State Employees' Southland Dental Plan

January 1, 2017

Administered by

Southland Benefit Solutions, LLC

P.O. Box 1250 ● Tuscaloosa, Alabama 35403 ● Telephone 866-327-6674
www.southlandseib.com

Discrimination is Against the Law

The State Employees' Insurance Board (SEIB) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The SEIB does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The SEIB:

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

If you need these services, contact 1-866-698-7428.

If you believe that the SEIB has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Section 1557 Coordinator, 201 South Union Street, Montgomery, Alabama, 36104; Direct: (334) 263-8413; Fax (334) 263-8711; Email: 1557Grievance@alseib.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-Language Interpreter Services

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-698-7428.

Korean: 주의 :만약 당신이 말하는 스페인어 ,당신은 당신의 처리 무료 언어 지원 서비스에 있다 . 전화는 1-866-698-7428.

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Vietnamese: Chú ý: Nếu bạn nói tiếng Tây Ban Nha, bạn có lúc xử lý ngôn ngữ miễn phí dịch vụ hỗ trợ của bạn. Gọi đến 1-866-698-7428.

Arabic: تنبيـــــه: إذا كـان يتحــدث الإســــبانية، وفـــي التخلــــص من خـدماتها بالمســـاعدة اللغويـــة. الـدعوة ـى 1-866-698-7428.

German: Achtung: Wenn Sie Spanisch sprechen, müssen Sie Ihre kostenlose Hilfe Serviceleistungen zur Verfügung. Aufruf an die 1-866-698-7428.

French: ATTENTION : Si vous parlez espagnol, vous avez à votre disposition linguistique gratuite assistance services. Appel à la 1-866-698-7428.

Gujarati: ચુના: જો તમે જરાતી બોલતા હો, તો િ ન:લ્કુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો 1-866-698-7428.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-698-7428.

Hindi: ध्यान दें: यिद स्पेनिश बोलते हैं, अपने निपटान पर सेवाओं की भाषाई सहायता नि: शुल्क है। कॉल 1-866-698-7428.

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວ ້າພາສາ ລາວ, ານ ບໍລິການຊ່ວຍເຫ ຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-866-698-7428.

Russian: ВНИМАНИЕ: Если вы говорите на испанском языке, вы имеете в вашем распоряжении бесплатные помощи услуги. Вызовите 1-866-698-7428.

Portuguese: Atenção: Se fala espanhol, tem em seus serviços de eliminação de assistência linguística. Ligue para o 1-866-698-7428.

Turkish: Dikkat: İspanyolca, elden çıkarma ücretsiz dil yardım hizmetlerinde varsa. Aramak için 1-866-698-7428.

Japanese: 注意: あなたがスペイン語を話す場合、あなたはあなたの処分無料言語アシスタンスサービスであります。1-866-698-7428.

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Introduction

This summary of dental benefits available to you through the State Employees' Southland Dental Plan (SESDP) is designed to help you understand your coverage. 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 Southland Benefit Solutions (Southland). The SEIB shall have absolute discretion and authority to interpret the terms and conditions of the plan and reserves the right to change the terms and conditions and/or end the plan at any time and for any reason.

Participation in this plan is completely voluntary, based on elections you make for yourself and your dependents in the time and manner described below.

The plan year begins on January 1 and runs through December 31.

THE INFORMATION IN THIS BOOKLET IS NOT A SUBSTITUTE FOR THE LAW. IF A DIFFERENCE OF INTERPRETATION OCCURS, THE LAW GOVERNS. THE LAW MAY CHANGE AT ANY TIME ALTERING INFORMATION IN THIS HANDBOOK. THE STATE EMPLOYEES' INSURANCE BOARD RESERVES THE RIGHT TO CHANGE BENEFITS DURING THE PLAN YEAR.

Eligibility and Enrollment Requirements

Eligible Participants
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 Alabama 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.

2. Part-time employees working at least ten hours per week if they agree to have the required premium paid through payroll deduction and if they are enrolled in the State Employees' Health Insurance Plan.

3. Members of the Legislature and the Lieutenant Governor during their term of office and if they are enrolled in the State Employees' Health Insurance Plan.

Exclusion: You are not eligible for coverage if you are employed on a seasonal, temporary, intermittent, emergency or contract basis unless you receive a W-2 and work an average of 30 hours per week, or 130 hours per month, during a designated measurement period as stipulated under the Affordable Care Act.

Eligible Dependents
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, or
   c. your stepchild;

3. Your grandchild, niece, or nephew:
   a. under 19 years of age, and
   b. for whom the court has granted custody to you or your spouse;

4. An incapacitated dependent over age 25 will be considered for coverage provided the 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;
      - spouse's loss of eligibility due to termination of employment or reduction of hours of employment; or
      - spouse's employer stopped contributing 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 approves 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 spouse or other dependents if they are independently covered as a State employee.

Professional civil engineer trainees 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 an ineligible person to coverage) or omission (such as failing to remove a person no longer eligible for coverage) of the subscriber results in or contributes to the payment of claims by the SESDP 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 SESDP, an SEIB enrollment form must be completed by the employee and his/her employer and submitted to the SEIB subject to the 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. 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.

Medical Child Support Orders
If the group (the plan administrator) receives an order from a court or administrative agency directing the SESDP 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 plan 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 SESDP 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 a copy of the order is submitted to the SEIB 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 a copy of the order is submitted to the SEIB 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 plan as a result of a QMCSO, all plan provisions and limits remain in effect with respect to the child's coverage except as otherwise required by federal law.

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 SESDP. 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 SESDP,
- 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 SESDP; and

2. the employee gains a new dependent through marriage, birth or adoption; or

3. the employee or dependent loses the other employer group 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 contributing to coverage; and

4. the employee requests enrollment in the SESDP in writing no later than 30 days after the loss of other coverage or within 60 days of gaining a new dependent through marriage, birth or adoption.

A request for special enrollment must include:

1. A letter requesting special enrollment submitted to the SEIB within 30 days of the loss of other coverage or within 60 days of gaining a new dependent, 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 SESDP who carried family coverage, the eligible dependents may continue coverage by making the appropriate premium payments to the SEIB. The SEIB must be notified within 90 days of the date of death.

Notice
Notice of any enrollment changes is the responsibility of the employee (e.g., status changes or address changes). Please visit 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 www.alseib.org.

Address Changes
All correspondence and notices required under the provisions of the SESDP 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.

When Coverage Terminates
Coverage under the SESDP 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. Once enrolled in the SESDP for twelve consecutive months, you can decline coverage during Open Enrollment for an effective date of January 1.

3. When the SESDP is discontinued.

Coverage under the SESDP will also terminate for a dependent:

1. On the last day of the month in which such person ceased to be an eligible dependent.

2. If the dependent, other than a spouse, 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.

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 covered 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 SESDP 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 SESDP 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 SESDP is lost because of a qualifying event. Under the SESDP, qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage.

Who is a Qualified Beneficiary?

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 SESDP 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. 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 a covered employee, you will become a qualified beneficiary if you lose your coverage under the SESDP 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 a covered employee, you will become a qualified beneficiary if you lose your coverage under the SESDP 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 SESDP 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 SESDP as a "dependent child."

What Coverage is Available?
If you choose COBRA 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 is COBRA Coverage Available?
COBRA continuation coverage will be offered to qualified beneficiaries only after the SEIB has been notified that a qualifying event has occurred.

When Should Your Agency Notify the SEIB?
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 Should You 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 SESDP 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.

How is COBRA Coverage Provided?
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 SESDP 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 SESDP, 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 SESDP will be retroactively terminated and payment of all claims incurred after the date coverage ceased will be rescinded. If you elect to buy COBRA continuation coverage 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 SESDP may pay claims incurred during the 60-day election period. If this happens, you should not assume that you have coverage under the SESDP. The only way your coverage will continue is if you elect to buy COBRA and pay your premiums on time.

What will be the Length of COBRA 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 SESDP.

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; (3) the date of Social Security's determination; or (4) the

date on which you, or the qualified beneficiary, is informed, through the furnishing of the SPD or COBRA general notice, of the responsibility to notify the plan and procedures for doing so. You must also notify the SEIB within 30 days of any revocation of Social Security disability benefits.

- Extensions of COBRA for Second Qualifying Events – 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.

Can New Dependents Be Added to Your COBRA Coverage?

You may add new dependents to your COBRA coverage under the circumstances permitted under the SESDP. 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.

How Does the Family and Medical Leave Act Affect my COBRA Coverage?

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.

How much is my COBRA Coverage Premium?

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.

When is my COBRA Coverage Premium Due?
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.

When Does my COBRA Coverage End?
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.
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.

In addition, COBRA coverage can be terminated if otherwise permitted under the terms of the SESDP. For example, if you submit fraudulent claims, your coverage will be terminated.

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.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.Healthcare.gov.

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
Attn: COBRA Section
201 S. Union St., Suite 200
PO Box 304900
Montgomery, AL 36130-4900

Retiree Eligibility and Enrollment Requirements

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

Eligible Dependent - (see page 2)

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

Open Enrollment
Retired employees who do not elect to continue their coverage under the SESDP 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 (HIPAA) 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 SESDP; and

2. The retiree gains a new dependent through marriage, birth or adoption; or

3. The retiree or dependent loses the other employer group 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 SESDP in writing no later than 30 days after the loss of other coverage or within 60 days of gaining a new dependent through marriage, birth or adoption.

A request for special enrollment must include:

1. A letter requesting special enrollment submitted to the SEIB within 30 days of the loss of other coverage or within 60 days of gaining a new dependent, 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.

General Provisions

Privacy of Your Protected Health Information

The confidentiality of your personal health information is important to the SEIB. Under 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 SESDP'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

Southland, and other business associates of the SESDP, has an agreement with the SESDP 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 SESDP, you agree that the SESDP, and its business associates, may obtain, use, and release all records about you and your minor dependents needed to administer the SESDP 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 plan. If you or any provider refuses to provide records, information or evidence we request within reason, we may deny your benefit payments. You also agree that we may call you at any telephone number provided to us by you, your employer, or any healthcare provider in accordance with applicable law.

The privacy provisions of HIPAA 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 visiting www.alseib.org, or you can request a copy by writing to us at:

State Employees' Insurance Board
Attn: Privacy Officer
PO 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 SESDP needs to share your protected health information with the plan sponsor (the state of Alabama). Following are circumstances under which the SESDP may disclose your protected health information to the plan sponsor:

- The SESDP may inform the plan sponsor whether you are enrolled in the SESDP.
- The SESDP 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 SESDP. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying you.
- The SESDP 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 SESDP.

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 SESDP'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 SESDP 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 SESDP 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 SESDP must follow in this regard. There are some exceptions.
- The plan sponsor will amend, or allow the SESDP 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. 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 SESDP 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 SESDP or from any business associate when the plan sponsor no longer needs your protected health information to administer the SESDP. 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 and will cooperate with the plan 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 SEIB 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 Southland finds at a later date that the payments were incorrect, you or the provider will be required to repay any overpayment or Southland may deduct the amount of the overpayment from any future payment to you or the provider. If Southland does this, they will notify you.

Responsibility for Actions of Providers of Services
Southland 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. Southland and the SEIB will not be responsible if any provider of service fails or refuses to admit you, or provide services to you. Southland 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 this plan will make your coverage invalid as of your effective date, and in that case Southland and the SEIB will not be obligated to return any portion of any fees paid by or for you. Any misrepresentation by the 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, Southland 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 SESDP, may be required, upon a determination by the SEIB (1) to repay all claims and other expenses, including interest, incurred by the SESDP related to the intentional submission of false or misleading information or fraudulent activity, and (2) be subject to disqualification from coverage under the SESDP.

Obtaining, Use and Release of Information
By submitting your application for coverage or any claims for benefits you authorize Southland 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 Southland any such records or information it requests.

You authorize Southland to use and release to other persons or organizations any such records and information as considered necessary or desirable in its judgment. Neither Southland 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 Southland.

- A provider that has furnished or prescribed any services or supplies to a member must provide the records, information, and evidence Southland 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 Southland requests.

Refusal by any member or provider of services to provide Southland 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 Southland 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 Southland upon consideration of the factors described in the definition of the allowed amount. If a provider charges you more than the amount of the allowed amount paid by Southland 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 SESDP at any time by an instrument in writing.

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

Rescission
Under the Patient Protection and Affordable Care Act (the ACA), the SEIB cannot rescind your coverage once you are covered under the SESDP 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 SESDP. 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.

Fraudulent Claims

Any person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act which is a crime. In addition to any disciplinary action already in place, any employee or retiree knowingly and willfully submitting false information to the SEIB will be required to repay all claims and other expenses incurred by the SESDP related to the false or misleading information, plus interest.

Customer Service

If you have questions about your coverage, or need additional information about how to file claims, you should contact Southland. Southland Customer Service (located in Tuscaloosa) is open for phone inquiries Monday through Friday, from 8:00 a.m. to 5:00 p.m. The phone number is: 1-866-327-6674.

Subrogation

Right of Subrogation

If Southland pays or provides any benefits for you under the SESDP, we are subrogated to all rights of recovery that you have in contract, tort, or otherwise against any person or organization for the amount of benefits Southland has paid or provided. Southland may use your right to recover money from that other person or organization. Your right to be made whole is superseded by our 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 the SESDP from the recovered money the amount of benefits we have paid or provided. That means that you will pay to Southland 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 Southland all information that you have concerning your rights of recovery or recoveries from other persons or organizations and to fully assist and cooperate with Southland in protecting and obtaining our 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 Southland 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 our reimbursement and subrogation rights 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, Southland may suspend or terminate payment or provision of any further benefits for you under the SESDP.

Southland Appeal Process

In the event payment of a claim is denied by Southland and the insured is of the opinion such denial was improper, the insured has the right of appeal. The appeal procedure is as follows:

1. To appeal, the insured must submit a request for review, in writing, to Southland within sixty (60) days from the date any writing is received by the insured from Southland denying payment of a claim. This request must contain the specific reasons the insured contends the claim denial was improper. Within the same time period, insured may submit any other evidence which insured contends supports his or her position.

2. Southland will review the claim, any written requests or other evidence received from the insured, and advise the insured of its final determination.

3. If the insured is still of the opinion that claim denial is improper, insured may obtain a judicial review of Southland's decision by the Circuit Court of Montgomery County, Alabama.

Payment and Claim Filing Limitations
All claims must be submitted in writing and such writing must be received by Southland **no later than 365 days** following the date covered expenses are incurred. If a claim is not submitted and received by Southland within this period, the claim for that benefit will not be paid. Claim forms must be completed, with proper documentation and certification from the health care provider, upon submission. Failure to provide a completed claim form may cause delays in claims processing and may be cause for the denial of the claim.

Claim forms resubmitted in an effort to obtain coverage not normally provided will not be accepted and will be denied.

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

SEIB Appeal Process

General Information

Members of the SESDP 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, Southland.

Informal Review

If you feel that an enrollment or eligibility ruling was not in conformity with the rules and procedures of the SESDP or, after exhausting all administrative procedures with Southland, you still feel that the SESDP'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 submitted to 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 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's 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 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

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.

is a Southland network of Participating Dentists benefiting SESDP members

Here Are The Top 3 Reasons To Use One Of Our Participating Dentists:

1. **THEY SAVE YOU MONEY**
2. **THEY SAVE THE SESDP MONEY**
3. **THEY SAVE YOU & THE SESDP MONEY**

DentaNet is one of the largest independent dental networks in the State of Alabama.
The network is designed to save you money.
One important reason you purchase benefits is to save money.

For a listing of Statewide DentaNet providers, visit www.southlandseib.com

FACT

DentaNet is the network of participating dentists designed to benefit SESDP members.

FACT

DentaNet is one of the largest dental networks in the state of Alabama.

FACT

By using DentaNet providers, SESDP members save money.

QUESTION: ARE YOU SAVING MONEY?

If you participate in the SESDP, you probably purchased dental insurance to save money.

DentaNet providers are all over the state.
To find a participating DentaNet provider in your area, visit **www.southlandseib.com** or call us, toll-free, at **1-866-327-6674** today.
You'll be glad you did.

DENTAL BENEFITS PROGRAM

Plan Summary*

Dental Benefit Schedule

	Plan I (Employee Only)	**Plan II** (Employee & Full Family)
Maximum benefits applicable Per person per plan year:	$1,250.00	$1,000.00
Diagnostic & Preventative Services: Based on Reasonable & Customary Charges		
Deductible	None	None
Oral Examinations	100%	100%
Cleaning of Teeth	100%	100%
Fluoride Applications for children	None	100%
Space Maintainers for children	None	Limited
X-Rays	100%	100%
Emergency Office Visits	100%	100%
Sealants	None	100%
Basic & Medical Services: Based on Reasonable & Customary Charges		
Deductible	None	$25.00
Fillings	80%	60%
General Anesthetics	80%	60%
Oral Surgery	80%	60%
Periodontics	80%	60%
Endodontics	80%	60%
Dentures	80%	60%
Crowns	80%	60%

NO ORTHODONTIC BENEFITS

1. Space maintainers limited to $125.00 per unit.
2. Deductibles are applied per person, per plan year with a maximum of three (3) per family.
3. Oral surgery excludes any procedures covered under a group medical program.
4. No benefits are provided for replacement of teeth removed before coverage is effective.
   - Expenses are incurred at the preparation date and not the installation, service, or “seating” date
   - Benefits are not provided for temporary partials

Covered Dental Expenses

Charges of a dentist or medical doctor which an employee is required to pay for services which are necessary for the diagnosis, prevention, or treatment of a dental condition, but only to the extent that such charges are reasonable and customary, and only if rendered in accordance with broadly accepted standards of dental practice.

Expenses are incurred at the preparation date and not the installation, service, or "seating" date.

The maximum benefits applicable per person, per plan year are Plan I (employee) $1,250.00, Plan II (employee and full family) $1,000.00.

Reasonable and Customary Charges

The term "reasonable and customary charges" means the actual fee charged by a dentist in Alabama for a service rendered, but only to the extent the fee is reasonable, taking into consideration the following items:

The usual fee which the individual dentist in Alabama most frequently charges the majority of his patients for service rendered;

The prevailing range of fees charged in the same areas by dentists in Alabama of similar training and experience for service rendered; and

Circumstances or complications requiring additional time, skill and experience.

Diagnostic and Preventive Expenses

This plan will pay all reasonable and customary charges for:

Oral examinations and office visits, but not more than two examinations or office visits in a plan year. An examination and office visit are synonymous for the purposes of this benefit. This category includes procedures performed by a dentist that aid in making diagnostic conclusions about the oral health of the individual patient and the dental care required. This limitation would not apply to emergency office visits.

Prophylaxis includes cleaning and scaling of teeth, but not more than two times in a plan year. Charges for this type of treatment performed by a licensed dental hygienist are also included if rendered under the supervision of a licensed dentist.

Topical application of fluoride: Benefits are provided to cover topical application of fluoride for two treatments per plan year. Benefits are available to insured persons to age 19.

Space maintainers are fixed or removable appliances designed to prevent adjacent and opposing teeth from moving, and/or that replace prematurely lost or extracted teeth. Coverage is for charges incurred to maintain existing space. Benefits are available to insured persons to age 14. Benefits are limited to $125.00 per space maintainer unit. However, no benefits will be provided for replacement of lost space maintainer units or replacement of outgrown space maintainer units which have been prescribed during the same plan year.

X-rays: Dental x-rays including full mouth x-rays, but not more than once in any 36 consecutive months. Supplementary bitewing x-rays, but not more than twice in a plan year.

Sealants: Pit and fissure sealants are the prophylactic application of composite resin material to cavity prone enamel pits and fissures. Benefits are provided for covered individuals to age 19. Limited to a one-time basis, per tooth.

Other Covered Dental Expenses

This plan will pay the percentage of reasonable and customary charges as shown in the Dental Benefits Schedule for the following:

Restorations, which includes fillings, inlays, onlays, crowns and the treatment necessary to restore the structure of a tooth or teeth. Benefits are provided for a replacement of gold or crown restoration if the restoration was installed while covered under this plan and at least five (5) years prior to this replacement.

Multiple restorations on one tooth will be paid on the same basis as a multiple surface restoration rather than as an individual restoration. Bonding will be considered equal to crowning with acceptance and replacement restrictions the same.

Endodontics: Procedures used for the prevention and treatment of diseases of the dental pulp and the surrounding structures.

General Anesthesia: when medically necessary and administered in connection with oral surgery.

Periodontics: Procedures for the treatment of the gum and tissue supporting the teeth.

Oral Surgery: Procedures performed in or about the mouth which involve, but are not limited to, the incision and excision procedures for the correction of disease, injury or preparation of the mouth for dentures. Dental surgery includes charges for removal of teeth.

Prosthodontics: Services performed to replace one or more teeth except third molars (wisdom teeth), extracted while the patient is covered under the plan. The plan will not cover replacement of existing bridgework or dentures; however, the plan will cover the installation of a permanent full denture that replaces, or is installed within 12 months of a temporary denture, repairing or recementing inlays, crowns, bridgework, dentures or relining of dentures. The plan will also cover the replacement of an existing partial by a new partial; replacement of a full denture or bridgework; or the addition of teeth to an existing denture or bridgework, but only if:

A. The existing denture or bridgework was provided while coverage under this plan was in effect, the existing denture or bridgework is at least five years old and cannot be made serviceable; or

B. The replacement or addition of teeth is required to replace one or more natural teeth extracted or accidentally lost while insured.

No benefits shall be provided under the plan for dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes.

No benefits are provided for replacement of teeth removed before coverage is effective.

Pre-Determination of Benefits

Before beginning a course of treatment for which dentists' charges are expected to be $150.00 or more, a description of the proposed course of treatment and charges to be made should be filed on the claim form with Southland. Southland will then determine the estimated benefits payable for covered dental expenses expected to be incurred and advise the employee and the dentist before treatment begins. Services must be completed within a reasonable length of time from date predetermination was processed.

Emergency treatments, oral examinations including prophylaxis and dental x-rays are considered part of a course of treatment, but these services may be rendered before the predetermination of benefits procedure is begun.

A course of treatment is a planned program of one or more services or supplies, whether rendered by one or more dentists for the treatment of a dental condition diagnosed by the attending dentist as a result of an oral examination. The course of treatment commences on the date a dentist first renders a service to correct or treat such diagnosed dental condition.

After the course of treatment is completed, the Plan benefit shall be paid in accordance with the final claim submitted by the dentist. In the event of any change in the final claim or treatment, Southland shall adjust

payment accordingly. In the event the dentist makes a major change in the treatment plan, the dentist should send in a revised plan.

In the event there is no claim for a predetermination of benefits, the benefit will be paid based upon the information submitted to Southland at the time of the claim.

Alternate Procedures
When it is determined that several methods of treatment exist to treat a particular problem, then benefits will be paid based on the least costly scheduled amount so long as the result meets generally acceptable dental standards. Unless prior written consent is received from Southland, dental benefits are limited to the least costly procedure.

Coordination of Dental Benefits
If an enrolled member is covered under more than one group dental plan or is entitled to any other source, the total amount that is payable under all plans will not be more than 100% of the maximum allowable expenses. **The SEIB's dental benefits will be secondary to all other dental coverages available to a claimant.**

DentaNet Benefits
The dental coverage administered by Southland will offer a dental network to members and dependents enrolled in the dental plan. Under the Southland dental network, known as "DentaNet", members have the opportunity to use the network dentists but still have the freedom to use any dentist. DentaNet dentists cannot balance bill you for the difference between the negotiated fee schedule and what they normally charge. On services requiring you to pay a coinsurance fee, the coinsurance payment will be based on a negotiated fee. The SEIB and its members save money when DentaNet dentists are used.

Extension of Dental Benefits
Even though the coverage for an enrolled member has terminated, the member will be entitled to extended coverage for the purpose of the completion of any dental service for which a treatment plan has been approved by the administrator, provided that the services are completed within 30 days of such approval.

Dental Exclusions
No benefits are payable for certain charges, including but not limited to charges for:

1. Expenses incurred by or on account of an individual prior to such persons effective date of coverage under the plan.

2. Replacement of teeth removed before coverage is effective.

3. Work done for appearance (cosmetic) purposes. Facing on crowns and pontics posterior to the second bicuspid, are always considered to be cosmetic.

4. Work done while not covered under this plan.

5. Services or supplies in connection with orthodontia except for extractions.

6. Extra sets of dentures or other appliances.

7. Broken appointment.

8. Replacing lost or stolen prosthetic appliances.

9. Completion of claim forms or filing of claims.

10. Educational or training programs, dietary instructions, plaque control programs, and oral hygiene information.

11. Implantology (implants).

12. Periodontal splinting.

13. Work covered under the group hospital medical indemnity plan.

14. Experimental procedures.

15. Drugs or their administration.

16. Anesthetic services billed by anyone other than the attending dentist or his assistant.

17. Services and supplies not ordered by a dentist or physician and not reasonably necessary for treatment of injury or dental disease.

18. Appliances, restorations, and procedures to alter vertical dimension including, but not limited to harmful habit.

19. Services, appliances or supplies that exceed the reasonable and customary charges in Alabama.

20. Treatment of an accident related to employment or sickness if either or both are covered under Workers' Compensation or similar laws.

21. Work that is otherwise free of charge to patients or charges that would not have been made if there were no insurance.

22. Work that is furnished or payable by the Armed Forces of any government.

23. Services or supplies furnished by the United States, state or local government.

24. Services received for injuries or sickness due to war or any act of war, whether declared or undeclared, which war or act of war shall have occurred after the effective date of this plan.

25. Expenses to the extent of benefits provided under any employer group plan other than this plan in which the state of Alabama participates in the cost thereof.

26. Such other expenses as may be excluded by regulations of the board.

27. Gold foil restorations.

28. Pulp capping or acid etching as a separate procedure.

29. Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes.

30. Periodontal cleaning aids or devices.

31. Specific charges for infection control and/or protection supplies, including but not limited to, gloves, masks, gowns, shoes or other items.

32. Microscopic bacteriological examinations.

33. Antimicrobial irrigation.

34. Temporomandibular joint (TMJ) disorders.

35. Benefits are not provided for temporary partials.

36. Expenses for which the individual is not required to make payment, including but not limited to, reductions or readjustments to the charges made by the health care provider.

37. All claims not submitted in writing, not completed, without the requisite certification of the health care provider, or received by Southland more than 365 days following the claim incurrence.

38. Hospital expenses for dental work performed in the hospital.

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