# LGHIP Voluntary Insurance Plan

## Dental – Vision

Effective January 1, 2021

SOUTHLAND
BENEFIT SOLUTIONS

# STATE OF ALABAMA
# LOCAL GOVERNMENT HEALTH INSURANCE BOARD
# PO Box 304900
# MONTGOMERY, ALABAMA 36130-4900
# 334-263-8326 | 1-866-836-9137
# LOCAL GOVERNMENT HEALTH INSURANCE BOARD
# VOLUNTARY 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 Local Government Health Insurance Board Voluntary 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 a 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 with respect to your protected health information;
- the Plan's obligations with respect to 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; 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, 2021.

**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 genetic protected health information for underwriting purposes. It also includes quality assessment and improvement and reviewing competence or qualifications of health care professionals. For example, the Plan may use medical benefit claims information to conduct a review of the accuracy of how benefit claims are being paid.

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 health plan or obtaining premium bids from health plans providing coverage under the group health 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 334-263-8326.

**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 an 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 334-263-8326.

**Your Privacy Rights**

This section of the notice describes your rights with respect to 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 unsecured PHI.

**Restrict Uses and Disclosures.** You have the right to request that the Plan restricts uses 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 health care 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 doesn't 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 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 334-263-8326. 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 334-263-8326.

**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 334-263-8326.

Revision 10-2020

## Table of Contents

# Introduction

This summary of health care benefits available to you through the Local Government Health Insurance Plan Voluntary Insurance Coverage Plan (hereinafter referred to as "the Plan") is designed to help you understand your coverage. All terms, conditions and limitations are not covered here. All benefits are subject to the terms, conditions and limitations of the contract or contracts between the Local Government Health Insurance Board (LGHIB) and Southland Benefit Solutions (Southland). The LGHIB shall have absolute discretion and authority to interpret the terms and conditions of the Plan and reserves the right to change the terms and conditions and/or end the Plan at any time and for any reason. Participation in this Plan is completely voluntary, based on elections you make for yourself and your dependents in the time and manner described below.

The Plan offers two plans of insurance, dental and vision, which can be purchased individually or together. They are administered by Southland Benefit Solutions (Southland).

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

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

# General Information

## Eligible Participants

All participants who are eligible for coverage through the Local Government Health Insurance Plan (LGHIP) are eligible to participate in the Plan.

Employees that elect to participate in the Plan will have coverage effective the first day of the second month following receipt by the LGHIB of their enrollment form.

Note: A minimum enrollment of 12 months is required for employees and/or dependents, unless there is a qualifying event (death, divorce or loss of dependent status).

## Eligible Dependents

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

1. Your spouse (excludes a divorced spouse).

2. A child under age 26, only if the child is:
   a. your son or daughter,
   b. a child legally adopted by you or your spouse, or
   c. your stepchild.

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

4. An incapacitated dependent over age 25 will be considered for coverage provided the dependent:
   a. is unmarried,
   b. is permanently mentally or physically disabled or incapacitated,
   c. is so incapacitated as to be incapable of self-sustaining employment,
   d. is dependent on you for 50% or more financial support,
   e. is otherwise eligible for coverage as a dependent except for age,
   f. the condition must have occurred prior to the dependent's 26th birthday, and
   g. is not eligible for any other group health insurance benefits.

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

To apply, contact the LGHIB to obtain an Incapacitated Dependent Certification form. Final approval of incapacitation will be determined by medical review. Proof of disability must be submitted to the LGHIB within 60 days from the date the child would otherwise cease to be covered because of age.

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

## Employee Enrollment

Employees may enroll for coverage at any time. Coverage will be effective the first day of the second month following receipt by the LGHIB of their enrollment form.

Enrollment in this plan requires a minimum participation of 12 months. Eligible participants may cancel coverage in the Plan during the next open enrollment after the 12-month minimum participation period has been met.

## Open Enrollment

There shall be an annual open enrollment held in November (for coverage to be effective January 1).

Eligible participants may add dependents or family coverage during the open enrollment period. If an employee wishes to add dependents or add family coverage during open enrollment, a change form (form LG08) must be filled out and submitted to the LGHIB.

Forms shall be completed and signed in November, with an effective date of January 1 indicated on the form, and submitted to the LGHIB office by November 30. If an employee does not want to make changes during open enrollment, no paperwork is necessary.

## Acquiring New Dependents

A newly acquired dependent may be enrolled if the LGHIB is notified within 60 days of acquiring the new dependent through marriage, birth, adoption, or custody of a grandchild, niece or nephew. The effective date of coverage will be the first day of the next month after the Southland change form is submitted to the LGHIB office. If the LGHIB is notified of a new dependent after the 60 days, the eligible participant will not

be allowed to enroll the newly acquired dependent at that time and will need to reapply during the annual open enrollment.

Appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.) must be submitted to the LGHIB. Note: to ensure that enrollment deadlines are met, change forms should be submitted to the LGHIB even if all the required documentation is not available. If the required documentation is not submitted with the Southland enrollment/change form, the LGHIB will send notice to the employee that the required documentation must be submitted to the LGHIB office within 60 days of the date of the letter from the LGHIB. If the documentation is not submitted to the LGHIB within those 60 days, the request to add dependent coverage will be denied.

## Cancellation of Dependent or Family Coverage

A minimum enrollment of 12 months is required for employees or dependents before coverage may be canceled during the next Open Enrollment unless there is a qualifying event (death, divorce or loss of dependent status).

Dropping dependent coverage requires a qualifying event (death, divorce, or otherwise losing dependent status) outside open enrollment. Coverage will be canceled at the end of the month of the qualifying event. The LGHIB may require proof of a qualifying event.

## Leave Without Pay and Military Leave

Enrollment in this plan requires a minimum participation of 12 months. If an employee returns to work and did not continue their coverage while on leave without pay or military leave, they will be re-enrolled in the Plan to satisfy the 12-month requirement. The employee may cancel coverage in the Plan the next open enrollment after the 12-month minimum participation has been met.

# General Provisions

## Privacy of Your Protected Health Information

The confidentiality of your protected health information is important to the LGHIB. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), plans such as this one are generally required to limit the use and disclosure of your protected health information to treatment, payment, and health care operations. Information is contained in the plan's notice of privacy practices. You may request a copy of this notice by contacting the LGHIB.

## Use and Disclosure of Your Protected Health Information

Southland, and other business associates of this plan, have an agreement with the plan that allows them to use your health information for treatment, payment, health care operations, and other purposes permitted or required under HIPAA. By applying for coverage and participating in the plan, you agree that the Plan, and its business associates, may obtain, use, and release all records about you and your dependents needed to administer the plan or to perform any function authorized or permitted by law. You further direct all persons to release all records about you and your dependents needed to administer the plan.

## Responsibility for Actions of Providers of Services

Southland and the LGHIB will not be responsible for any acts or omissions, whether negligent, intentional, or otherwise, by any institution, facility, or individual provider in furnishing or not furnishing any services, care, treatment, or supplies to you. Southland and the LGHIB 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. Southland and the LGHIB are not required to do anything to enable providers to furnish services, supplies, or facilities to you.

## Misrepresentation

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

## Obtaining, Use and Release of Information

By submitting your application for coverage or any claims for benefits, you authorize Southland to obtain from all providers, hospitals, facilities, other providers of service, and all other persons or institutions having information concerning you, all records which in its judgment are necessary or desirable for processing your claim, performing

our contractual duties or complying with any law. You also authorize providers of health services, and any other person or organization, to furnish to Southland any such records or information it requests.

Further, you authorize Southland to use and release to other persons or organizations any such records and information as considered necessary or desirable in its judgment. Neither Southland nor any provider, other person or organization will be liable for obtaining, furnishing, using, or releasing any such records or information.

### Responsibility of Members and Providers to Furnish Information

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

- A claim for the benefits must be properly submitted to and received by Southland.
- A provider, hospital, or other provider that has furnished or prescribed any services or supplies to a member must provide the records, information, and evidence Southland requests in connection with benefits claimed or paid.
- A member who receives services or supplies for which benefits are claimed must provide the records, information and evidence Southland requests.

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

### Applicable State Law

The Plan is administered in the state of Alabama and will be governed by the law of Alabama to the extent that state law is applicable.

### I.D. Card

An identification card will be provided by Southland.

### Claim Forms

Claim forms may be obtained from Southland (www.SouthlandLGHIP.com) and may also be downloaded from the LGHIB's website.

## Claims Administrator

The claims administrator for the Plan is:

**Southland Benefit Solutions**
**PO Box 1250**
**Tuscaloosa, Alabama 35403**
**1-866-327-6674**

## Payment and Claim Filing Limitations

All claims must be submitted in writing and such writing must be received by Southland **no later than 365 days** following the date covered expenses are incurred. If a claim is not submitted and received by Southland within this period, the claim for that benefit will not be paid.

Claim forms must be completed, with proper documentation and certification from the health care provider, upon submission. Failure to provide a completed claim form may cause delays in claims processing and may be cause for the denial of the claim.

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

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

**THE TOTAL AMOUNT THAT IS PAYABLE UNDER ALL PLANS WILL NOT BE MORE THAN 100% OF THE MAXIMUM ALLOWABLE EXPENSES.**

## Termination of Coverages

Coverage remains in effect through the last day of the month in which employment terminates.

Coverage will be terminated in accordance with applicable federal and state laws and regulations. Please see the section “Continuation of Coverage” in this brochure which outlines your rights under the Public Health Service Act [42 USC Sections 300bb-1 through 300bb-8].

## Incorrect Benefit Payments

Every effort is made to promptly and correctly process claims. If payments are made to you in error, or to a provider who furnished services or supplies to you, and Southland later determines that an error has been made, you or the provider will be required to repay any overpayment. If repayment is not made, Southland may deduct

the amount of the overpayment from any future payment to you or the provider. If this action is taken, Southland will notify you in writing.

## Fraudulent Claims

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

## Customer Service

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

## Southland Appeal Process

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

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

2. Southland will review the claim, any written requests or other evidence received from the participant and advise the participant of its final determination. The Southland decision will be final and will exhaust all administrative remedies.

## LGHIB Appeal Process

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

Medical 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:

**Local Government Health 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 LGHIB 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 LGHIB within 60 days from the date of an adverse decision by the LGHIB. 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 LGHIB within 60 days from the date of the informal review decision. Untimely requests will be denied. If the LGHIB determines that an administrative review is appropriate, you will be sent an LGHIB 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 LGHIB. 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. Requests for a formal appeal must be received by the LGHIB 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 LGHIB. If your request for a formal appeal is granted, generally, a decision will be issued within 90 days following approval of the request for formal

appeal. The number of days may be extended by notice from the LGHIB. If you have not received a decision or notice of extension within 90 days, you may consider your appeal denied. The Board's decision will be final and all member administrative appeal options will be exhausted.

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

# Continuation of Group Health Coverage (COBRA)

## Introduction

The Public Health Service Act [42 USC Sections 300bb-1 through 300bb-8] requires that the LGHIB offer covered employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plan would otherwise end. COBRA coverage can be particularly important as it will allow you to continue this Plan's 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 carefully.***

## What is COBRA Continuation Coverage?

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

## Who is a Qualified Beneficiary?

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

## COBRA Rights for Covered Employees

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

- 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 LGHIB that you do not intend to return to work, whichever occurs first.

### COBRA Rights for a Covered Spouse and Dependent Children

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

- 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 Plan because any of the following qualifying events occurs:

- 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 Plan as a dependent child.

### What Coverage is Available?

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

### When is COBRA Coverage Available?

COBRA continuation coverage will be offered to qualified beneficiaries only after the LGHIB has been notified that a qualifying event has occurred.

### When Should Your Unit Notify the LGHIB?

Your employer is responsible for notifying the LGHIB of the following qualifying events:

- End of employment
- Reduction of hours of employment or
- Death of an employee

### When Should You Notify the LGHIB?

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

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

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

### How is COBRA Coverage Provided?

When the LGHIB 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 coverage under the Plan will end.

After the LGHIB receives timely notice that a qualifying event has occurred, the LGHIB 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 Plan, or (2), the date on which the LGHIB 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 LGHIB.

Once the LGHIB has been notified of your qualifying event, your coverage under the Plan 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 LGHIB will retroactively reinstate your coverage and process claims incurred during the 60-day election period.

Because there may be a lag between the time your coverage under the plan ends and the time we learn of your loss of coverage, it is possible that the Plan may pay claims incurred during the 60-day election period. If this happens, you should not assume that you have coverage under the Plan.

The only way your coverage will continue is if you elect to buy COBRA coverage and pay your premiums on time.

### What will be the Length of COBRA Coverage?

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

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

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

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

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

- Disability – if you or a covered member of your family is or becomes disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act and you timely notify the LGHIB, 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 LGHIB 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 LGHIB within 30 days of any revocation of Social Security disability benefits.

- Extensions of COBRA for Second Qualifying Events – for a spouse and children receiving COBRA coverage, the 18-month period may be extended to 36 months if another qualifying event occurs during the 18-month period, if you give the LGHIB timely notice of the second qualifying event. The 36-month period will run from the date of the termination of employment or reduction in hours. This extension is available to a spouse and children receiving COBRA coverage if the covered employee or former employee dies, becomes enrolled in Medicare, gets divorced, or if the child stops being eligible under the plan

as a dependent child, but only if the event would have caused the spouse or child to lose coverage under the plan had the first qualifying event not occurred. For example, if a covered employee is terminated from employment, elects family coverage under COBRA, and then later enrolls in Medicare, this second event will rarely be a second qualifying event that would entitle the spouse and children to extended COBRA coverage. This event would not cause the spouse or dependent children to lose coverage under the plan if the covered employee had not been terminated from employment.

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

## Can New Dependents Be Added to Your COBRA Coverage?

You may add new dependents to your COBRA coverage under the circumstances permitted under the Plan. Except as explained below, any new dependents that you add to your COBRA coverage will not have independent COBRA rights. For example, 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 LGHIB 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 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 COBRA Coverage?

If you qualify for continuation coverage, you will be required to pay the group's premium plus a 2% administrative fee directly to the LGHIB. 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 months 19 through 29 of coverage, or the month that begins more than 30 days after the date is determined that you are no longer disabled under Title II or Title XVI of the Social Security Act, whichever comes first. (If the only persons who elect the disability extension are non-disabled family members, the cost of coverage will remain at 102% of the full cost of coverage).

Your coverage will be canceled if you fail to pay the entire amount in a timely manner.

## When is my COBRA Coverage Premium Due?

Your initial premium payment must be submitted to the LGHIB within forty-five (45) days from your date of election. All subsequent premiums are due on the first day of the month of coverage. There is a 30-day grace period.

## Termination of Continuation Coverage

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

1. The LGHIB no longer provides group health coverage;
2. The unit withdraws from the LGHIP;
3. The premium for your continuation coverage is not paid on time;
4. You become covered, after electing continuation coverage, under another group plan;
5. You become entitled to Medicare;
6. 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 Plan. For example, if you submit fraudulent claims, your coverage will be terminated.

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

**Note**: If you are entitled to Medicare before you become a qualified beneficiary, you may elect COBRA continuation coverage; however, your Medicare coverage will be

primary and your COBRA continuation coverage will be secondary. You must have Medicare Parts A and B in order to have full coverage.

## Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

## Keep the LGHIB Informed of Address Changes

In order to protect your family's rights, you must keep the LGHIB 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 LGHIB.

## If You Have Any Questions

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. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

## LGHIB Contact Information

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

**Local Government Health Insurance Board**
**LGHIB COBRA Section**
**201 South Union Street, Suite 200**
**PO Box 304900**
**Montgomery, AL 36130-4900**

# Dental Benefits Program

## Plan Summary

Dental Benefit Schedule

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

**NO ORTHODONTIC BENEFITS**

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

## Covered Dental Expenses

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

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

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

## Reasonable and Customary Charges

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

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

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

- **Circumstances or complications** requiring additional time, skill and experience.

## Diagnostic and Preventive Expenses

This plan will pay all reasonable and customary charges for:

Oral examinations and office visits, but not more than two (2) examinations or office visits in a plan year. An examination and office visit are synonymous for the purposes of this benefit. This category includes procedures performed by a dentist that aid in making diagnostic conclusions about the oral health of the individual patient and the dental care required. This limitation would not apply to emergency office visits.

Prophylaxis, includes cleaning and scaling of teeth, but not more than two (2) times in a plan year. Charges for this type of treatment performed by a licensed dental hygienist are also included if rendered under the supervision of a licensed dentist.

Topical application of fluoride, benefits are provided to cover topical application of fluoride for two (2) treatments per plan year. Benefits are available for covered children to age 19.

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

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

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

## Other Covered Dental Expenses

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

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

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

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

General anesthesia: When medically necessary and administered in connection with oral surgery.

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

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

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

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

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

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

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

## Pre-Determination of Benefits

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

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

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

After the course of treatment is completed, the Plan benefit shall be paid in accordance with the final claim submitted by the dentist. In the event of any change in the final claim or treatment, Southland shall adjust payment accordingly. In the event the dentist makes a major change in the treatment plan, the dentist should send in a revised plan.

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

### Alternate Procedures

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

### COBRA

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

2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

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

### Longer/Shorter Length of Coverage

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

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

**Determination of Amount of Payment**

1. If this plan is primary, it shall pay benefits as if the secondary plan did not exist.

2. If our records indicate this plan is secondary, we will not process your claims until you have filed them with the primary plan and the primary plan has made its benefit determination.

If this plan is a secondary plan on a claim, should it wish to coordinate benefits (that is, pay benefits as a secondary plan rather than as a primary plan with respect to that claim), this plan shall calculate the benefits it would have paid on the claim in the absence of other healthcare coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. When paying secondary, this plan may reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other healthcare coverage. 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.

## DentaNet Benefits

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

## Dental Exclusions

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

1. Expenses incurred by or on account of an individual prior to such person's effective date of coverage under the plan.
2. Replacement of teeth removed before coverage is effective.
3. Work done for appearance (cosmetic) purposes. Facing on crowns and pontics posterior to the second bicuspid are always considered to be cosmetic.
4. Work done while not covered under this plan.
5. Services or supplies in connection with orthodontia except for extractions.
6. Extra sets of dentures or other appliances.
7. Missed appointment.
8. Replacing lost or stolen prosthetic appliances.
9. Completion of claim forms or filing of claims.
10. Educational or training programs, dietary instructions, plaque control programs, and oral hygiene information.
11. Implantology (implants).
12. Periodontal splinting.
13. Work covered under the group health plan.
14. Experimental procedures.
15. Drugs or their administration.
16. Anesthetic services billed by anyone other than the attending dentist or his or her assistant.
17. Services and supplies not ordered by a dentist or physician and not reasonably necessary for treatment of injury or dental disease.
18. Appliances, restorations, and procedures to alter vertical dimension including, but not limited to, harmful habit appliances.
19. Services or supplies that exceed the reasonable and customary charges in Alabama.
20. Treatment of an accident related to employment or sickness if either or both are covered under Workers' Compensation or similar laws.
21. Work that is otherwise free of charge to patients or charges that would not have been made if there were no insurance.
22. Work that is furnished or payable by the Armed Forces of any government.
23. Services or supplies furnished by the United States, state or local government.

24. Services received for injuries or sickness due to war or any act of war, whether declared or undeclared, which war or act of war shall have occurred after the effective date of this plan.
25. Expenses to the extent of benefit provided under any employer group plan other than this plan in which the state of Alabama participates in the cost thereof.
26. Such other expenses as may be excluded by regulations of the board.
27. Gold foil restorations.
28. Pulp capping or acid etching as a separate procedure.
29. Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes.
30. Periodontal cleaning aids or devices.
31. Specific charges for infection control and/or protection supplies, including but not limited to, gloves, masks, gowns, shoes or other items.
32. Microscopic bacteriological examinations.
33. Antimicrobial irrigation.
34. Temporomandibular joint (TMJ) disorders.
35. Benefits are not provided for temporary partials.
36. Expenses for which the individual is not required to make payment, including but not limited to, reductions or readjustments to the charges made by the health care provider.
37. All claims not submitted in writing, not completed, without the requisite certification of the health care provider, or received by Southland more than 365 days following the claim incurrence.
38. Services of a dentist who is related to the member by blood or marriage or who regularly resides in the same household.
39. Hospital expenses for dental work performed in the hospital.

## Coordination of Dental Benefits

If an enrolled member is covered under more than one group dental plan or is entitled to any other source, the total amount that is payable under all plans will not be more than 100% of the maximum allowable expenses.

Order of Benefit Determination

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

Noncompliant Plan

If the other plan is a noncompliant plan, then the other plan shall be primary and this

plan shall be secondary unless the coordination of benefits terms of both plans provide that this plan is primary.

Employee/Dependent

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

Dependent Child – Parents Not Separated or Divorced

If both plans cover the patient as a dependent child of parents who are married or living together (regardless of whether they have ever been married), the plan of the parent whose birthday falls earlier in the year will be primary. If the parents have the same birthday, the plan covering the patient longer is primary.

Dependent Child – Separated or Divorced Parents

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

1. If there is no court decree allocating responsibility for the child's dental care expenses or dental care coverage, the order of benefits for the child are as follows:

    a. first, the plan of the custodial parent;

    b. second, the plan covering the custodial parent's spouse;

    c. third, the plan covering the non-custodial parent; and

    d. last, the plan covering the non-custodial parent's spouse.

2. If a court decree states that a parent is responsible for the dependent child's dental care expenses or dental care coverage and the plan of that parent has actual knowledge of those terms, the plan of the court-ordered parent is

primary.

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

a. first, the plan of the spouse of the court-ordered parent;

b. second, the plan of the non-court-ordered parent; and

c. last, the plan of the spouse of the non-court-ordered parent. If a court decree states that both parents are responsible for the dependent child's dental care expenses or dental care coverage, the provisions of “Dependent Child – Parents Not Separated or Divorced” (the “birthday rule”) above shall determine the order of benefits.

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

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

Active Employee or Retired or Laid-Off Employee

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

2. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.

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.

**Coordination of Benefits 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: (a) the amount of any reduction in benefits under a primary plan because the covered person failed to comply with the primary plan's provisions concerning second surgical opinions or precertification of admissions or services, or (b) the covered person had a lower benefit because he or she did not use an in-network dentist.

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

**Custodial Parent:** The term "custodial parent" means:

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

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

**Noncompliant Plan**: The term "noncompliant plan" means a plan with coordination of benefits rules that are inconsistent in substance with the order of benefit determination

rules of this plan. Examples of noncompliant plans are those that state their benefits are “excess” or “always secondary.”

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

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

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

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

# Vision Program

## Coverage and Maximum Annual Benefits

| | |
|---|---|
| Examination (actual charges not to exceed): | $75.00 |
| AND | |
| Frames | $75.00 |
| Lenses not to exceed: | |
| Single Vision | $80.00 |
| Bifocals | $105.00 |
| Trifocals | $150.00 |
| Lenticular | $175.00 |
| OR | |
| Contacts | $150.00 |
| OR | |
| Refractive Surgery | $150.00 |

Plan provides benefits for only one of the following in the same plan year: (a) contacts, (b) frames and lenses, or (c) refractive surgery.

It is the responsibility of the member to submit a claim for (a) contacts, (b) frames and lenses, or (c) refractive surgery, and the payment will be made based on the date the claim is received.

### Limitations

Examinations: One in any plan year.

Only one of the following in a plan year:

- Contacts – One new prescription or replacement, or
- Frames and Lenses: One new or replacement frame and one new lens prescription or replacement, or
- Refractive Surgery: One surgery per eye

Vision Examination**:** Consisting of one or more, but not limited to the following component services when performed by a licensed ophthalmologist or optometrist:

- case history
- external examination of the eye and adnexa
- determination of refractive status
- ophthalmoscopy

- application of pharmaceutical agents for diagnostic purposes when indicated and allowed by state law
- tonometry test for glaucoma when indicated
- binocular measure
- summary finding and recommendations
- prescribing corrective lenses, if needed

## Definitions

Bifocal lenses: Lenses containing two foci (points of convergence of rays of light), usually arranged with the focus for distance above and a smaller segment for near focus below.

Trifocal lenses: Lenses containing three foci, usually arranged with the focus for distance above, for intermediate distance in the middle, and for near vision below.

Lenticular lenses: Special non-contact lenses for persons who have cataracts.

Contact lenses: Lenses which fit directly on the eyeball under the eyelids.

Frames: A standard eyeglass frame into which two lenses are fitted.

Ophthalmologist: A licensed doctor of medicine or osteopathy legally qualified to practice medicine and who, within the scope of his or her license, performs vision examinations, prescribes lenses to improve visual acuity, and performs surgical procedures to the eye.

Optometrist: Any doctor of optometry legally qualified to practice optometry in the state in which vision care services are rendered, that performs vision examinations and prescribes lenses to improve visual acuity.

Optician: A person qualified in the state in which the service is rendered to supply eye-glasses according to prescriptions written by an ophthalmologist or optometrist, to grind or mold lenses or have them ground or molded according to prescription, to fit them into a frame and to adjust the frame to fit the face.

Lens or Lenses: Ophthalmic corrective lens or lenses, glass or plastic, ground or molded, as prescribed by an ophthalmologist or optometrist, to be fitted into a frame.

Refractive Surgery: Refractive eye surgery is a surgical method of vision correction by changing the refractive properties of the eye, with the goal to reduce or remove the need for corrective lenses. Types of surgery to correct refractive errors include: laser assisted in-situ keratomileusis (LASIK); photorefractive keratectomy (PRK); radial

keratotomy (RK); astigmatic keratotomy (AK); automated lamellar keratoplasty (ALK); laser thermal keratoplasty (LTK); conductive keratoplasty (CK); intracorneal ring (Intacs). Refractive surgery does not include any procedures covered under another health insurance plan.

## Vision Exclusions

Vision care plan benefits will not be provided for certain charges, including but not limited to charges for:

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

2. Services or supplies for which coverage is provided or available under the Local Government Health Insurance Program, or by Workers' Compensation Laws, or by any safety lens program;

3. Drugs or any other medication;

4. Any medical or surgical treatments (with the exception of refractive surgery);

5. Special or unusual treatment such as orthoptics, vision training, sub-normal vision aids, aniseikonia lenses or tonography;

6. Services or supplies not prescribed by a licensed physician, optometrist, or ophthalmologist, and lenses which do not require a prescription;

7. Service or supplies which are experimental in nature or are not approved by the American Ophthalmology Association;

8. The extra charge for oversized, photo sensitive, or anti-reflective lenses, whether or not medically necessary;

9. Sunglasses, including lenses and frames;

10. Follow-up visits, fitting fees, dispensing fees, coating or care kits;

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

12. All claims not submitted in writing, not completed, with the requisite certification of the health care provider or received by Southland more than 365 days following the claim occurrence.

13. Services of a physician who is related to the member by blood or marriage or who regularly resides in the same household.

## Coordination of Vision Benefits

If an enrolled member is covered under more than one group vision plan or is entitled to any other source, the total amount that is payable under all plans will not be more than 100% of the covered expenses.

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