESCRIPTION

The following information constitutes the Summary Plan Description of the Employee Benefit Plan required under the Employee Retirement Income Security Act of 1974.

Plan Sponsor:	Louisiana Sheriff's Association 1175 Nicholson Drive Baton Rouge, LA 70802 (504) 343-8402
Plan Identification Number	501
Type of Plan	Welfare Benefit Plan providing dental benefits
Type of Administration	Employer Administration
Plan Administrator	Insurance Advisory Committee of the Louisiana Sheriff's Association Group Benefits Plan 1175 Nicholson Drive Baton Rouge, LA 70802 (504) 343-8402
Agent for Service of Legal Process	Executive Director, Louisiana Sheriff's Association
Plan Trustee	Premier Bancorp, Inc. 451 Florida Boulevard Baton Rouge, LA 70801
Contributions to the Plan	The participating Sheriff's and participants make the necessary contributions to fund the Plan.
Funding Medium of the Plan	Plan assets are held under the Louisiana Sheriff's Association Group Benefits Trust. Benefits are paid from the trust fund.
Plan's Fiscal Year	The Plan's fiscal year ends on June 30 of each year.

Participant Rights:

As a Participant in the Plan you are entitled to certain rights and protection. All Plan Participants shall be entitled to:

- a. Examine, without charge, at the Plan Administrator's office, and at other locations, all Plan documents such as annual reports and Plan descriptions.
- b. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
- c. Obtain a summary of the Plan's annual financial report. The Administrator may make a reasonable charge for the copies.

Administered by



**BlueCross BlueShield
of Louisiana**

An independent licensee of the Blue Cross and Blue Shield Association.

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