The State Employees' Dental Insurance Plan

State of Alabama

Effective January 1, 2023

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

STATE OF ALABAMA

STATE EMPLOYEES' INSURANCE BOARD
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STATE EMPLOYEES' DENTAL INSURANCE PLAN
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

The State Employees' Dental Insurance Plan (the "Plan") considers personal information to be confidential. The Plan protects the privacy of that information in accordance with applicable privacy laws, as well as its own privacy policies.

THE PLAN'S RESPONSIBILITIES

The Plan is required by federal law to keep your health information private, to give you notice of the Plan's legal duties and privacy practices, and to inform you about:

- the Plan's uses and disclosures of your protected health information;
- your privacy rights concerning your protected health information;
- the Plan's obligations concerning your protected health information;
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services (HHS); and
- the person or office to contact for further information about the Plan's privacy practices.

Effective Date of Notice: This notice is effective as of January 1, 2023.

HOW THE PLAN MAY USE AND DISCLOSE HEALTH INFORMATION

This section of the notice describes uses and disclosures that the Plan may make of your health information for certain purposes without first obtaining your permission as well as instances in which we may request your written permission to use or disclose your health information. The Plan also requires its business associates to protect the privacy of your health information through written agreements.

Uses and disclosures related to payment, health care operations, and treatment. The Plan and its business associates may use your health information without your permission to carry out payment or health care operations. The Plan may also disclose health information to the Plan Sponsor, the State of Alabama for purposes related to payment or health care operations.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, review for medical necessity and appropriateness of care and utilization review, and preauthorizations). For example, the Plan may tell an insurer what percentage of a bill will be paid by the Plan.

Health care operations include but are not limited to underwriting, premium rating, and other insurance activities relating to creating or renewing insurance contracts, disease management, case management, conducting or arrangement for medical review, legal services, and auditing functions, including fraud and abuse programs, business planning and development, business management, and general administrative activities. However, the Plan will not use protected genetic information for underwriting purposes. It also includes quality assessment and improvement and reviewing the competence or qualifications of health care professionals. For example, the Plan may use medical benefit claims information to review the accuracy of benefit payments.

The Plan will only disclose the minimum information necessary with respect to the amount of health information used or disclosed for these purposes. In other words, only information relating to the task being performed will be used or disclosed. Information not required for the task will not be used or disclosed.

The Plan may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other uses and disclosures that do not require your written authorization. The Plan may disclose your health information:

- To persons and entities that provide services to the Plan and assure the Plan they will protect the information;
- If it constitutes summary health information, and it is used only for modifying, amending, or terminating a group dental plan or obtaining premium bids from health plans providing coverage under the group dental plan;
- If it constitutes de-identified information;
- If it relates to workers' compensation programs;
- If it is for judicial and administrative proceedings;
- If it is about decedents;
- If it is for law enforcement purposes;
- If it is for public health activities;
- If it is for health oversight activities;
- If it is about victims of abuse, neglect, or domestic violence;
- If it is for cadaveric organ, eye, or tissue donation purposes;
- If it is for certain limited research purposes;
- If it is to avert a serious threat to health or safety;
- If it is for specialized government functions;
- If it is for limited marketing activities.

Additional disclosures to others without your written authorization. The Plan may disclose your health information to a relative, a friend, or any other person you identify provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, the Plan may confirm whether or not a claim has been received and paid. You have the right to request that this kind of disclosure be limited or stopped by contacting the Plan's Privacy Officer at (334) 263-8300.

Uses and Disclosures Requiring Your Written Authorization. In all situations other than those described above, the Plan will ask for your written authorization before using or disclosing your health information. If you have given the Plan written authorization, you may revoke it at any time, if the Plan has not already acted on it. If you have questions regarding authorizations, contact the Plan's Privacy Officer at (334) 263-8300.

YOUR PRIVACY RIGHTS

This section of the notice describes your rights concerning your health information and a brief description of how you may exercise these rights.

Notice of Breach. You have a right to notice of a breach of protected health information (PHI).

Restrict Uses and Disclosures. You have the right to request that the Plan restricts use and disclosure of your health information for activities related to payment, health care operations, and treatment. The Plan will consider, but may not agree to, such requests. (Exception: the Plan must grant a restriction on PHI disclosed to a health plan for payment or health care operations purposes if the PHI pertains solely to a health care item or service for which the healthcare provider involved has been paid out of pocket in full.)

Alternative Communication. The Plan will accommodate reasonable requests to communicate with you at a certain location or in a certain way. For example, if you are covered as an adult-dependent, you may want the Plan to send health information to a different address than that of the employee.

Inspect or Copy Health Information. You have a right to inspect or obtain a copy of health information that is contained in a "designated record set" – records used in making enrollment, payment, claims adjudication, and other decisions. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial. If the Plan does not maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

You may request your records in an electronic format. The Plan may provide you with a summary of the health information if you agree in advance to the summary. You may also be asked to pay a fee of $1.00 per page based on the Plan's copying, mailing, and other preparation costs.

Amend Health Information. You have the right to request an amendment to health information that is in a "designated record set." You must provide a statement to support the request. The Plan may deny your request to amend your health information if the Plan did not create the health information, if the information is not part of the Plan's records, if the information was not available for inspection or if the information is accurate and complete.

Accounting of Certain Disclosures. You have the right to receive a list of certain disclosures of your health information. The accounting will not include: (1) disclosures made for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosure for national security purpose; and (6) disclosures incident to other permissible disclosures.

You may receive information about disclosures of your health information going back for six (6) years from the date of your request. You may make one (1) request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You will be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to access electronic records. You may request access to electronic copies of your health information, or you may request in writing or electronically that another person receive an electronic copy of these records. The electronic protected health information will be provided in a mutually agreed-upon format, and you may be charged for the cost of any electronic media (such as a USB flash drive) used to provide an electronic copy.

Right to a Copy of Privacy Notice. You have the right to receive a paper copy of this notice upon request, even if you agreed to receive the notice electronically.

Complaints. You may complain to the Plan or the Secretary of HHS if you believe your privacy rights have been violated. To file a complaint with the Plan, contact the Plan's Privacy Officer at (334) 263-8300. You will not be penalized for filing a complaint.

How to exercise your rights in this notice

To exercise your rights listed in this notice, you should contact the Plan's Privacy Officer at (334) 263-8300.

THIS NOTICE IS SUBJECT TO CHANGE

The terms of this notice and the Plan's privacy policies may be changed at any time. If changes are made, the new terms and policies will then apply to all health information maintained by the Plan. If any material changes are made, the Plan will distribute a new notice to participants and beneficiaries.

YOUR QUESTIONS AND COMMENTS

If you have questions regarding this notice, please contact the Plan's Privacy Officer at (334) 263-8300.

Revision 10-2022

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. This benefit is 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. This benefit is for dependent children under age 19 only. Member is responsible for the difference in billed charges & allowed fee schedule.
Annual Maximum	There is a $1,500 per person annual maximum for all covered services.	

This is not a contract. Benefits are subject to the terms, limitations, and conditions of the group contract.

Table of Contents

Introduction

This summary of the State Employees' Dental Insurance Plan ("SEDIP") is designed to help you understand your coverage. This planbook 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 and Blue Shield of Alabama (BCBS) or other third-party administrators.

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

Chapter 1
Overview of the Plan

The following provisions of this planbook contain a summary of your rights and benefits under the SEDIP. If you have questions about your benefits, please contact Blue Cross and Blue Shield of Alabama's (BCBS) Customer Service at 1-800-292-8868.

Purpose of the Plan

The SEDIP is intended to help you and your covered dependents pay for the costs of dental care. The SEDIP does not pay for all of your dental care. For example, you may be required to pay deductibles, copayments, and coinsurance.

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

Blue Cross and Blue Shield of Alabama's home page is www.AlabamaBlue.com. If you go there, you will see a section on the home page called myBlueCross. Registering for myBlueCross 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 SEDIP.

Definitions

Near the end of this planbook, you will find a "Definitions" section, which identifies words and phrases that have specialized or particular meanings. To make this planbook 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 SEDIP 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 "Eligibility" section of this planbook will tell you what is required for you to be covered under the SEDIP and when your coverage begins.

Dental Necessity

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

In-Network Benefits

One way in which the SEDIP tries to manage dental care costs and provide enhanced benefits is through negotiated discounts with in-network dentists. In-network dentists are dentists that contract with BCBS (directly or indirectly) for furnishing dental care services at a reduced price. Preferred dentists are in-network dentists in the state of Alabama. To locate in-network dentists for the SEDIP, 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 above the allowable amounts under the SEDIP.

Relationship between Blue Cross and Blue Shield Plans and the Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Alabama (BCBS) 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 BCBS to use the Blue Cross and Blue Shield service marks in the state of Alabama. BCBS is not acting as an agent of the Blue Cross and Blue Shield Association. No representation is made that any organization other than BCBS and the SEIB 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 BCBS not created under the original agreement.

Limitations and Exclusions

The SEDIP contains several 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 to take maximum advantage of the SEDIP.

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 BCBS for reimbursement under the terms of the SEDIP. If BCBS denies a claim in whole or in part, you may file an appeal with BCBS. BCBS will give you a full and fair review. The provisions of the SEDIP dealing with claims or appeals are found further on in this planbook.

Termination of Coverage

The “Eligibility” section tells you when coverage will terminate under the SEDIP. If coverage terminates, no benefits will be provided thereafter, even for a condition that began before the SEDIP 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 planbook.

Chapter 2
Active Employee Eligibility and Enrollment

Visit our website at www.alseib.org to download forms.

Eligible Employees

The term "employee" includes only:

- 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, County Soil & Water Conservation Districts, and the Alabama Community College System.

- Part-time employees working at least 10 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 (SEHIP).

- Members of the Legislature and the Lieutenant Governor during their term of office.

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 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 Dependent

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

- Your spouse (excludes divorced or common-law spouse);

- A child under age 26, only if the child is:
  - your son or daughter,
  - legally adopted by you or your spouse,
  - your stepchild; or
  - a dependent for whom the subscriber, or his or her spouse, has legal and physical custody granted by a court of competent jurisdiction.

- Your incapacitated child* over age 25 will be considered for coverage provided the incapacitation occurred prior to the child's 26th birthday and the child is:
  - unmarried,
  - permanently mentally or physically incapacitated,
  - so incapacitated as to be incapable of self-sustaining employment,
  - dependent on you for 50% or more support,
  - otherwise eligible for coverage as a dependent except for age,
  - covered as a dependent on your SEDIP immediately prior to the child's 26th birthday, and
  - not eligible for any other group dental insurance benefits.

*The above requirements must be met to be eligible for coverage as an incapacitated child. The SEIB shall decide whether an application for incapacitated status will be accepted and final approval of incapacitation will be determined by Medical Review. Neither a reduction in work capacity nor the inability to find employment is, of itself, evidence of eligibility. If a mentally or physically incapacitated child is working, the extent of his or her earning capacity will be evaluated.

See the "Enrolling an Incapacitated Child" section for critical enrollment deadlines. If deadlines are not met and/or continuous coverage is not maintained on the child, an Incapacitated Child over the age of 25 is not eligible for coverage.

Ineligible Dependents

- Your dependents, other than your spouse, if they are independently covered as a state employee unless they are employed as a professional civil engineer trainee with ALDOT and their employment is part of their educational training
- An ex-spouse, regardless of what the divorce decree may state
- Ex-stepchildren, regardless of what the divorce decree may state
- Your biological child if the child has been adopted by someone other than your spouse and you have been relieved of your parental rights and responsibilities
- Children age 26 and older
- Incapacitated children age 26 and older who do not meet the Incapacitated Child eligibility requirements listed above under Eligible Dependent
- A child of a dependent child
- A daughter-in-law or son-in-law
- Grandchildren or other children related to the member by blood or marriage for which the member does not have legal and physical custody
- Grandparents
- Parents
- A fiancé or live-in girlfriend or boyfriend

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 SEDIP 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

To be covered under the SEDIP, 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.

Enrolling an Incapacitated Child

If your child meets the other Incapacitated Child eligibility requirements listed above under Eligible Dependent, you must contact the SEIB to obtain an Incapacitated Child Certification form. A completed Incapacitated Child Certification form and proof of incapacity must be provided to the SEIB no more than 60 days after the child's 26th birthday. If you fail to submit the form and proof of incapacity within the required time period, or, if you do not maintain continuous coverage on the incapacitated child thereafter, your child is not eligible for future enrollment except in the following two situations:

1. When a new employee requests coverage for an incapacitated child within 60 days of employment; or

2. When an employee's incapacitated child is covered under a spouse's employer group dental insurance for at least 18 consecutive months and:

    a. the employee's spouse loses the other coverage because:
        - the employer ceases operations, or
        - termination of employment or reduction of hours of employment, or
        - employer stopped contributing to coverage,

    b. a change form is submitted to the SEIB within 30 days of the incapacitated child's loss of other coverage, and

    c. Medical Review approved incapacitation status.

In these two situations, your child must meet all Incapacitated Child eligibility requirements.

National Medical Support Notices

A National Medical Support Notice (Notice) is an order from a child support enforcement agency directing the Plan to cover the employee's child regardless of whether the employee has enrolled the child for coverage. If the SEIB receives a Notice from a child support enforcement agency directing the SEDIP to cover a child, the SEIB will determine whether the Notice is qualified. The SEIB has adopted procedures for determining whether such an order is a Notice. You have a right to obtain a copy of those procedures free of charge by contacting the SEIB.

The SEDIP will cover an employee's child if required to do so by a Notice. If the SEIB determines that an order is a Notice, the child will be enrolled for coverage effective as of a date specified by the SEIB, but not earlier than the first day of the month following the SEIB's determination that the order is a Notice.

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 SEIB may increase the employee's payroll deductions. During the period the child is covered under the SEDIP as a result of a Notice, all SEDIP provisions and limits remain in effect concerning the child's coverage except as otherwise required by federal law.

While the Notice is in effect, the SEDIP will make benefit payments – other than payments to providers – to the parent or legal guardian who has been awarded custody of the child. The SEIB will also provide sufficient information and forms to the child's custodial parent or legal guardian to allow the child to enroll in the SEDIP. The SEIB 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 SEDIP;
- employees who wish to change plans;
- part-time employees who wish to begin coverage; and
- employees who wish to add family coverage or add a dependent to existing family coverage.

Special Enrollment

HIPAA requires that a special enrollment period be provided in addition to the regular enrollment period for employees and eligible dependents if:

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

A request for special enrollment must be 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. In addition, the following documentation must be submitted within 60 days of the qualifying event:

- proof of gaining a new dependent (e.g., marriage certificate, birth certificate, adoption papers); or
- 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 SEDIP 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, including status changes or address changes, is the responsibility of the employee.

Status Changes

A status change form must be completed for an addition or deletion of dependent coverage. The Membership Status Change form must be submitted by visiting our website at www.alseib.org., by mail, or by facsimile.

Address Changes

All correspondence and notices required under the provisions of the SEDIP 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 by visiting our website at www.alseib.org. or at PO Box 304900, Montgomery, Alabama 36130-4900. An address cannot be updated by BCBS or made from the information shown on claim forms.

Employee Name Changes

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

Premium Refunds

In the event you are entitled to a premium refund or any other refund from the SEIB and you die, become incompetent, or are a minor, the SEIB may pay your estate, your guardian, or any relative that, in its judgment, is entitled to the payment. Payment of the refund to one of these people will satisfy the SEIB's obligation to you.

Chapter 3
Termination of Coverage

When Coverage Terminates

Coverage under the SEDIP will terminate:

- 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, sickness, or 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.
- Once enrolled in the SEDIP for 12 consecutive months, you can decline coverage during Open Enrollment for an effective date of January 1.
- When the SEDIP is discontinued.

Coverage under the SEDIP will also terminate for a dependent:

- On the last day of the month in which such person ceased to be an eligible dependent.
- If the dependent, other than a spouse, becomes covered as an employee.
- When premium payments cease for coverage of a deceased active or deceased retired employee.
- 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 the 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

SEDIP coverage for employees on official leave without pay (LWOP) 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 the 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 Dental 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 dental coverage (called "continuation coverage") at group rates in certain instances where coverage under the SEDIP would otherwise end. COBRA coverage can be particularly important because it will allow you to continue group dental 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 SEDIP 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 SEDIP is lost because of a qualifying event. Under the SEDIP, qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage.

Who are 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, to be a qualified beneficiary, an individual must generally be covered under the SEDIP 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 SEDIP 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 SEDIP because 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 SEDIP 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 SEDIP as a dependent child.

What Coverage is Available?

If you choose continuation coverage, the SEIB is required to offer you coverage that is identical at the time coverage is being provided 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 within 30 days 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 within 60 days of the following qualifying events:

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

Written notice must be given to the SEIB within the applicable timeframe listed above from the date of the event or the date on which coverage would end under the SEDIP 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 dental 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 SEDIP, 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 SEDIP 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, the SEDIP may pay claims incurred during the 60-day election period. If this happens, you should not assume that you have coverage under the SEDIP. 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 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 SEDIP.

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 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 the 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 Event** - If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the SEIB is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage had the first qualifying event not occurred. You must notify the SEIB within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

Can a New Dependent be Added to your COBRA Coverage?

You may add new dependents to your COBRA coverage under the circumstances permitted under the SEDIP. 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 a 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 is due 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 End?

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

- SEIB no longer provides group dental coverage.
- The premium for your continuation coverage is not paid on time.
- You become covered under another group dental plan.
- 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 SEDIP. For example, if you submit fraudulent claims, your coverage will terminate.

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.

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 other group dental plan coverage (such as a spouse's plan) through what is known as a special enrollment period. Some of these options may cost less than COBRA continuation coverage.

Keep the SEIB Informed of Address Changes

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 by mail at the contact listed below. For more information about your COBRA rights, visit the Centers for Medicare & Medicaid Services (CMS) website at //www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/COBRA.html

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
PO 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 and receives a monthly benefit from the Employees' Retirement System or Teachers' Retirement System of Alabama or Judicial Retirement Fund.

Eligible Dependent
Please see the “Eligible Dependent” section in Chapter 1 for more information.

Enrollment/Continuation
A retiring employee may elect coverage under the SEDIP 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 SEDIP may enroll 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:

- The retired employee declined to enroll in the SEDIP and submitted a completed SEIB form declining coverage in the SEDIP; and
- The retiree gains a new dependent through marriage, birth or adoption; or
- The retiree or dependent loses the other employer group dental coverage because:
    - COBRA coverage (if elected) is exhausted; or
    - loss of eligibility (including separation, divorce, death, termination of employment, or reduction of hours of employment); or
    - employer stopped contributing to coverage.

A request for special enrollment must be 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. In addition, the following documentation must be submitted within 60 days of the qualifying event:

- proof of gaining a new dependent (e.g., marriage certificate, birth certificate, adoption papers);
- 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 SEDIP 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 a preferred provider or not) who is recognized by BCBS as an approved provider for the type of service or supply being furnished. Call BCBS Customer Service if you have any questions about whether your provider is recognized by BCBS as an approved provider for the services or supplies you plan on receiving.

- Services and supplies must be furnished when the SEDIP and your coverage are both in effect and fully paid for. No benefits will be provided for services you receive after the SEDIP or your coverage ends, even if they are for a condition that began before the SEDIP or your coverage ends.

Chapter 7
Cost Sharing

Calendar Year Deductible	**$25 per person each calendar year (does not apply to diagnostic and preventive services) (maximum three deductibles per family)**
Calendar Year Maximum Benefits	**$1,500**

Calendar Year Deductible

Here are some special rules concerning the 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 SEDIP 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 above 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 above the allowable amount.

Chapter 8
Dental Benefits

The SEDIP'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 accept our payment as 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 SEDIP benefits from you except for deductibles and coinsurance. They must bill BCBS first except for services that are not SEDIP benefits, such as implants.

Basic Diagnostic and Preventative Services

SERVICE	BENEFIT
Basic Diagnostic and Preventative 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 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 are 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.

Basic Restorative Services

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.

Supplemental Services

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.

Prosthetic Services

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 choose 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 cannot 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.

Periodontic Services

SERVICE	BENEFIT
Periodontic Services	50%

- Periodontic exams twice every 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.

Orthodontic Services

SERVICE	BENEFIT
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. This benefit is 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 the months that you have orthodontic coverage. There are no benefits for orthodontic services 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 receive 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 are 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 SEDIP 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 an 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 their present state or restore 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 malalignment 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 **BCBS 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 BCBS has not been received by BCBS, or (b) for which a claim is received by BCBS 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 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.

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

E

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, a trustee, or a 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.

G

Gold foil restorations.

I

Charges for **implants**.

Charges for **infection** control.

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

L

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 provides or pays for care, through insurance or any other means. This applies even if the law does not cover all your expenses.

M

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

N

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

O

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

P

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**.

R

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.

W

Dental services or expenses in cases covered in whole or in part by **workers' compensation** or employers' liability laws, state or federal. This applies to 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
Respecting Your Privacy

Privacy of Your Protected Health Information

The confidentiality of your protected health information (PHI) is important to the SEIB. Under HIPAA, plans such as this one are generally required to limit the use and disclosure of your PHI to treatment, payment, and health care operations. This section of this planbook explains some of HIPAA's requirements. Additional information is contained in the SEDIP's notice of privacy practices at the front of this planbook. You may also request a copy of this notice by contacting the SEIB.

Disclosures of Protected Health Information to the Plan Sponsor

For your benefits to be properly administered, the SEDIP needs to share your PHI with the plan sponsor (the State of Alabama). The SEDIP may disclose your PHI to the plan sponsor under the following circumstances:

- The SEDIP may disclose your PHI to the plan sponsor for plan administrative purposes, as required by law, or as permitted under HIPAA regulations. This is because employees of the plan sponsor perform some of the administrative functions necessary for the management and operation of the SEDIP.

The following restrictions apply to the plan sponsor's use and disclosure of your PHI:

- The plan sponsor will only use or disclose your PHI for plan administrative purposes, as required by law, or as permitted under HIPAA regulations. See the SEDIP's privacy notice for more information about permitted uses and disclosures of PHI under HIPAA.

- If the plan sponsor discloses any of your PHI to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to keep your PHI as required by HIPAA regulations.

- The plan sponsor will not use or disclose your PHI 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 SEDIP any use or disclosure of your PHI that is inconsistent with the uses or disclosures allowed in this section of this planbook.

- The plan sponsor will allow you or the SEDIP to inspect and copy any PHI about you that is in the plan sponsor's custody and control. HIPAA regulations set forth the rules that you and the SEDIP must follow in this regard. There are some exceptions.

- The plan sponsor will amend, or allow the SEDIP to amend, any portion of your PHI to the extent permitted or required under HIPAA regulations.

- Concerning 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 PHI available to the SEDIP 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 PHI in the plan sponsor's custody or control that the plan sponsor has received from the SEDIP or any business associate when the plan sponsor no longer needs your PHI to administer the SEDIP. If it is not feasible for the plan sponsor to return or destroy your PHI, the plan sponsor will limit the use or disclosure of any PHI 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 PHI in accordance with 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 PHI 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 SEDIP to correct the violation, impose appropriate sanctions, and 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 PHI:

- The plan sponsor will have in place appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of your electronic PHI, 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 PHI in accordance with HIPAA regulations.

- If the plan sponsor discloses any of your electronic PHI 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 HIPAA regulations.

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

Our Use and Disclosure of Your Personal Health Information

BCBS and other business associates of the SEDIP have an agreement with the SEDIP that allows them to use your PHI for treatment, payment, health care operations, and other purposes permitted or required under HIPAA. By applying for coverage and participating in the SEDIP, you agree that the SEDIP, and its business associates, may obtain, use, and release all records about you and your minor dependents

needed to administer the SEDIP 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 SEDIP. 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.

HIPAA privacy provisions 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 of 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
PO Box 304900
Montgomery, AL 36130-4900

Chapter 12
General Provisions

Delegation of Discretionary Authority to Blue Cross

The SEIB has delegated to BCBS the discretionary responsibility and authority to determine claims under the SEDIP, to construe, interpret, and administer claims, and to perform every other act necessary or appropriate in connection with claims administration services under the SEDIP.

Whenever BCBS makes reasonable determinations that are neither arbitrary nor capricious in the administration of claims of the SEDIP, those determinations will be final and binding on you, subject only to your right of review under the SEDIP.

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 incorrect, 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 the 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 the SEIB are not required to do anything to enable providers to furnish services, supplies, or facilities to you.

Misrepresentation

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

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 SEDIP, may be required, upon a determination by the SEIB (1) to repay all claims and other expenses, including interest, incurred by the SEDIP related to the intentional submission of false or misleading information or fraudulent activity and (2) be subject to disqualification from coverage under the SEDIP.

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 nor 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 applying for coverage or a claim for benefits, you agree that 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 allowed amount paid by BCBS as benefits, you are responsible for the charges above 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 SEDIP 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 SEDIP, make any agreement or promise, not specifically contained in the SEDIP, or waive any provision of the SEDIP.

Rescission

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

No Assignment

The SEDIP will not honor an assignment of your claim to anyone. Some of the contracts BCBS has with

providers require BCBS to pay benefits directly to the providers. With other claims, BCBS may choose whether to pay you or the provider. If you or the provider owes the SEDIP money, BCBS may deduct the amount owed from the benefit paid. When BCBS pays or deducts the amount owed from you or the provider, this completes our obligation to you under the SEDIP. Upon your death or incompetence, or if you are a minor, the SEDIP may pay your estate, your guardian, or any relative the SEDIP believes is due to be paid. This, too, completes SEDIP's plan obligation to you.

Chapter 13
Coordination of Benefits (COB)

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 considering the existence of any other plan.

A secondary plan is one that takes into consideration the benefits of the primary plan before determining the 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:

Non-compliant Plan: If the other plan is a non-compliant 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 is 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) third, 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 for 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. In some instances, when this plan is a secondary plan, it may be more cost-effective for the plan to pay on a claim as if it were the primary plan. If the plan elects to pay a claim as if it were primary, it shall calculate and pay benefits as if no other coverage were involved.

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 (a) 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 the 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 “non-compliant plan” means a plan with COB rules that are inconsistent in substance with the order of benefit determination rules of this plan. Examples of non-compliant 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 considering the existence of any other plan. 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 provision; or
- All plans that cover the person use the order of benefit determination rules required by this provision, 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 to apply these rules and determine benefits payable under this plan and other plans covering the person claiming benefits. BCBS is not required to tell

or get the consent of any person to do this. Each person claiming benefits under this plan must give BCBS any facts it needs 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, BCBS 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. BCBS 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 BCBS is more than it should have paid under this COB provision, BCBS 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 14
Subrogation

Right of Subrogation

If BCBS pays or provides any benefits for you under the SEDIP, 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 SEDIP has paid or provided. SEDIP may use your right to recover money from that other person or organization. Your right to be made whole is superseded by SEDIP's right of subrogation.

Right of Reimbursement

Besides the right of subrogation, the SEDIP has a separate right to be reimbursed or repaid from any money you, including your family members, recover for an injury or condition for which the SEDIP has paid plan benefits. This means that you promise to repay the SEDIP the amount the SEDIP has paid or provided in plan benefits from any money you recover. It also means that if you recover money as a result of a claim or a lawsuit, whether by settlement or otherwise, you must repay the SEDIP. And, if you are paid by any person or company besides the SEDIP, including the person who injured you, that person's insurer, or your own insurer, you must repay the SEDIP. In these and all other cases, you must repay the SEDIP.

The SEDIP has the right to be reimbursed or repaid first from any money you recover, even if you are not paid for your entire claim for damages and you are not made whole for your loss. This means that you promise to repay the SEDIP first even if the money you recover is for (or said to be for) a loss besides plan benefits, such as pain and suffering. It also means that you promise to repay the SEDIP first even if another person or company has paid for part of your loss, and it means that you promise to repay the SEDIP first even if the person who recovers the money is a minor. In these and all other cases, the SEDIP still has the right to first reimbursement or repayment out of any recovery you receive from any source.

Right to Recovery

You agree to promptly furnish BCBS with 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 the three questionnaires will have their claims suspended until they have complied with the questionnaire**.

You or your attorney will notify BCBS before filing any suit or settling any claim to enable the SEDIP to participate in the suit or settlement to protect and enforce this Plan's rights under this section. If you do notify BCBS so that the SEDIP can and does recover the amount of SEDIP benefit payments for you, the SEDIP will share proportionately with you in any attorney's fees charged to you by your attorney for obtaining the recovery. If you do not give us that notice, or we retain our own attorney to appear in any court (including bankruptcy court), our reimbursement or subrogation recovery under this section will not be decreased by any attorney's fee for your attorney or under the common fund theory.

You further agree not to allow the reimbursement and subrogation rights of SEDIP 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, the SEIB may suspend or terminate payment or provision of any further benefits for you under the SEDIP.

Chapter 15
Filing a Claim, Claim Decisions & Appeal of Benefit Denial

The following explains the rules under the SEDIP for filing claims and appeals with BCBS.

Filing of Claims Required

A claim prepared and submitted to BCBS must be received by BCBS before it can consider any claim for payment of benefits for services or supplies. In addition, certain services must be approved by BCBS in advance before they will be recognized as benefits. No communications with BCBS 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 BCBS 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 BCBS 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

BCBS's 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. BCBS 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, BCBS may pay 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 SEDIP will pay for covered services you receive after the effective date of your coverage.

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

Your dental plan includes a provision for pre-determination of benefits for bridgework, crowns, onlays, 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) above $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 planbook. 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 www.AlabamaBlue.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 planbook.

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.

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. Inform BCBS of the type of service or supply for which you wish to file a claim (e.g., hospital, physician 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 within365 days 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 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: BCBS encourages, but does 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 (e.g., BCBS cannot get the information it needs to make an informed decision), BCBS will let you know. In either case, courtesy pre-determinations are not claims under the SEDIP. 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 SEDIP 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 hours-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 Planbooks

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

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 www.AlabamaBlue.com. 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
PO Box 12185
Birmingham, Alabama 35202-2185

Please note that if you call or write BCBS without following the rules just described for filing an appeal, BCBS will not treat your inquiry as an appeal. BCBS will strive to resolve your questions or concerns.

Conduct of the Appeal

BCBS will assign your appeal to one or more persons within the organization who are neither the persons who made the initial determination nor the subordinates of those persons. If the 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 its 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
- you may file a voluntary appeal (discussed below);

You may file a claim for external review for a claim involving medical judgment or rescission of your plan coverage (discussed below).

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 its decision. You must request this external review within four months of the date of your receipt of BCBS's 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
PO Box 10744
Birmingham, AL 35202-0744

If you request an external review, an independent organization will review BCBS's 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 allow BCBS 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 16
SEIB Appeals Process

General Information

Issues involving eligibility and enrollment should be addressed directly with the SEIB through the appeal process outlined below. However, all issues regarding benefit determinations should be addressed through the BCBS appeal process outlined in Chapter 15. The following issues will not be reviewed under the SEIB appeal process:

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

Note: Medical decisions will not be questioned.

All requests must be sent to the following address:

State Employees' Insurance Board
Attention: Legal Department
P.O. Box 304900
Montgomery, Alabama 36130-4900

Informal Review

If you feel an enrollment or eligibility decision was not in conformity with SEIB rules, policies, or procedures, you may request an informal review. In many cases, the issue can be resolved over the phone without the need for an administrative review or formal appeal. A request for an informal review must be received by the SEIB within 60 days from the date of an adverse decision by the SEIB. Untimely requests will be denied.

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 received by the SEIB within 60 days from the date of the informal review decision. Untimely requests will be denied. If the SEIB determines that an administrative review is appropriate, you will be sent an SEIB administrative review form to complete and return. A copy of the initial adverse determination and informal review decision must be submitted with the administrative review form. The administrative review committee will review the request, usually within 60 days. Oral arguments will not be considered unless approved by the SEIB. The administrative review committee will issue a decision in writing to all parties involved in the review.

Formal Appeal

If you do not agree with the administrative review decision, you may file a request for a formal appeal before the Board of Directors. Requests for a formal appeal must be received by the SEIB within 60 days following the date of the administrative review committee's decision. Untimely requests will be denied. Oral arguments will not be considered unless approved by the SEIB. If your request for a formal appeal is granted, generally, a decision will be issued within 90 days following approval of the request for a formal appeal. The number of days may be extended by notice from the SEIB. If you have not received a decision or notice of extension within 90 days, you may consider your appeal denied. The Board's decision is the final step in the SEIB appeal process and will exhaust all administrative remedies.

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

Chapter 17
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 or Allowance: The amount of a dentist's charge that BCBS will recognize as covered expenses for medically/dentally necessary services provided by the SEDIP. 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 above the allowable amount.

Blue Cross and Blue Shield of Alabama (BCBS): 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 planbook.

Dental Necessity or Dentally Necessary: 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; and
- not primarily for the convenience and/or comfort of you, your family, your dentist, or another provider of services.

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 supply 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 to determine whether to pay for the service or supply. All decisions concerning your treatment must be made solely by your attending dentist and other medical providers.

Member: An active/retired state employee or eligible dependent who has coverage under the SEDIP 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 1st through November 30th for a January 1st 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' Dental Insurance Plan (SEDIP): A self-insured dental benefits 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.

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

We, Us, Our: BCBS, the SEDIP, 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) 263-8300

Toll Free: 1-866-836-9737

Website: **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

Website: **AlabamaBlue.com**

Group Number 72013