The State Employees' Dental Insurance Plan

State of Alabama

Effective January 1, 2014

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

INTRODUCTION

This summary of the State Employees' Blue Cross Blue Shield Dental Plan ("SEBDP") benefits is designed to help you understand your coverage. This booklet replaces any previously issued information. All terms, conditions and limitations are not covered here. All benefits are subject to the terms, conditions and limitations of the contract or contracts between the State Employees' Insurance Board (SEIB) and Blue Cross Blue Shield of Alabama (BCBS) or other third party administrators that the SEIB may contract with that it deems is necessary to carry out its statutory obligations. Copies of all contracts are kept on file at the SEIB office and are available for review.

The SEIB shall have absolute discretion and authority to interpret the terms and conditions of the SEBDP and reserves the right to change the terms and conditions and/or end the SEBDP at any time and for any reason.

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CHAPTER 1
OVERVIEW OF THE PLAN

The following provisions of this booklet contain a summary in English of your rights and benefits under the SEBDP. If you have questions about your benefits, please contact Customer Service at 1-800-292-8868. If needed, simply request a Spanish translator and one will be provided to assist you in understanding your benefits.

Atención por favor - Spanish

Este folleto contiene un resumen en inglés de sus beneficios y derechos del SEBDP. Si tiene alguna pregunta acerca de sus beneficios, por favor póngase en contacto con el departamento de Servicio al Cliente llamando al 1-800-292-8868. Solicite simplemente un intérprete de español y se proporcionará uno para que le ayude a entender sus beneficios.

Purpose of the Plan

The SEBDP is intended to help you and your covered dependents pay for the costs of dental care. The SEBDP does not pay for all of your dental care. For example, you may be required to contribute through payroll deduction before you obtain coverage under the SEBDP. You may also be required to pay deductibles and coinsurance.

Using *my*BlueCross to Get More Information Over the Internet

Blue Cross and Blue Shield of Alabama's home page on the Internet is www.AlabamaBlue.com. If you go there, you will see a section of our home page called *my*BlueCross. Registering for *my*BlueCross is easy and secure; and once you have registered you will have access to information and forms that will help you take maximum advantage of your benefits under the SEBDP.

Definitions

Near the end of this booklet you will find a section called "Definitions", which identifies words and phrases that have specialized or particular meanings. In order to make this booklet more readable, we generally do not use initial capitalized letters to denote defined terms. Please take the time to familiarize yourself with these definitions so that you will understand your benefits.

Receipt of Dental Care

Even if the plan does not provide benefits, you and your provider may decide that care and treatment are necessary. You and your provider are responsible for making this decision.

Beginning of Coverage

The section of this booklet called "Eligibility" will tell you what is required for you to be covered under the SEBDP and when your coverage begins.

Dental Necessity

The SEBDP will only pay for care that is dentally necessary and not investigational, as determined by us. The definition of dental necessity and investigational are found in the Definitions section of this booklet.

In-network Benefits

One way in which the SEBDP tries to manage dental care costs and provide enhanced benefits is through negotiated discounts with dental providers. In-network dentists are dentists that contract with Blue Cross and

Blue Shield of Alabama for furnishing dental care services at a reduced price. Preferred Dentists are in-network dentists for the SEBDP. To locate in-network dentists for the SEBDP, go to www.AlabamaBlue.com. Assuming the services are covered, you will normally only be responsible for out-of-pocket costs such as deductibles and coinsurance when using in-network dentists.

If you receive covered services or supplies from an out-of-network dentist, in most cases, you will have to pay significantly more than what you would pay an in-network dentist because these out-of-network dental care providers can bill you amounts in excess of the allowable amounts under the SEBDP.

Relationship Between Blue Cross and/or Blue Shield Plans and the Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Alabama 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 Blue Cross and Blue Shield Association permits us to use the Blue Cross and Blue Shield service marks in the state of Alabama. Blue Cross and Blue Shield of Alabama is not acting as an agent of the Blue Cross and Blue Shield Association. No representation is made that any organization other than Blue Cross and Blue Shield of Alabama and your employer will be responsible for honoring this contract. The purpose of this paragraph is for legal clarification; it does not add additional obligations on the part of Blue Cross and Blue Shield of Alabama not created under the original agreement.

Limitations and Exclusions

The SEBDP contains a number of provisions that limit or exclude benefits for certain services and supplies, even if dentally necessary. You need to be aware of these limits and exclusions in order to take maximum advantage of the SEBDP.

Claims and Appeals

When you receive services from an in-network dentist, your dentist will generally file claims for you. In other cases, you may be required to pay the dentist and then file a claim with us for reimbursement under the terms of the SEBDP. If we deny a claim in whole or in part, you may file an appeal with us. We will give you a full and fair review. The provisions of the SEBDP dealing with claims or appeals are found further on in this booklet.

Termination of Coverage

The section below called “Eligibility” tells you when coverage will terminate under the SEBDP. If coverage terminates, no benefits will be provided thereafter, even if for a condition that began before the SEBDP or your coverage termination. In some cases you will have the opportunity to buy COBRA coverage after your group coverage terminates. COBRA coverage is explained in detail later in this booklet.

Summary of Benefits

DENTAL BENEFITS		
	PREFERRED	**NON-PREFERRED**
Deductible	$25 per person each calendar year; maximum of three deductibles per family.	$25 per person each calendar year; maximum of three deductibles per family. Member responsible for any difference between billed charge and fee schedule reimbursement.
Diagnostic & Preventive Services	Covered at 100% of the Preferred Dental Fee Schedule with no deductible.	Covered at 100% of the Preferred Dental Fee Schedule with no deductible. Member responsible for any difference between billed charge and fee schedule reimbursement.
Basic and Major Services (Fillings, Oral Surgery, Periodontics, Endodontics, Prosthodontics)	Covered at 50% of the Preferred Dental Fee Schedule subject to a $25 annual deductible.	Covered at 50% of the Preferred Dental Fee Schedule subject to a $25 annual deductible. Member responsible for any difference between billed charge and fee schedule reimbursement.
Orthodontic Services	Covered at 50% of the Preferred Dental Fee Schedule subject to a $25 annual deductible; limited to a separate lifetime maximum of $1,000 per person for Dependent Children under age 19 only.	Covered at 50% of the Preferred Dental Fee Schedule subject to a $25 annual deductible: limited to a separate lifetime maximum of $1,000 per person for Dependent Children under age19 only. Member is responsible for difference in billed charges & allowed fee schedule.
Annual Maximum	There is a $1,500 annual maximum for all covered services.	

***These services do not apply to the out-of-pocket maximums. This is not a contract. Benefits are subject to the terms, limitations and conditions of the group contract.**

Dental coverage is a part of the health insurance coverage provided to employees, retirees and dependents and is only provided for the diagnosis and treatment of dental disease or illness.

Chapter 2
ELIGIBILITY AND ENROLLMENT

Visit our web page at www.alseib.org to download forms.

Eligible Employees
The term "employee" includes only:

1. Full-time State employees and employees of County Health Departments, who are paid by the State Comptroller, the State Department of Mental Health, Historic Blakeley, Ft. Payne Improvement Authority, Historic Ironworks Commission, Bear Creek Development Authority, International Motor Sports Hall of Fame, Space and Rocket Center, the Sports Hall of Fame, the State Docks, St. Stephens Historical Commission, USS ALABAMA Battleship Commission, Red Mountain Greenway Commission and County Soil & Water Conservation Districts are to be eligible for coverage under the SEBDP.

2. Part-time employees working at least ten hours per week are eligible if they agree to have the required premium paid through payroll deduction.

3. Members of the Legislature and the Lieutenant Governor are eligible during their term of office (excluding optional and supplemental plans).

Exclusion: You are not eligible for coverage if the SEIB determines that you are classified as an employee employed on a seasonal, temporary, intermittent, emergency or contract basis.

Eligible Dependent

The term "dependent" includes the following individuals, subject to appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.):

1. Your spouse (excludes divorced or common-law spouse).
2. A child under age 26, only if the child is:
   a. your son or daughter,
   b. a child legally adopted by you or your spouse (including any probationary period during which the child is required to live with you),
   c. your stepchild,
   d. your grandchild, niece, or nephew for whom the court has granted custody to you or your spouse.
3. An incapacitated dependent over age 25 will be considered for coverage provided dependent:
   a. is unmarried,
   b. is permanently mentally or physically disabled or incapacitated,
   c. is so incapacitated as to be incapable of self-sustaining employment,
   d. is dependent on you for 50% or more support,
   e. is otherwise eligible for coverage as a dependent except for age,
   f. the condition must have occurred prior to the dependent's 26th birthday, and
   g. is not eligible for any other group health insurance benefits.

Neither a reduction in work capacity nor inability to find employment is, of itself, evidence of eligibility. If a mentally or physically disabled dependent is working, despite his disability, the extent of his earning capacity will be evaluated.

To apply, contact the SEIB to obtain an Incapacitated Dependent Certification Form. Final approval of incapacitation will be determined by Medical Review. Proof of disability must be provided to the SEIB within 60 days from the date the child would cease to be covered because of age.

Exception: There are two situations under which it may be possible to add an incapacitated dependent who meets the eligibility requirements except for age:

1. When a new employee requests coverage for an incapacitated dependent within 60 days of employment; or
2. When an employee's incapacitated dependent is covered under a spouse's employer group health insurance for at least 18 consecutive months and:
   a. the employee's spouse loses the other coverage because:
      - spouse's employer ceases operations, or
      - spouse's loss of eligibility due to termination of employment or reduction of hours of employment, or
      - spouse's employer stopped contribution to coverage,
   b. a change form is submitted to the SEIB within 30 days of the incapacitated dependent's loss of other coverage, and
   c. Medical Review approved incapacitation status.

The above requirements must be met as a minimum threshold in order to be considered for incapacitation status. The SEIB shall make the final decision as to whether an application for incapacitated status will be accepted. NOTE: The SEIB reserves the right to periodically re-certify incapacitation.

In the event of the death of an active employee, who carried family coverage, the eligible dependents may continue coverage by making the appropriate premium payment to the SEIB. The SEIB must be notified within 90 days of the death.

Exclusion: You may not cover your wife, husband, or other dependents if they are independently covered as a State employee.

PCET's with ALDOT may remain dependents if their employment is part of their educational training.

Changes in Dependent Eligibility

It is the responsibility of the subscriber to notify the SEIB immediately when the eligibility of a covered dependent changes. If it is determined that an act (such as adding a ineligible person to coverage) or omission (such as failing to remove a person no longer eligible from coverage) of the subscriber results in or contributes to the payment of claims by the SEBDP for persons ineligible for coverage, the subscriber will be personally responsible for all such overpayments and shall be subject to disciplinary action including termination of coverage. (Note: an ex-spouse is ineligible for coverage and cannot be maintained as a dependent under your family coverage regardless of a judgment or divorce decree requiring you to provide health care for your ex-spouse. However, an ex-spouse may be eligible for COBRA continuation coverage.)

Enrollment & Commencement

Employees and dependents can enroll and coverage commences as stated below.

Employee

In order to be covered under the SEBDP, an SEIB enrollment form must be completed by the employee and his/her employer and submitted to the SEIB, subject to SEIB Rules and Procedures. Coverage for new employees will be effective on their date of employment, subject to appropriate premium payment, or on the first day of the month following their first payroll deduction.

Dependents

When adding dependents to family coverage, you must submit appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.) to the SEIB. NOTE: to avoid enrollment deadlines you should submit enrollment forms to the SEIB even if you do not have all of the appropriate documentation at the time of enrollment.

New employees may elect to have dependent coverage begin on the date of their employment or no later than the first day of the second month following their hire date, subject to appropriate premium payments.

You may enroll dependents, subject to appropriate premium payments, within 60 days of acquiring a new dependent and the effective date of coverage will be the date of marriage, birth or adoption.

A **direct payment** for dependent coverage premium must be submitted with the enrollment form for any coverage period before payroll deduction. The deduction from your payroll check or the deposit by the SEIB of your direct payment does not constitute acceptance of coverage.

Qualified Medical Child Support Orders

If the group (the plan administrator) receives an order from a court or administrative agency directing the SEBDP to cover a child, the group will determine whether the order is a Qualified Medical Child Support Order (QMCSO). A QMCSO is a qualified order from a court or administrative agency directing the SEBDP to cover the employee's child regardless of whether the employee has enrolled the child for coverage. The group has adopted procedures for determining whether such an order is a QMCSO. You have a right to obtain a copy of those procedures free of charge by contacting your group.

The SEBDP will cover an employee's child if required to do so by a QMCSO. If the group determines that an order is a QMCSO, we will enroll the child for coverage effective as of a date specified by the group, but not earlier than the later of the following:

- If we receive a copy of the order within 30 days of the date on which it was entered, along with instructions from the group to enroll the child pursuant to the terms of the order, coverage will begin as of the date on which the order was entered.
- If we receive a copy of the order later than 30 days after the date on which it was entered, along with instructions from the group to enroll the child pursuant to the terms of the order, coverage will begin as of the date on which we receive the order. We will not provide retroactive coverage in this instance.

Coverage may continue for the period specified in the order up to the time the child ceases to satisfy the definition of an eligible dependent. If the employee is required to pay extra to cover the child, the group may increase the employee's payroll deductions. During the period the child is covered under the SEBDP as a result of a QMCSO, all SEBDP provisions and limits remain in effect with respect to the child's coverage except as otherwise required by federal law. For example, a child covered by a QMCSO may be subject to a pre-existing condition exclusion.

While the QMCSO is in effect we will make benefit payments – other than payments to providers – to the parent or legal guardian who has been awarded custody of the child. We will also provide sufficient information and forms to the child's custodial parent or legal guardian to allow the child to enroll in the SEBDP. We will also send claims reports directly to the child's custodial parent or legal guardian.

Open Enrollment

Open enrollment is November 1 through November 30 for an effective date of coverage of January 1 and is available for:

- employees who have declined coverage and now wish to enroll in the SEBDP,
- employees who wish to change plans,
- part-time employees who wish to begin coverage,
- employees who wish to add family coverage or add a dependent to existing family coverage.

Special Enrollment

The Health Insurance Portability and Accountability Act of 1996 requires that a special enrollment period be provided in addition to the regular enrollment period for employees and eligible dependents if:

1. the employee declined to enroll in the SEBDP; and
2. the employee gains a new dependent through marriage, birth or adoption; or
3. the employee or dependent loses their other employer group dental coverage because:
    a. COBRA coverage (if elected) is exhausted, or
    b. loss of eligibility (including separation, divorce, death, termination of employment or reduction of hours of employment), or
    c. employer stopped contribution to coverage; and

4. the employee requests enrollment in the SEBDP in writing no later than 30 days after the loss of other coverage.

A request for Special Enrollment must include:
1. A letter requesting special enrollment submitted to the SEIB within 30 days of the qualifying event, along with a completed enrollment form or status change form if only adding dependents.
2. Thereafter, the following documentation must be submitted within 60 days of the qualifying event:
   a. proof of gaining a new dependent (e.g. marriage certificate, birth certificate, adoption papers, etc.) or
   b. proof of coverage loss listing the reason and the date of the coverage loss for all individuals affected (e.g. employment termination on company letterhead).

Survivor Enrollment

In the event of the death of an employee covered under the SEBDP who carried family coverage, the eligible dependents may continue coverage by making the appropriate premium payments to the SEIB. SEIB must be notified within 90 days of the date of death.

Notice

Notice of any enrollment changes is the responsibility of the employee (for example, status changes or address changes). Please visit our web page at www.alseib.org to download applicable forms.

Status Changes

A status change form must be completed for an addition or deletion of dependent coverage. The Status Change Form must be submitted directly to the SEIB by mail or by visiting our website at www.alseib.org.

Address Changes

All correspondence and notices required under the provisions of the SEBDP or state or federal law will be delivered to the address provided by you in our records. It is your responsibility to ensure that your address of record is accurate. To change an address, a written request may be submitted to the SEIB office at PO Box 304900, Montgomery, Alabama 36130-4900 or by visiting our web page at www.alseib.org.

Employee Name Changes

Name changes are processed electronically once they are changed on payroll with your agency.

Chapter 3
TERMINATION OF COVERAGE

When Coverage Terminates

Coverage under the SEBDP will terminate:

1. On the last day of the month in which your employment terminates. The SEIB may continue your coverage if you are absent from work because of injury or sickness, or if you are absent from work due to leave of absence or temporary layoff, but only for a limited period. Premiums may be required from the employee by direct pay. For details, contact the SEIB.
2. On the last day of the month in which you decline coverage or opt out of the SEBDP.
3. When the SEBDP is discontinued.

Coverage under the SEBDP will also terminate for a dependent:

1. On the first day of the following month in which such person ceased to be an eligible dependent.
2. If the dependent becomes covered as an employee.
3. When premium payments cease for coverage of a deceased active or deceased retired employee.
4. When dependent premium payments cease.

When dependent coverage is terminated, it is your responsibility to notify the SEIB to discontinue payroll deductions. If deductions are still being made from your paycheck after the month of termination, this does not mean that your dependents have coverage. It is your responsibility to request a refund from SEIB.

In many cases you will have the option to choose continuation of group benefits as provided by the Public Health Service Act. (See COBRA Section.)

Family & Medical Leave Act

The SEIB will follow the provisions of the Family and Medical Leave Act as approved by the appropriate authority.

Employees on Leave without Pay (LWOP)

State health insurance coverage for employees on official leave without pay may be continued for a maximum of 12 months provided the employee elects to make the premium payment required for coverage directly to the SEIB. Official leave without pay is established when an employee has received approval of the Personnel Department (for classified employees) or appointing authority, where applicable, to be taken off the payroll for an extended period.

Chapter 4
CONTINUATION OF GROUP HEALTH COVERAGE (COBRA)

Introduction

The Public Health Service Act [42 USC Sections 300bb-1 through 300bb-8] requires that the SEIB offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the SEBDP would otherwise end. COBRA coverage can be particularly important because it will allow you to continue group health care coverage beyond the point at which you would ordinarily lose it.

This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of this law. ***You and your spouse should take the time to read this notice carefully.***

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of coverage under the SEBDP when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed under the section entitled "Qualified Beneficiaries" below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. You, your spouse and your dependent children could become qualified beneficiaries if coverage under the SEBDP is lost because of a qualifying event. Under the SEBDP, qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage.

Qualified Beneficiaries

Individuals entitled to COBRA continuation coverage are called qualified beneficiaries. Individuals who may be qualified beneficiaries are the spouse and dependent children of a covered employee and, in certain circumstances, the covered employee. Under current law, in order to be a qualified beneficiary, an individual must generally be covered under the SEBDP on the day before the event that caused a loss of coverage, such as termination of employment, or a divorce from, or death of, the covered employee. (An increase in the cost of retiree coverage relative to active employee coverage is also considered a loss of coverage for COBRA purposes.) In addition, a child born to the covered employee, or who is placed for adoption with the covered employee, during the period of COBRA continuation coverage, is also a qualified beneficiary.

COBRA Rights for Covered Employees

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the SEBDP because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than gross misconduct.

COBRA coverage will continue for up to a total of 18 months from the date of your termination of employment or reduction in hours, assuming you pay your premiums on time.

If you are on a leave of absence covered by the Family and Medical Leave Act of 1993 (FMLA), and you do not return to work, you will be given the opportunity to buy COBRA coverage. The period of your COBRA coverage will begin when you fail to return to work following the expiration of your FMLA leave or you inform the SEIB that you do not intend to return to work, whichever occurs first.

COBRA Rights for a Covered Spouse and Dependent Children

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the SEBDP because either one of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the SEBDP because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the SEBDP as a "dependent child."

Coverage Available

If you choose continuation coverage, the SEIB is required to offer you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members.

When Your Agency Should Notify the SEIB

COBRA continuation coverage will be offered to qualified beneficiaries only after the SEIB has been notified that a qualifying event has occurred. Your agency is responsible for notifying the SEIB of the following qualifying events:

- end of employment,
- reduction of hours of employment or
- death of an employee.

When You Should Notify the SEIB

The employee or a family member has the responsibility to inform the SEIB of the following qualifying events:

- divorce,
- legal separation, or
- a child losing dependent status.

Written notice must be given to the SEIB within 60 days of the date of the event or the date in which coverage would end under the SEBDP because of the event, whichever is later. All notices should be sent to the address listed under "SEIB Contact Information" at the end of this section.

Election Period: When the SEIB is notified that a qualifying event has happened, COBRA continuation coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. In addition, a Covered employee may elect COBRA continuation coverage on behalf of his or her spouse and either covered parent may elect COBRA continuation coverage on behalf of their children.

If you do not choose continuation coverage, your group health insurance will end.

After the SEIB receives timely notice that a qualifying event has occurred, the SEIB will (1) notify you that you have the option to buy COBRA, and (2), send you a COBRA election notice.

You have 60 days within which to elect to buy COBRA coverage. The 60-day period begins to run from the later of (1) the date you would lose coverage under the SEBDP, or (2), the date on which the SEIB notifies you that you have the option to buy COBRA coverage. Each qualified beneficiary has an independent right to elect COBRA coverage.

You may elect COBRA coverage on behalf of your spouse, and parents may elect COBRA coverage on behalf of their children. An election to buy COBRA coverage will be considered made on the date the election notice is sent back to the SEIB.

Once the SEIB has been notified of your qualifying event, your coverage under the SEBDP will be retroactively terminated and payment of all claims incurred after the date coverage ceased will be rescinded. If you elect to buy COBRA during the 60-day election period, and if your premiums are paid on time, the SEIB will retroactively reinstate your coverage and process claims incurred during the 60-day election period.

Because there may be a lag between the time your coverage under the plan ends and the time we learn of your loss of coverage, it is possible that the SEBDP Plan may pay claims incurred during the 60-day election period. If this happens, you should not assume that you have coverage under the SEBDP. The only way your coverage will continue is if you elect to buy COBRA and pay your premiums on time.

Length of Coverage

COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage will last for up to a total of 36 months when one of the following qualifying events occurs:

- Death of the employee,
- Divorce or legal separation, or
- Dependent child loses eligibility as a "dependent child" under SEBDP.

COBRA continuation coverage will last for up to a total of 18 months when one of the following qualifying events occurs:

- End of employment or
- Reduction in the hours of employment

There are only two ways to extend the 18-month COBRA continuation coverage period:

Disability –if you or a covered member of your family is or becomes disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act and you timely notify the SEIB, the 18-month period of COBRA coverage for the disabled person may be extended to up to 11 additional months (for a total of up to 29 months) or the date the disabled person becomes covered by Medicare, whichever occurs sooner. This 29-month period also applies to any non- disabled family members who are receiving COBRA coverage, regardless of whether the disabled individual elects the 29-month period for him or herself. The 29-month period will run from the date of the termination of employment or reduction in hours. For this disability extension to apply, the disability must have started at some time before the 60th day of COBRA coverage and must last at least until the end of the 18-month period of COBRA coverage.

The cost for COBRA coverage after the 18th month will be 150% of the full cost of coverage under the plan, assuming that the disabled person elects to be covered under the disability extension. If the only persons who elect the disability extension are non-disabled family members, the cost of coverage will remain at 102% of the full cost of coverage.

For a spouse and children, the disability extension may be further extended to 36 months if another qualifying event (death, divorce, enrollment in Medicare, or loss of dependent status) occurs during the 29-month period. See the following discussion under Extensions of COBRA for Second Qualifying Events for more information about this.

For this disability extension of COBRA coverage to apply, you must give the SEIB timely notice of Social Security's disability determination before the end of the 18-month period of COBRA coverage and within 60 days after the later of (1) the date of the initial qualifying event, (2) the date on which coverage would be lost because of the initial qualifying event, or (3) the date of Social Security's determination. You must also notify the SEIB within 30 days of any revocation of Social Security disability benefits.

Second Qualifying Event

For a spouse and children receiving COBRA coverage, the 18-month period may be extended to 36 months if another qualifying event occurs during the 18-month period, if you give the SEIB timely notice of the second qualifying event. The 36-month period will run from the date of the termination of employment or reduction in hours.

This extension is available to a spouse and children receiving COBRA coverage if the covered employee or former employee dies, becomes enrolled in Medicare, gets divorced, or if the child stops being eligible under the plan as a dependent child, *but only if the event would have caused the spouse or child to lose coverage under the plan had the first qualifying event not occurred.* For example, if a covered employee is terminated from employment, elects family coverage under COBRA, and then later enrolls in Medicare, this second event will rarely be a second qualifying event that would entitle the spouse and children to extended COBRA coverage. This is so because this event would not cause the spouse or dependent children to lose coverage under the plan if the covered employee had not been terminated from employment.

For this 18-month extension to apply, you must give the SEIB timely notice of the second qualifying event within 60 days after the event occurs or within 60 days after the date on which coverage would be lost because of the event, whichever is later.

Adding New Dependents to COBRA

You may add new dependents to your COBRA coverage under the circumstances permitted under the SEBDP. Except as explained below, any new dependents that you add to your COBRA coverage will not have independent COBRA rights. This means, for example, that if you die, they will not be able to continue coverage.

If you are the covered employee and you acquire a child by birth or placement for adoption while you are receiving COBRA coverage, then your new child will have independent COBRA rights. This means that if you die, for example, your child may elect to continue receiving COBRA benefits for up to 36 months from the date on which your COBRA benefits began.

If your new child is disabled within the 60-day period beginning on the date of birth or placement of adoption, the child may elect coverage under the disability extension if you timely notify the SEIB of Social Security's disability determination as explained above.

Family and Medical Leave Act

If you are on a leave of absence covered by the Family and Medical Leave Act of 1993 (FMLA), and you do not return to work, you will be given the opportunity to elect COBRA continuation coverage. The period of your COBRA continuation coverage will begin when you fail to return to work following the expiration of your FMLA leave or you inform your employer that you do not intend to return to work, whichever occurs first.

Premium Payment

If you qualify for continuation coverage, you will be required to pay the group's premium plus 2% administrative fee, directly to the SEIB. Members who are disabled under Title II or Title XVI of the Social Security Act when a qualifying event occurs, will be required to pay 150% of the group's premium for the 19th through the 29th month of coverage or the month that begins more than 30 days after the date is

determined that you are no longer disabled under Title II or Title XVI of the Social Security Act, whichever comes first. (If the only persons who elect the disability extension are non-disabled family members, the cost of coverage will remain at 102% of the full cost of coverage.) Your coverage will be canceled if you fail to pay the entire amount in a timely manner.

Your initial premium payment must be received by the SEIB within 45 days from your date of election. All subsequent premiums are due on the first day of the month of coverage. There is a 30-day grace period.

Termination of Continuation Coverage

The law provides that your COBRA continuation coverage may be terminated for any of the following reasons:

1. SEIB no longer provides group health coverage.
2. The premium for your continuation coverage is not paid on time.
3. You become covered, after electing continuation coverage, under another group plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary. (Note: there are limitations on plans imposing a preexisting condition of exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act.);
4. You become entitled to Medicare.
5. You extend coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled.

You do not have to show that you are insurable to choose COBRA continuation coverage. However, under the law, you may have to pay all or part of the premium for your COBRA continuation coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium.

Note: If you are entitled to Medicare before you become a qualified beneficiary, you may elect COBRA continuation coverage; however, your Medicare coverage will be primary and your COBRA continuation coverage will be secondary. You must have Medicare Parts A and B in order to have full coverage.

Keep the SEIB Informed of Address Changes

In order to protect your family's rights, you must keep the SEIB informed of any changes in the address of family members. You should also keep a copy for your records of any notices you send to the SEIB.

If You Have Any Questions:

Questions concerning your COBRA continuation coverage rights may be addressed by calling the SEIB at 1-866-836-9737 or 334-263-8300 or by mail at the contact listed below. For more information about your COBRA rights, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272.

SEIB Contact Information

All notices and requests for information should be sent to the following address:

State Employees' Insurance Board
COBRA Section
201 S. Union St., Suite 200
P.O. Box 304900
Montgomery, AL 36130-4900

Chapter 5
RETIREE ELIGIBILITY AND ENROLLMENT

Eligible Retired State Employee
A retired employee of the State of Alabama who has at least 10 years of creditable coverage in the SEHIP and receives a monthly benefit from the Employees' Retirement System or Teachers' Retirement System of Alabama or Judicial Retirement System.

Eligible Dependent - **(see page 6)**

Enrollment/Continuation
A retiring employee may elect coverage under the SEBDP by agreeing to have the monthly premium amount (if applicable) deducted from his or her retirement check.

Open Enrollment
Retired employees who do not elect to continue their coverage under the SEBDP may do so during the annual open enrollment held each November for coverage to be effective January 1. Retirees may elect to add family coverage. Contact the SEIB for details.

Special Enrollment Period
The Health Insurance Portability and Accountability Act of 1996 requires that a special enrollment period be provided in addition to the regular enrollment period for retired employees and eligible dependents if:

1. The retired employee declined to enroll in the SEBDP; and
2. The retiree gains a new dependent through marriage, birth or adoption; or
3. The retiree or dependent loses the other employer group dental coverage because:
   a. COBRA coverage (if elected) is exhausted, or
   b. loss of eligibility (including separation, divorce, death, termination of employment or reduction of hours of employment), or
   c. employer stopped contribution to coverage; and,
4. The retiree requests enrollment in the SEBDP in writing no later than 30 days after the loss of other coverage.

A request for Special Enrollment must include:

1. A letter requesting special enrollment submitted to the SEIB within 30 days of the qualifying event, along with a completed enrollment form or status change form if only adding dependents.
2. Thereafter, the following documentation must be submitted within 60 days of the qualifying event:
   a. proof of gaining a new dependent (e.g. marriage certificate, birth certificate, adoption papers, etc.)
   b. proof of coverage loss listing the reason and the date of the coverage loss for all individuals affected (e.g. employment termination on company letterhead).

Survivor Enrollment
In the event of the death of a retired employee who carried family coverage, the eligible dependents may continue coverage by making appropriate premium payments to the SEIB. The SEIB must be notified within 90 days of the date of death.

Chapter 6
BENEFIT CONDITIONS

To qualify as plan benefits, dental services and supplies must meet the following:

- They must be furnished after your coverage becomes effective.
- BCBS must determine before, during, or after services and supplies are furnished that they are dentally necessary.
- Preferred Dentist benefits must be furnished while you are covered by the SEBDP and the provider must be a Preferred Dentist when the services are furnished to you.
- Separate and apart from the requirement in the previous paragraph, services and supplies must be furnished by a provider (whether Preferred Provider or not) who is recognized by Blue Cross as an approved provider for the type of service or supply being furnished. Call Blue Cross Customer Services if you have any question whether your provider is recognized by Blue Cross as an approved provider for the services or supplies you plan on receiving.
- Services and supplies must be furnished when the SEBDP and your coverage are both in effect and fully paid for. No benefits will be provided for services you receive after the SEBDP or your coverage ends, even if they are for a condition that began before the SEBDP or your coverage ends.

Chapter 7
COST SHARING

Calendar Year Deductible	**$25** **(does not apply to diagnostic and preventive services)**
Calendar Year Maximum Benefits	**$1,500**

Calendar Year Deductible

Here are some special rules concerning application of the calendar year deductible:

- The calendar year deductible must be satisfied on a per person per calendar year basis. Once the maximum number of family members specified above has met the full deductible, no additional covered expenses will be applied toward any family member's individual deductible for the rest of the calendar year; however, all charges applied toward individual deductibles until that point are non-refundable.
- The deductible will be applied to claims in the order in which they are processed regardless of the order in which they are received.

Other Cost Sharing Provisions

The SEBDP may impose other types of cost sharing requirements such as the following:

- Coinsurance: Coinsurance is the amount that you must pay as a percent of the allowable amount.
- Amount in excess of the allowable amount: As a general rule, the allowable amount may often be less than the dentist's actual charges. When you receive benefits from an out-of-network dentist, you may be responsible for paying the dentist's charges in excess of the allowable amount.

Chapter 8
DENTAL BENEFITS

The SEBDP's dental network is Preferred Dentist. We pay benefits toward the lesser of the allowable amount or the dentist's actual charge for services whether you receive services from an in-network or out-of-network dentist. There are three differences:

- All in-network dentists agree our payment is payment in full except for your deductible and coinsurance. If you are covered under another group dental plan, an in-network dentist may bill that plan for any difference between the allowable amount and his usual charge for a service.
- Out-of-network dentists may charge you the difference between the allowable amount and their billed charges.
- In-network dentists may not collect their fee for plan benefits from you except for deductibles and coinsurance. They must bill us first except for services which are not plan benefits, such as implants.

SERVICE	BENEFIT
Basic – Diagnostic and Preventive Services	100%

- Dental exams, up to twice per calendar year.
- Dental X-ray exams:
  - Full mouth X-rays, one set during any 36 months in a row;
  - Bitewing X-rays, up to twice per calendar year; and
  - Other dental X-rays, used to diagnose a specific condition.
- Tooth sealants on 1st permanent molars, teeth numbers 3, 14, 19 and 30, limited to two applications per tooth per benefit period. Benefits are limited to a maximum payment of $20 per tooth and limited to children under age 19.
- Fluoride treatment for children through age 18, twice per calendar year.
- Routine cleanings, twice per calendar year.
- Space maintainers (not made of precious metals) that replace prematurely lost teeth for children through age 18.

SERVICE	BENEFIT
Basic – Restorative Services	50%

- Fillings made of silver amalgam and tooth color materials (tooth color materials include composite fillings on the front upper and lower teeth numbers 5-12 and 21-28; payment allowance for composite fillings used on posterior teeth is reduced to the allowance given on amalgam fillings).
- Simple tooth extractions.
- Direct pulp capping, removal of pulp, and root canal treatment.
- Repairs to removable dentures.
- Emergency treatment for pain.

SERVICE	BENEFIT
Supplemental Services	**50%**

- Oral surgery, i.e., tooth extractions and impacted teeth and to treat mouth abscesses of the intra-oral and extra-oral soft tissue.
- General anesthesia when given for oral or dental surgery. This means drugs injected or inhaled to relax you or lessen the pain, or make you unconscious, but not analgesics, drugs given by local infiltration, or nitrous oxide.
- Treatment of the root tip of the tooth including its removal.

SERVICE	BENEFIT
Prosthetic Services	**50%**

- Full or partial dentures.
- Fixed or removable bridges.
- Inlays, onlays, veneers, or crowns to restore diseased or accidentally broken teeth, if less expensive fillings will not restore the teeth.

Limits on prosthetic services:

- Partial dentures – If a removable partial denture can restore the upper or lower dental arch satisfactorily, we will pay as though it were supplied even if you chose a more expensive means.
- Precision attachments – There are no benefits for precision attachments.
- Dentures – We pay only toward standard dentures.
- Replacement of existing dentures, fixed bridgework, veneers, or crowns – We pay toward replacing an existing denture, fixed bridgework, veneer, or crown only if the old one can't be fixed. If one can be fixed, we will pay toward fixing it (this includes repairs to fixed dentures). We only pay to replace these items every five years.
- There are no benefits to replace lost or stolen items.

SERVICE	BENEFIT
Periodontic Services	**50%**

- Periodontic exams twice each 12 months.
- Removal of diseased gum tissue and reconstructing gums.
- Removal of diseased bone.
- Reconstruction of gums and mucous membranes by surgery.
- Removing plaque and calculus below the gum line for periodontal disease.

SERVICE	BENEFIT
Orthodontic Services Limited to a per member lifetime maximum of $1,000	Covered at 50% of the Preferred Dental Fee Schedule subject to a Subject to a $25 annual deductible. Limited to a separate lifetime maximum of $1,000 per person for Dependent Children under age 19 only.

Orthodontic benefits are provided for the initial and subsequent treatment and installation of orthodontic equipment.

Exclusions and limitations on orthodontic benefits:

- The benefits for orthodontic services shall be paid only for months that you have orthodontic coverage. There are no benefits for orthodontic services to you before your coverage by this contract is in effect. If you started orthodontic services before this coverage began and complete them while covered, we'll prorate the benefits for the services you actually get while covered.
- Any charge for the replacement and/or repair of any appliance furnished under the treatment plan shall not be paid.

Chapter 9
DENTAL BENEFIT LIMITATIONS

Limits to all benefits:

- Examination and diagnosis no more than twice during any calendar year.
- Full mouth X-rays will be provided once each 36 months; bitewings no more than twice during any calendar year.
- Routine cleaning will be provided no more than twice during any calendar year.
- Fluoride treatment will be provided to members through age 18 no more than twice during any calendar year.
- Tooth sealants on first permanent molars, teeth numbers 3, 14, 19 and 30, limited to two applications per tooth per benefit period. Benefits are limited to a maximum payment of **$20 per tooth** and limited to children under age 19.
- If you change dentists while being treated, or if two or more dentists do one procedure, we'll pay no more than if one dentist did all the work.
- When there are two ways to treat you and both would otherwise be plan benefits, we'll pay toward the less expensive one. The dentist may charge you for any excess.
- Prosthetic – Gold, baked porcelain restorations, veneers, crowns and jackets – If a tooth can be restored with a material such as amalgam, we'll pay toward that procedure even if a more expensive means is used.
- Prosthetic – Payment will be made toward eliminating oral disease and replacing missing teeth.

Chapter 10
DENTAL BENEFIT EXCLUSIONS

The following benefits will not be provided:

A **Anesthetic** services performed by and billed for by a dentist other than the attending dentist or his assistant.

Appliances or restorations to alter vertical dimensions from its present state or restoring the occlusion. Such procedures include but are not limited to equilibration, periodontal splinting, full mouth rehabilitation, restoration of tooth structure lost from the grinding of teeth or the wearing down of the teeth and restoration from the mal-alignment of teeth. This does not apply to covered orthodontic services.

B Dental services to the extent coverage is available to the member under any other **Blue Cross and Blue Shield contract.**

C Dental services for which you are not **charged.**

Services or expenses for intraoral delivery of or treatment by **chemotherapeutic** agents. Services or expenses for which a **claim** is not properly submitted.

Services or expenses of any kind either (a) for which a **claim** submitted for a member in the form prescribed by Blue Cross has not been received by Blue Cross, or (b) for which a claim is received by Blue Cross later than 12 months after the date services were performed.

Services or expenses of any kind for **complications** resulting from services received that are not covered as benefits under this contract.

Services or expenses for treatment of injury sustained in the commission of a **crime** (except for treatment of injury as a result of a medical condition or as a result of domestic violence) or for treatment while confined in a prison, jail, or other penal institution.

D **Dental** care or treatment not specifically identified as a covered dental expense.

E Dental services you receive before your **effective date of coverage**, or after your effective date of termination.

Dental services you receive from a dental or medical department maintained by or on behalf of an **employer**, a mutual benefit association, a labor union, trustee or similar person or group.

F Charges to use any **facility** such as a hospital in which dental services are rendered, whether the use of such a facility was dentally necessary.

Charges for your **failure** to keep a scheduled visit with the dentist.

Gold foil restorations.

Charges for **implants**.

Charges for **infection c**ontrol.

Any dental treatment or procedure, drugs, drug usage, equipment, or supplies that is **investigational**, including services that are part of a clinical trial.

Services or expenses covered in whole or in part under the **laws** of the United States, any state, county, city, town or other governmental agency that provide or pay for care, through insurance or any other means. This applies even if the law does not cover all your expenses.

Dental services with respect to **malformations** from birth or primarily for appearance.

Services or expenses of any kind, if not required by a dentist, or if **not dentally necessary**.

Charges for **oral** hygiene and dietary information.

Charges for dental care or treatment by a **person** other than the attending dentist unless the treatment is rendered under the direct supervision of the attending dentist.

Charges for **plaque control program**.

Services of a dentist rendered to a member who is **related** to the dentist by blood or marriage or who regularly resides in the dentist's household.

Dental services or expenses in cases covered in whole or in part by **workers' compensation** or employers' liability laws, state or federal. This applies whether you fail to file a claim under that law. It applies whether the law is enforced against or assumed by the employer. It applies whether the law provides for dental services as such. Finally, it applies whether your employer has insurance coverage for benefits under the law.

Chapter 11
GENERAL PROVISIONS

Privacy of Your Protected Health Information

The confidentiality of your personal health information is important to the SEIB. Under a new federal law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), plans such as this one are generally required to limit the use and disclosure of your protected health information to treatment, payment, and health care operations. This section of this booklet explains some of HIPAA's requirements. Additional information is contained in the SEBDP's notice of privacy practices. You may request a copy of this notice by contacting the SEIB.

Use and Disclosure of Your Personal Health Information: BCBS and other business associates of the SEBDP, have an agreement with the SEBDP that allows them to use your personal health information for treatment, payment, health care operations, and other purposes permitted or required under HIPAA. By applying for coverage and participating in the SEBDP, you agree that the SEBDP, and its business associates, may obtain, use, and release all records about you and your minor dependents needed to administer the SEBDP or to perform any function authorized or permitted by law. You further direct all persons to release all records about you and your minor dependents needed to administer the SEBDP.

The privacy provisions of the Health Insurance Portability and Accountability Act require that you be notified at least once every three years about the availability of the SEIB's privacy practices [45 CFR 164.520(c)(1)(ii)]. Accordingly, you may obtain a copy for our privacy practices by going to our website at www.alseib.org or you can request a copy by writing to us at:

State Employees' Insurance Board
Attn: Privacy Officer
P. O. Box 304900
Montgomery, AL 36130-4900.

Disclosures of Protected Health Information to the Plan Sponsor:
In order for your benefits to be properly administered, the SEBDP needs to share your protected health information with the plan sponsor (the State of Alabama). Following are circumstances under which the SEBDP may disclose your protected health information to the plan sponsor:

- The SEBDP may inform the plan sponsor whether you are enrolled in the SEBDP.
- The SEBDP may disclose summary health information to the plan sponsor. The plan sponsor must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the SEBDP. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying you.
- The SEBDP may disclose your protected health information to the plan sponsor for plan administrative purposes. This is because employees of the plan sponsor perform some of the administrative functions necessary for the management and operation of the SEBDP.

Following are the restrictions that apply to the plan sponsor's use and disclosure of your protected health information:

- The plan sponsor will only use or disclose your protected health information for plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. See the SEBDP's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.
- If the plan sponsor discloses any of your protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to keep your protected health information as required by the HIPAA regulations.

- The plan sponsor will not use or disclose your protected health information for employment-related actions or decisions or in connection with any other benefit or benefit plan of the plan sponsor.
- The plan sponsor will promptly report to the SEBDP any use or disclosure of your protected health information that is inconsistent with the uses or disclosures allowed in this section of this booklet.
- The plan sponsor will allow you or the SEBDP to inspect and copy any protected health information about you that is in the plan sponsor's custody and control. The HIPAA regulations set forth the rules that you and the SEBDP must follow in this regard. There are some exceptions.
- The plan sponsor will amend, or allow the SEBDP to amend, any portion of your protected health information to the extent permitted or required under the HIPAA regulations.
- With respect to some types of disclosures, the plan sponsor will keep a disclosure log. The disclosure log will go back for six years (but not before April 14, 2003). You have a right to see the disclosure log. The plan sponsor does not have to maintain the log if disclosures are for certain plan related purposes, such as payment of benefits or healthcare operations.
- The plan sponsor will make its internal practices, books, and records, relating to its use and disclosure of your protected health information available to the SEBDP and to the U.S. Department of Health and Human Services, or its designee.
- The plan sponsor will, if feasible, return or destroy all of your protected health information in the plan sponsor's custody or control that the plan sponsor has received from the SEBDP or from any business associate when the plan sponsor no longer needs your protected health information to administer the SEBDP. If it is not feasible for the plan sponsor to return or destroy your protected health information, the plan sponsor will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

The following classes of employees or other workforce members under the control of the plan sponsor may use or disclose your protected health information in accordance with the HIPAA regulations that have just been explained:

- Benefits Administration and Operations
- Legal
- Finance

If any of the foregoing employees or workforce members of the plan sponsor use or disclose your protected health information in violation of the rules that are explained above, the employees or workforce members will be subject to disciplinary action and sanctions – which may include termination of employment. If the plan sponsor becomes aware of any such violation, the plan sponsor will promptly report the violation to the SEIB and will cooperate with the SEBDP to correct the violation, to impose appropriate sanctions, and to relieve any harmful effects to you.

Security of Your Personal Health Information:
Following are restrictions that will apply to the plan sponsor's storage and transmission of your electronic protected health information:

- The plan sponsor will have in place appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of your electronic protected health information, as well as to ensure that only those classes of employees or other workforce members of the plan sponsor described above have access to use or disclose your electronic protected health information in accordance with the HIPAA regulations.
- If the plan sponsor discloses any of your electronic protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to have in place the appropriate safeguards as required by the HIPAA regulations.

The plan sponsor will report to the SEBDP any security incident of which it becomes aware in accordance with the HIPAA regulations.

Incorrect Benefit Payments

Every effort is made to process claims promptly and correctly. If payments are made to you or to a provider who furnished services or supplies to you, and BCBS finds at a later date that the payments were correct, you or the provider will be required to repay any overpayment or BCBS may deduct the amount of the overpayment from any future payment to you or the provider. If BCBS does this, they will notify you.

Responsibility for Actions of Providers of Services

BCBS and the SEIB will not be responsible for any acts or omissions, whether negligent, intentional, or otherwise, by any institution, facility, or individual provider in furnishing or not furnishing any services, care, treatment, or supplies to you. BCBS and SEIB will not be responsible if any provider of service fails or refuses to admit you to a facility, or treat you, or provide services to you. BCBS and SEIB are not required to do anything to enable providers to furnish services, supplies, or facilities to you.

Misrepresentation

Any misrepresentation by you in application for or in connection with coverage under the contract will make your coverage invalid as of your effective date, and in that case BCBS and SEIB will not be obligated to return any portion of any fees paid by or for you. Any misrepresentation by SEIB in application for or in connection with the contract will make the entire contract invalid as of the contract effective date, and in that case BCBS will not be obligated to return any fees paid by the group for you or any other member.

Any employee or retiree knowingly and willfully submitting materially false information to the SEIB or engaging in fraudulent activity that causes financial harm to the SEBDP, may be required, upon a determination by the SEIB, (1) to repay all claims and other expenses, including interest, incurred by the SEBDP related to the intentional submission of false or misleading information or fraudulent activity and (2) be subject to disqualification from coverage under the SEBDP.

Obtaining, Use and Release of Information

By submitting your application for coverage or any claims for benefits you authorize BCBS to obtain from all providers, hospitals, facilities, other providers of service, and all other persons or institutions having information concerning you, all records which in its judgment are necessary or desirable for processing your claim, performing our contractual duties or complying with any law. You also authorize providers of health services, and any other person or organization, to furnish to BCBS any such records or information it requests. Further, you authorize BCBS to use and release to other persons or organizations any such records and information as considered necessary or desirable in its judgment. Neither BCBS or any provider or other person or organization will be liable for obtaining, furnishing, using, or releasing any such records or information.

Responsibility of Members and Providers to Furnish Information

By submitting an application for coverage or a claim for benefits you agree that in order to be eligible for benefits:

A claim for the benefits must be properly submitted to and received by BCBS.

A provider that has furnished or prescribed any services or supplies to a member must provide the records, information, and evidence BCBS requests in connection with benefits claimed or paid for the services or supplies.

A member who receives services or supplies for which benefits are claimed must provide the records, information and evidence BCBS requests.

Refusal by any member or provider of services to provide BCBS records, information, or evidence reasonably requested will be grounds for denial of any further payments of benefits to or for this member or provider.

Providers of Services Subject to Contract Provisions

Any provider of services or supplies for which benefits are claimed or paid will be considered, through acceptance of the benefits or payment, to be bound by this contract's provisions.

Benefit Decisions

By submitting a claim for benefits you agree that any determination BCBS makes in deciding claims or administering the contract that is reasonable and not arbitrary or capricious will be final.

Charges for More than the Allowed Amount

When benefits for provider services are based on the allowed amount, the amounts of benefit payments are determined and made by BCBS upon consideration of the factors described in the definition of the Allowed Amount (see Definitions). If a provider charges you more than the amount of the allowed amount paid by BCBS as benefits, you are responsible for the charges in excess of the allowed amount.

Applicable State Law

This contract is issued and delivered in the State of Alabama and will be governed by the law of Alabama to the extent that state law is applicable.

Plan Changes

The SEIB may amend any or all of the provisions of the SEBDP at any time by an instrument in writing.

No representative or employee of BCBS is authorized to amend or vary the terms and conditions of the SEBDP, make any agreement or promise, not specifically contained in the SEBDP, or waive any provision of the SEBDP.

Rescission

Under the Patient Protection and Affordable Care Act (the ACA), the SEIB cannot rescind your coverage once you are covered under the SEBDP unless you perform an act, practice, or omission that constitutes fraud, or unless you make an intentional misrepresentation of material fact as prohibited by the terms of the SEBDP. The SEIB must provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded.

A rescission is a retroactive cancellation or discontinuance of coverage. A cancellation of coverage is not a rescission if (a) the cancellation or discontinuance of coverage has only a prospective effect; or (b) the cancellation or discontinuance of coverage is effective retroactively due to a failure to timely pay required premiums or contributions towards the cost of coverage.

Chapter 12
COORDINATION OF BENEFITS

COB is a provision designed to help manage the cost of dental care by avoiding duplication of benefits when a person is covered by two or more benefit plans. COB provisions determine which plan is primary and which is secondary. A primary plan is one whose benefits for a person's dental care coverage must be determined first without taking the existence of any other plan into consideration. A secondary plan is one which takes into consideration the benefits of the primary plan before determining benefits available under its plan. Some COB terms have defined meanings. These terms are set forth at the end of this COB section.

Order of Benefit Determination

Which plan is primary is decided by the first rule below that applies:

Noncompliant Plan: If the other plan is a noncompliant plan, then the other plan shall be primary and this plan shall be secondary unless the COB terms of both plans provide that this plan is primary.

Employee/Dependent: The plan covering a patient as an employee, member, subscriber, or contract holder (that is, other than as a dependent) is primary over the plan covering the patient as a dependent. In some cases, depending upon the size of the employer, Medicare secondary payer rules may require us to reverse this order of payment. This can occur when the patient is covered as an inactive or retired employee, is also covered as a dependent of an active employee, and is also covered by Medicare. In this case, the order of benefit determination will be as follows: first, the plan covering the patient as a dependent; second, Medicare; and third, the plan covering the patient as an inactive or retired employee.

Dependent Child – Parents Not Separated or Divorced: If both plans cover the patient as a dependent child of parents who are married or living together (regardless of whether they have ever been married), the plan of the parent whose birthday falls earlier in the year will be primary. If the parents have the same birthday, the plan covering the patient longer is primary.

Dependent Child – Separated or Divorced Parents: If two or more plans cover the patient as a dependent child of parents who are divorced, separated, or no longer living together (regardless of whether they have ever been married), benefits are determined in this order:

1. If there is no court decree allocating responsibility for the child's dental care expenses or dental care coverage, the order of benefits for the child are as follows:
    a. first, the plan of the custodial parent;
    b. second, the plan covering the custodial parent's spouse;
    c. third, the plan covering the non-custodial parent; and,
    d. last, the plan covering the non-custodial parent's spouse.
2. If a court decree states that a parent is responsible for the dependent child's dental care expenses or dental care coverage and the plan of that parent has actual knowledge of those terms, the plan of the court-ordered parent is primary.

    If the court-ordered parent has no dental care coverage for the dependent child, benefits will be determined in the following order:

    a. first, the plan of the spouse of the court-ordered parent;
    b. second, the plan of the non-court-ordered parent; and,
    c. last, the plan of the spouse of the non-court-ordered parent.

If a court decree states that both parents are responsible for the dependent child's dental care expenses or dental care coverage, the provisions of "Dependent Child – Parents Not Separated or Divorced" (the "birthday rule") above shall determine the order of benefits.

If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental care expenses or dental care coverage of the dependent child, the provisions of the "birthday rule" shall determine the order of benefits.

3. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under the "birthday rule" as if those individuals were parents of the child.

Active Employee or Retired or Laid-Off Employee:

1. The plan that covers a person as an active employee (that is, an employee who is neither laid off nor retired) or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

2. 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.

3. This rule does not apply if the rule in the paragraph "Employee/Dependent" above can determine the order of benefits. For example, if a retired employee is covered under his or her own plan as a retiree and is also covered as a dependent under an active spouse's plan, the retiree plan will be primary and the spouse's active plan will be secondary.

COBRA or State Continuation Coverage:

1. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

2. 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.

3. This rule does not apply if the rule in the paragraph "Employee/Dependent" above can determine the order of benefits. For example, if a former employee is receiving COBRA benefits under his former employer's plan (the "COBRA plan") and is also covered as a dependent under an active spouse's plan, the COBRA plan will be primary and the spouse's active plan will be secondary. Similarly, if a divorced spouse is receiving COBRA benefits under his or her former spouse's plan (the "COBRA plan") and is also covered as a dependent under a new spouse's plan, the COBRA plan will be primary and the new spouse's plan will be secondary.

Longer/Shorter Length of Coverage: If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

Equal Division: If the plans cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been the primary plan.

Determination of Amount of Payment

1. If this plan is primary, it shall pay benefits as if the secondary plan did not exist.
2. If our records indicate this plan is secondary, we will not process your claims until you have filed them with the primary plan and the primary plan has made its benefit determination.

If this plan is a secondary plan on a claim, should it wish to coordinate benefits (that is, pay benefits as a secondary plan rather than as a primary plan with respect to that claim), this plan shall calculate the benefits it would have paid on the claim in the absence of other healthcare coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. When paying secondary, this plan may reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other healthcare coverage. If this plan is required to make a secondary payment according to the above rules, it will subtract the amount paid by the primary plan from the amount it would have paid in the absence of the primary plan, and pay the difference, if any. In many cases, this will result in no payment by this plan.

COB Terms

Allowable Expense: Except as set forth below or where a statute requires a different definition, the term "allowable expense" means any dental care expense, including coinsurance, copayments, and any applicable deductible that is covered in full or in part by any of the plans covering the person.

The term "allowable expense" does not include the following:

- An expense or a portion of an expense that is not covered by any of the plans.
- Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person.
- Any type of coverage or benefit not provided under this plan. In addition, the term "allowable expense" does not include the amount of any reduction in benefits under a primary plan because the covered person failed to comply with the primary plan's provisions concerning second surgical opinions or precertification of admissions or services, or (b), the covered person had a lower benefit because he or she did not use an in-network dentist.

Birthday: The term "birthday" refers only to month and day in a calendar year and does not include the year in which the individual is born.

Custodial Parent: The term "custodial parent" means:

- A parent awarded custody of a child by a court decree; or,
- In the absence of a court decree, the parent with whom the child resides for more than one half of the calendar year without regard to any temporary visitation.

Group-Type Contract: The term "group-type contract" means 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. The term 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 insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

Noncompliant Plan: The term "noncompliant plan" means a plan with COB rules that are inconsistent in substance with the order of benefit determination rules of this plan. Examples of noncompliant plans are those that state their benefits are "excess" or "always secondary."

Plan: The term “plan” includes group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); dental care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

The term “plan” does not include non-group or individual health or medical reimbursement insurance contracts. The term “plan” also does not include hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Primary Plan: The term “primary plan” means a plan whose benefits for a person's dental care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if:

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

Secondary Plan: The term “secondary plan” means a plan that is not a primary plan.

Right to Receive and Release Needed Information

Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. We are not required to 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 apply these COB rules and to determine benefits payable as a result of these rules.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, 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. We will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons it has paid to or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Special Rules for Coordination with Medicare

Except where otherwise required by federal law, the plan will pay benefits on a secondary basis to Medicare or will pay no benefits at all for services or supplies that are included within the scope of Medicare's coverage, depending upon, among other things, the size of your group, whether your group is a member of an association, and the type of coordination method used by your group. For example, if this plan is secondary to Medicare under federal law, this plan will pay no benefits for services or supplies that are included within the scope of Medicare's coverage if you fail to enroll in Medicare when eligible.

Chapter 13
SUBROGATION

Right of Subrogation

If BCBS pays or provides any benefits for you under the SEBDP, it is **subrogated** to all rights of recovery that you have in contract, tort, or otherwise against any person or organization for the amount of benefits BCBS has paid or provided. BCBS may use your right to recover money from that other person or organization. Your right to be made whole is superseded by BCBS's right of subrogation.

Right of Reimbursement

Separate from and in addition to the right of subrogation, if you or a member of your family recovers money from the other person or organization for any injury or condition for which benefits were provided, you agree to **reimburse** BCBS from the recovered money the amount of benefits we have paid or provided. That means that you will pay to BCBS the amount of money recovered by you through judgment or settlement from the third person or his insurer, as well as from any person, organization, or insurer, up to the amount of benefits paid or provided by us. Our right to reimbursement comes first even if others have paid for part of your loss or if the payment you receive is for, or is described as for, your damages (such as for personal injuries) other than health or dental care expenses, or if the member recovering the money is a minor.

Right to Recovery

You agree to promptly furnish BCBS all information that you have concerning your rights of recovery or recoveries from other persons or organizations and to fully assist and cooperate with BCBS in protecting and obtaining its reimbursement and subrogation rights in accordance with this Section. **You may receive questionnaires requesting more information. Any member who has not responded within 30 days of receiving three questionnaires will have their claims suspended until they have complied with the questionnaire.**

You or your attorney will notify us before filing any suit or settling any claim so as to enable us to participate in the suit or settlement to protect and enforce our rights under this section. If you do notify us so that we are able to and do recover the amount of our benefit payments for you, we will share proportionately with you in any attorney's fees charged you by your attorney for obtaining the recovery. If you do not give BCBS such notice, our reimbursement or subrogation recovery under this section will not be decreased by any attorney's fee for your attorney.

You further agree not to allow the reimbursement and subrogation rights of BCBS under this section to be limited or harmed by any other acts or failures to act on your part. It is understood and agreed that if you do, BCBS may suspend or terminate payment or provision of any further benefits for you under the SEBDP.

Chapter 14
FILING A CLAIM, CLAIM DECISIONS & APPEAL OF BENEFIT DENIAL

The following explains the rules under the SEBDP for filing claims and appeals with Blue Cross and for filing voluntary appeals with the SEIB.

Filing of Claims Required

A claim prepared and submitted to Blue Cross must be received by Blue Cross before it can consider any claim for payment of benefits for services or supplies. In addition, there are certain services must be approved by BCBS in advance before they will be recognized as benefits. No communications with Blue Cross by you, your provider, or anyone else about the existence or extent of coverage can be relied on by you or your provider or will be binding in any way on Blue Cross when the communications are made before the services or supplies are provided and a claim for them is submitted and received.

Who Files Claims

Providers of services who have agreements with Blue Cross generally prepare and submit claims directly to BCBS. Claims for services or supplies furnished to you by providers without agreements with BCBS must be prepared and submitted by either you or the provider.

Who Receives Payment

Blue Cross' agreements with some providers require it to pay benefits directly to them. On all other claims it may choose to pay either you or the provider. If you or the provider owes BCBS any sums, it may deduct from its benefit payment the amount that it is owed. Its payment to you or the provider (or deduction from payments to either) of amounts owed will be considered to satisfy its obligation to you. Blue Cross does not have to honor any assignment of your claim to anyone, including a provider.

Nothing in the contract gives a provider the right to sue for recovery from BCBS for benefits payable under the contract.

If you die or become incompetent or are a minor, Blue Cross pays your estate, your guardian or any relative that, in its judgment, is entitled to the payment. Payment of benefits to one of these people will satisfy its obligation to you.

How to File Claims

When you use your benefits, a claim must be filed before payment can be made. The SEBDP will pay for covered services you receive after the effective date of your coverage.

Pre-determination of Benefits for Bridgework, Crowns, Onlays and Inlays and Osseous surgery

Your dental plan includes a provision for pre-determination of benefits for bridgework, crowns, onlays and inlays and osseous surgery. The purpose of pre-determination of benefits is to assure you and the dentist that the proposed dental treatment is covered by your dental plan. If a patient expects to incur charges for one of the services listed above or for periodontic or prosthetic services (excluding full and partial dentures) in excess of $500, a Request for Pre-Determination of Benefits should be filed by the dentist on a dental claim form. The treatment plan along with pre-operative radiographs should be submitted to BCBS.

Include the findings of the oral examination, recommended course of treatment, and other information to identify the services to be rendered. Verification is then made as to the availability of these benefits under the dental plan and you and the dentist are notified in advance of treatment.

Preferred Dentists will file your dental claims when dental work is completed. Preferred Dentists are provided claim forms by BCBS to use in filing your claims.

However, if your dentist is not a Preferred Dentist, you may have to file the claim yourself by completing a dental claim form. Send the completed form to BCBS, Attention: Dental Claims Department. Be sure to have your dentist complete his portion of the form and sign the claim.

When Claims Must Be Submitted

All claims for benefits must be submitted properly by you or your provider of services within 365 days of the date you receive the services or supplies. Claims not submitted and received by BCBS within this 365-day period will not be considered for payment of benefits.

Receipt and Processing Claims

Claims for dental benefits are always post-service.

You must act on your own behalf or through an authorized representative if you wish to exercise your rights under this section of your booklet. An authorized representative is someone you designate in writing to act on your behalf. BCBS has developed a form that you must use if you wish to designate an authorized representative. You can also go to the BCBS Internet web site at www.bcbsal.com and ask BCBS to mail you a copy of the form. If a person is not properly designated as your authorized representative, BCBS will not be able to deal with him or her in connection with the exercise of your rights under this section of your booklet.

Post-Service Claims

What Constitutes a Post-Service Claim? For you to obtain benefits after dental services have been rendered or supplies purchased (a post-service claim), BCBS must receive a properly completed and filed claim from you or your provider.

In order for BCBS to treat a submission by you or your provider as a post-service claim, it must be submitted on a properly completed standardized claim form or, in the case of electronically filed claims, must provide BCBS with the data elements that BCBS specifies in advance. Most providers are aware of BCBS's claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call the BCBS customer service department and ask for a claim form. Tell BCBS the type of service or supply for which you wish to file a claim (for example, hospital, physician, or pharmacy), and BCBS will send you the proper type of claim form. When you receive the form, complete it, attach an itemized bill, and send it to BCBS at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858. Claims must be submitted and received by BCBS within 24 months after the service takes place to be eligible for benefits.

If BCBS receives a submission that does not qualify as a claim, it will notify you or your provider of the additional information needed. Once BCBS receives that information, it will process the submission as a claim.

Processing of Claims: Even if BCBS has received all of the information needed to treat a submission as a claim, from time to time it might need additional information in order to determine whether the claim is payable. The most common example of this is dental records needed to determine whether services or supplies were dentally necessary. If additional information is needed, BCBS will ask you to furnish it, and will suspend further processing of your claim until the information is received. You will have 90 days to provide the information to BCBS. To expedite receipt of the information, BCBS may request it directly from your provider. BCBS will send you a copy of its request. However, you will remain responsible for seeing that BCBS gets the information on time.

Ordinarily, BCBS will notify you of the decision within 30 days of the date on which your claim is filed. If it is necessary to ask you for additional information, BCBS will notify you of its decision within 15 days after it receives the requested information. If BCBS does not receive the information, your claim will be considered denied at the expiration of the 90-day period BCBS gave you for furnishing the information.

In some cases, BCBS may ask for additional time to process your claim. If you do not wish to give BCBS additional time, it will go ahead and process your claim based on the information it has. This may result in a denial of your claim.

Courtesy Pre-Determinations of Treatment Plan: We encourage, but do not require, you or your provider to submit a treatment plan to BCBS for a courtesy pre-determination of benefits. If you ask for a courtesy pre-determination of a treatment plan, BCBS will do its best to provide you with a timely response. If BCBS decides that it cannot provide you with a courtesy pre-determination (for example, we cannot get the information BCBS needs to make an informed decision), BCBS will let you know. In either case, courtesy pre-determinations are not claims under the SEBDP. When BCBS processes requests for courtesy pre-determinations, BCBS is not bound by the time frames and standards that apply to claims.

Your Right To Information: You have the right, upon request, to receive copies of any documents that BCBS relied on in reaching its decision and any documents that were submitted, considered, or generated by BCBS in the course of reaching a decision. You also have the right to receive copies of any internal rules, guidelines, or protocols that BCBS may have relied upon in reaching the decision. If the decision was based on a dental or scientific determination (such as dental necessity), you may also request that BCBS provide you with a statement, explaining its application of those dental and scientific principles to you. If BCBS obtained advice from a health care professional (regardless of whether it relied on that advice), you may request that BCBS give you the name of that person. Any request that you make for information under this paragraph must be in writing. BCBS will not charge you for any information that you request under this paragraph.

Member Satisfaction

If you are dissatisfied with the adverse benefit determination of a claim, you may file an appeal with BCBS. You cannot file a claim for benefits under the SEBDP in federal or state court unless you exhaust these administrative remedies.

Customer Service

If you have questions about your coverage, or need additional information about how to file claims, you should contact BCBS. BCBS Customer Service (located in Birmingham) is open for phone inquiries from 8:00 a.m. to 5:00 p.m. Monday through Friday. The phone number is:

1.800.824.0435

When you call about a claim, be sure to have the following information available:

- Your contract number
- Name of your employer
- Date of service
- Name of provider.

BCBS also has a special 24 hour-a-day, 7 days a week, Customer Service request line, called Rapid Response, for you to use when you need claim forms and other printed materials relevant to your benefits. Rapid Response is quick and easy to use, so we encourage you to use it when you need materials such as:

- Claim forms
- Replacement ID cards
- Brochures
- Benefit Booklets

A voice activated system will ask for your name, complete mailing address, daytime phone number, what materials you are requesting, how many you need, and the contract number from your ID card. If you know the BCBS form number, you can request the item by that number.

The numbers for Rapid Response are:

205.988.5401 in Birmingham or 1.800.248.5123 toll free.

Your request is recorded and will be mailed to you the next working day if you answer all the questions completely. Allowing mailing time, you should receive your requested materials within 3-5 days (excluding weekends and holidays).

Blue Cross Blue Shield Appeals

In General: The rules in this section of the summary allow you or your authorized representative to appeal any adverse benefit determination by BCBS. In all cases other than determinations by BCBS to limit or reduce previously approved care, you have 180 days following an adverse benefit determination by BCBS within which to submit an appeal.

How to Appeal Post-Service Adverse Benefit Determinations

If you wish to file an appeal of an adverse benefit determination relating to a post-service claim, BCBS recommends that you use a form that is developed for this purpose. The form will help you provide BCBS with the information that it needs to consider your appeal. To get the form, you should call the BCBS Customer Service Department. You may also go to the Internet web site at www.bcbsal.org. Once there, you may ask BCBS to send you a copy of the form.

If you choose not to use the BCBS appeal form, you may send BCBS a letter. Your letter must contain at least the following information:

- the patient's name;
- the patient's contract number;
- sufficient information to reasonably identify the claim or claims being appealed, such as date of service, provider name, procedure (if known), and claim number (if available) (the best way to satisfy this requirement is to include a copy of your Claims Report with your appeal); and,
- a statement that you are filing an appeal.

You must send your appeal to the following address:

Blue Cross Blue Shield of Alabama
Attention: Customer Service Appeals
P.O. Box 12185
Birmingham, Alabama 35202-2185

Please note that if you call or write Blue Cross without following the rules just described for filing an appeal, Blue Cross will not treat your inquiry as an appeal. Blue Cross will, of course, use best efforts to resolve your questions or concerns.

Conduct of the Appeal

Blue Cross will assign your appeal to one or more persons within the organization who are neither the persons who made the initial determination nor subordinates of those persons. If resolution of your appeal requires BCBS to make a dental judgment (such as whether services or supplies are dentally necessary), BCBS will consult a dental care professional who has appropriate expertise. If BCBS consulted a dental care professional during its initial decision, it will not consult that same person or a subordinate of that person during our consideration of your appeal.

If BCBS needs more information, BCBS will ask you to provide it to them. In some cases BCBS may ask your provider to furnish that information directly to them. If so, BCBS will send you a copy of its request. However, you will remain responsible for seeing that BCBS gets the information. If BCBS does not get the information, it may be necessary for BCBS to deny your appeal.

BCBS will consider your appeal fully and fairly.

Time Limits for Consideration of Your Appeal: BCBS will notify you of its decision within 60 days of the date on which you filed your appeal. In some cases, BCBS may ask for additional time to process your appeal. If you do not wish to give BCBS additional time, BCBS will go ahead and decide your appeal based on the information they have. This may result in a denial of your appeal.

If You Are Dissatisfied After Exhausting Your Mandatory Plan - Administrative Remedies

If you have filed an appeal and are dissatisfied with the response, you may do one or more of the following:

- you may ask the BCBS Customer Service Department for further help; or
- if you have exhausted your appeals with BCBS and you are still dissatisfied, you may file a voluntary appeal with the SEIB, as described under "SEIB Appeals Process."

Voluntary Appeals: If BCBS has given you its appeal decision and you are still dissatisfied, you may file a second appeal (called a voluntary appeal). If your voluntary appeal relates to a pre-service adverse benefit determination, you may file your appeal in writing or over the phone. If over the phone, you should call the phone number you called to submit your first appeal. If in writing, you should send your letter to the same address you used when you submitted your first appeal. Your written appeal must state that you are filing a voluntary appeal.

If you file a voluntary appeal (whether oral or written), BCBS will not assert in court a failure to exhaust administrative remedies if you fail to exhaust the voluntary appeal. BCBS will also agree that any defense based upon timeliness or statutes of limitations will be tolled during the time that your voluntary appeal is pending. In addition, BCBS will not impose any fees or costs on you as part of your voluntary appeal. You may ask BCBS to provide you with more information about voluntary appeals. This additional information will allow you to make an informed judgment about whether to request a voluntary appeal.

External Reviews

For claims involving medical judgment and/or rescissions of coverage, you may also file a request with BCBS for an independent, external review of our decision. You must request this external review within 4 months of the date of your receipt of our adverse benefit determination or final adverse appeal determination. Your request for an external review must be in writing, must state you are filing a request for external review, and must be submitted to the following address:

Blue Cross and Blue Shield of Alabama
Attention: Customer Service Appeals
P.O. Box 10744, Birmingham, AL 35202-0744.

If you request an external review, an independent organization will review our decision. You may submit additional written comments to the review organization. Once your external review is initiated, you will receive instructions about how to do this. If you give the review organization additional information, the review organization will give BCBS copies of this additional information to give BCBS an opportunity to reconsider its denial. Both you and BCBS will be notified in writing of the review organization's decision. The decision of the review organization will be final and binding on both you and BCBS.

Chapter 15
SEIB APPEALS PROCESS

General Information
Members of the SEBDP have a right to question the decisions of the SEIB. Issues involving eligibility and enrollment must be addressed directly with the SEIB. Before addressing an issue involving a benefit claim with the SEIB, however, you must exhaust all administrative procedures with the claims administrator, BCBS.

Informal Review
If you feel that an enrollment or eligibility ruling was not in conformity with the rules and procedures of the SEBDP or, after exhausting all administrative procedures with BCBS, you still feel that the SEBDP's benefits were incorrectly applied, you may then contact the SEIB for an Informal Review. In many cases, the problem can be handled over the phone through the Informal Review process without the need for a formal review or appeal.

Administrative Review
If you are unsatisfied with the informal review decision, you may then request an administrative review. All requests for administrative review must be submitted to the SEIB legal department. If it is determined by the SEIB that an administrative review is merited, you will be sent a form to complete and return to the SEIB.

Receipt of your Administrative Review will be acknowledged by returning a copy of the received form to you. Oral arguments will not be considered in an Administrative Review process unless approved by the SEIB.

An Administrative Review request must be received in the SEIB office within 60 days following receipt of the final notice of a partial or total denial of your claim from the claims administrator or within 60 days of the receipt of any determination of the SEIB. A copy of the decision of the claims administrator or the SEIB ruling must be attached to the Administrative Review form IB5. The Administrative Review Committee will review the grievance, usually within sixty (60) days. The Administrative Review Committee shall issue a decision in writing to all parties involved in the grievance.

Formal Appeal
If you do not agree with the response to your Administrative Review, you may file a request for a Formal Appeal before the Board of Directors. Requests for a Formal Appeal must be received in the SEIB office within 60 days following the date of the Administrative Review decision.

The subject of a Formal Appeal shall be limited to exclusions or exceptions to coverage based on extenuating or extraordinary circumstances, or policy issues not recently addressed or previously contemplated by the Board.

If your request for a formal appeal is granted, generally, a decision will be issued within ninety (90) days following approval of the Request for Formal Appeal. The number of days may be extended by notice from the SEIB. The decision by the Board is the final step in the administrative proceedings and will exhaust all administrative remedies.

Items That Will Not Be Reviewed Under the Administrative Review or Formal Appeal Process:

- Dental Necessity
- Cosmetic Surgery
- Investigational Related Services
- Custodial Care
- Allowed Amounts

If you have not received a decision or notice of extension of the Administrative Review or Formal Appeal within 90 days, you may consider your request denied.

Chapter 16
DEFINITIONS

Affordable Care Act: The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Educational Reconciliation Act, and its implementing rules and regulations.

Allowable Amount: The amount of a dentist's charge that Blue Cross will recognize as covered expenses for medically/dentally necessary services provided by the SEBDP. This amount is generally limited to the lesser of the dentist's charge for care or the fee for a procedure in the in-network dentists' fee schedule. In-network dentists normally accept this allowable amount (subject to any applicable copayments, coinsurance, or deductibles that are the responsibility of the patient) as payment in full for covered services. Out-of-network dentists may bill the member for charges in excess of the allowable amount.

Blue Cross Blue Shield of Alabama: Company chosen by the SEIB, through competitive bid, to process benefit claims filed by members (also referred to as BCBS).

Claims Administrator: The Company chosen by the SEIB, through competitive bid, to process benefit claims filed by members. The Claims Administrator is BCBS.

COBRA: See the explanation in the "Termination of Coverage" section of this booklet.

Dental Necessity: Services or supplies that are necessary to treat your illness, injury, or symptom. To be dentally necessary, services or supplies must be determined by BCBS to be:

- appropriate and necessary for the symptoms, diagnosis, or treatment of your dental condition;
- provided for the diagnosis or direct care and treatment of your dental condition;
- in accordance with standards of direct care and treatment of your dental condition;
- in accordance with standards of good dental practice accepted by the organized dental community;
- not primarily for the convenience and/or comfort of you, your family, your dentist, or another provider of services;
- is not "investigational."

Dentist: One of the following when licensed and when acting within the scope of his license at the time and place where the service is rendered: Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.).

Dependent: See explanation in the "Eligibility and Enrollment" section.

Effective Date: The date on which the coverage of each individual member begins as listed in the SEIB records.

Employee: See the "Eligibility and Enrollment" section.

Family Coverage: Coverage for an employee and one or more dependents.

Investigational: Any treatment, procedure, facility, equipment, drugs, drug usage, or supplies that either BCBS has not recognized as having scientifically established medical value, or that does not meet generally accepted standards of medical practice. When possible, BCBS will develop written criteria (called medical criteria) concerning services or supplies that BCBS considers to be investigational. BCBS bases these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. BCBS puts these medical criteria in policies that BCBS makes available to the

medical community and our members. BCBS does this so that you and your providers will know in advance, when possible, what BCBS will pay for. If a service or supply is considered investigational according to one of BCBS's published medical criteria policies, BCBS will not pay for it. If the investigational nature of a service or supply is not addressed by one of BCBS's published medical criteria policies, BCBS will consider it to be non-investigational only if the following requirements are met:

- The technology must have final approval from the appropriate government regulatory bodies;
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
- The technology must improve the net health outcome;
- The technology must be as beneficial as any established alternatives; and,
- The improvement must be attainable outside the investigational setting.

It is important for you to remember that when BCBS makes determinations about the investigational nature of a service or supply BCBS is making them solely for the purpose of determining whether to pay for the service or supply. All decisions concerning your treatment must be made solely by your attending physician and other medical providers.

Member: An active/retired State Employee or eligible dependent who has coverage under the SEBDP and whose application for coverage under the contract is made and accepted by the SEIB. A member also is a former dependent and/or employee eligible for and covered under COBRA.

Open Enrollment: The annual open enrollment period is held each November for a January 1 effective date. During this time you may choose between the insurance carriers available and/or change from single to family coverage.

Out-of-network dentist: A dentist licensed to practice dentistry in any state who is not an in-network dentist.

Retired Employee: Former employee who receives a monthly benefit check from the State of Alabama.

State Employees' Blue Cross Blue Shield Dental Plan (SEBDP): A self-insured dental benefit plan administered by the State Employees' Insurance Board.

State Employees' Insurance Board (SEIB): The State agency charged with the administration of the dental benefit plan for state employees and their dependents. This agency is also referred to as SEIB.

Subscriber: The individual whose application for coverage is made and accepted.

We, Us, Our: BCBS, the SEBDP or SEIB as shown by the context.

You, Your: The contract holder or member as shown by the context.

State Employees' Insurance Board

Post Office Box 304900
Montgomery, Alabama 36130-4900

Phone: 334.263.8341
Toll-Free: 1.866.836.9737
Web site: www.alseib.org

Claims Administrator

Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35298

Customer Service: 1.800.824.0435
Rapid Response: 1.800.248.5123
Fraud Hot Line: 1.800.824.4391
Web site: www.bcbsal.com

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