Local Government Dental Benefit Plan

Effective January 1, 2023

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

STATE OF ALABAMA

LOCAL GOVERNMENT HEALTH INSURANCE BOARD

201 S. Union Street, Suite 200
MONTGOMERY, ALABAMA 36104
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LOCAL GOVERNMENT DENTAL BENEFIT 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 Dental Benefit 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, 2023.

HOW THE PLAN MAY USE AND DISCLOSES 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 their 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 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 can 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 11-2022

PREFERRED DENTAL BENEFITS

BENEFITS	PREFERRED	NON-PREFERRED
Deductible	$25 per member each calendar year; Maximum of three deductibles per family.	$25 per member 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 & 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. No dollar limit for medically necessary services for members under age 19*. All other services limited to a separate lifetime maximum of $1,000 per person. Coverage available to Dependent Children under age 19 **only***.	Covered at 50% of the Preferred Dental Fee Schedule subject to a $25 annual deductible. No dollar limit for medically necessary services for members under age 19*. All other services limited to a separate lifetime maximum of $1,000 per person. Coverage available to Dependent Children under age 19 **only***. Member responsible for difference in billed charges and allowed fee schedule.
Annual Benefit Maximum	No maximum for members under age 19*. $1,500 per member age 19 and over for all covered services.	
Annual Out-of-Pocket Maximum	For members under age 19*, deductibles and coinsurance for in-network (preferred) dental services will apply to the annual health in-network out-of-pocket maximum.	

*Applicable pediatric dental benefits apply to members through the end of the month in which the member turns 19.

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

Table of Contents

Chapter 1
Introduction

This summary of dental benefits available is designed to help you understand your coverage. This planbook supplements the Local Government Health Insurance Plan (LGHIP) planbook. Both planbooks must be used in conjunction when determining the terms, conditions, and limitations of your dental benefits. However, not all terms, conditions and limitations are covered in these planbooks. All benefits are subject to the terms, conditions and limitations of the contract or contracts between the Local Government Health Insurance Board (LGHIB) and Blue Cross Blue Shield of Alabama or other third-party administrators that the LGHIB may contract with that it deems is necessary to carry out its statutory obligations. 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.

Chapter 2
Overview of the Plan

Purpose of the Plan

The dental benefits offered through the LGHIP are intended to help you and your covered dependents pay for the costs of dental care. The LGHIP does not pay for all of your dental care. For example, you may also be required to pay deductibles, copayments, and coinsurance.

The LGHIP complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex.

Using myBlueCross to Get More Information

Blue Cross and Blue Shield of Alabama's (BCBS) website is www.AlabamaBlue.com. On their home page, you will see a section called ***my*BlueCross**, which will prompt you to register. Once you have registered, you will have access to information and forms that will help you take maximum advantage of your benefits under the LGHIP.

BlueCare Health Advocate

By being a member of the LGHIP, you have access to a BlueCare Health Advocate who serves as a personal coach and advisor. Your BlueCare Health Advocate can explain your benefits, help you to locate a doctor or specialist and help you make an appointment, research, and resolve hospital and doctor billing issues, assist you in finding support groups and community services available to you, and much more. To find out more or to contact your BlueCare Health Advocate, call BCBS's Customer Service Department at the number on the back of your ID card.

Definitions

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

Receipt of Dental Care

Even if the LGHIP 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

To be eligible for dental benefits, you must be enrolled in the LGHIP and your employer must elect dental coverage through the LGHIP for its employees.

Limitations and Exclusions

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

Dental Necessity

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

In-Network Benefits

One way in which the LGHIP manages dental care costs and provide enhanced dental 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. The National Dental Network (Dentemax) are in-network dentists located outside the state of Alabama. To locate in-network dentists for the LGHIP, visit 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 certain covered services or supplies from an out-of-network dentist, in most cases, you will have to pay significantly more than you would pay an in-network dentist because these out-of-network dental care providers can bill you amounts more than the allowable amounts under the LGHIP.

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

BCBS is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent BCBS plans. The Blue Cross and Blue Shield Association permits BCBS to use the BCBS service marks in 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 your employer will be responsible for honoring this contract. The purpose of this paragraph is for legal clarification; it does not add additional obligations on the part of BCBS not created under the original agreement.

Claims and Appeals

When you receive services from in-network dentists, your dentist will generally file claims for you. In other cases, you may be required to pay the provider and then file a claim with BCBS for reimbursement under the terms of the LGHIP. If a claim is denied in whole or in part, you may file an appeal. You will be given a full and fair review. For more information about claims and appeals, please refer to the LGHIP Health Benefits handbook.

Termination of Coverage

If coverage terminates, no benefits will be provided for services received after the coverage termination date, even if for a condition that began before the LGHIP or your coverage termination. In some cases, you will have the opportunity to buy COBRA coverage after your group coverage terminates.

Chapter 3
Eligibility

Members are only eligible for dental benefits through the LGHIP if their employer has elected BCBS dental coverage through the LGHIP and they are eligible for, and enrolled in, LGHIP coverage. For the LGHIP's eligibility requirements, please refer to the LGHIP planbook.

Chapter 4
Summary of Benefits

PREFERRED DENTAL BENEFITS		
BENEFITS	**PREFERRED**	**NON-PREFERRED**
Deductible	$25 per member each calendar year; maximum of three deductibles per family.	$25 per member each calendar year; maximum of three deductibles per family. Member responsible for any difference between billed charge and fee schedule reimbursement.
Diagnostic & Preventative 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 & 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. No dollar limit for medically necessary services for members under age 19*. All other services limited to a separate lifetime maximum of $1,000 per person. Coverage **only** available to dependent children under age 19**.**	Covered at 50% of the Preferred Dental Fee Schedule subject to a $25 annual deductible. No dollar limit for medically necessary services for members under age 19. All other services limited to a separate lifetime maximum of $1,000 per person. Coverage **only** available to dependent children under age of 19. Member responsible for difference in billed charges and allowed fee schedule.
Annual Benefit Maximum	No maximum for members under age 19. $1,500 per member age 19 and over for all covered services.	
Annual Out-of-Pocket Maximum	For members under age 19, deductibles and coinsurance for in-network (preferred) dental services will apply to the annual health in-network out-of-pocket maximum.	

*Applicable pediatric dental benefits apply to members through the end of the month in which the member turns 19.

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

Chapter 5
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 LGHIP and the provider must be a preferred dentist when the services are furnished to you.

- Separate and apart from the requirement in the previous paragraph, services and supplies must be furnished by a provider (whether preferred provider or not) who is recognized by BCBS as an approved provider for the type of service or supply being furnished. Call BCBS Customer Service if you have a question whether your provider is recognized by BCBS as an approved provider for the services or supplies you plan to receive.

- Services and supplies must be furnished when you are eligible and enrolled in the LGHIP and your coverage is fully paid for. If it is determined later that you or your dependent(s) were not eligible for coverage, you will be responsible to pay for services provided during the period of ineligibility. No benefits will be provided for services you receive after the LGHIP or your coverage ends, even if they are for a condition that began before the LGHIP or your coverage ends.

Chapter 6
Cost Sharing

Calendar Year Deductible	$25 (Does not apply to Diagnostic and Preventive Services.)
Calendar Year Maximum Benefits for Adults	$1,500

Calendar Year Deductible

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

- The calendar year deductible must be satisfied on a per person per calendar year basis. Once the maximum number of family members specified in the summary of benefits 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 LGHIP 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 more than the allowable amount. Generally, 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 more than the allowable amount.

Chapter 7
Dental Benefits

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

- All in-network dentists agree our payment is payment in full except for your deductible and coinsurance. If you are covered under another group dental plan, an in-network dentist may bill that plan for any difference between the allowable amount and his usual charge for a service.

- Out-of-network dentists may charge you the difference between the allowable amount and their billed charges.

- In-network dentists may not collect their fee for plan benefits from you except for deductibles and coinsurance. They must bill us first, except for services that are not plan benefits, such as implants.

SERVICE	BENEFIT
Basic – Diagnostic and Preventive Services	100%

- Dental exams, up to twice per calendar year.

- Dental X-ray exams:
  - Full mouth X-rays, one set during any 36 months in a row;
  - Bitewing X-rays, up to twice per calendar year; and
  - Other dental X-rays, used to diagnose a specific condition.

- Tooth sealants on first permanent molars, teeth numbers 3, 14, 19 and 30, limited to two applications per tooth per benefit period. Benefits are limited to a maximum payment of $20 per tooth and limited to children under age 19.

- Dental caries (cavities or tooth decay) prevention for children through age 5, four per calendar year.

- Fluoride treatment for children through the age of 18, twice per calendar year.

- Routine cleanings, twice per calendar year.

- Space maintainers (not made of precious metals) that replace prematurely lost teeth for children through age 18.

SERVICE	BENEFIT
Basic – Restorative Services	50%

- Fillings made of silver amalgam and tooth color materials (tooth color materials include composite fillings on the front upper and lower teeth numbers 5-12 and 21-28; payment allowance for composite fillings used on posterior teeth is reduced to the allowance given on amalgam fillings).

- Simple tooth extractions.

- Direct pulp capping, removal of pulp, and root canal treatment.

- Repairs to removable dentures.

- Emergency treatment for pain.

SERVICE	BENEFIT
Supplemental Services	50%

- Oral surgery, i.e., tooth extractions and impacted teeth and to treat mouth abscesses of the intra-oral and extra-oral soft tissue.

- General anesthesia when given for oral or dental surgery. This means drugs injected or inhaled to relax you or lessen the pain, or make you unconscious, but not analgesics, drugs given by local infiltration, or nitrous oxide.

- Treatment of the root tip of the tooth including its removal.

SERVICE	BENEFIT
Prosthetic Services	50%

- Full or partial dentures.

- Fixed or removable bridges.

- Inlays, onlays, veneers, or crowns to restore diseased or accidentally broken teeth, if less expensive fillings will not restore the teeth.

Limits on prosthetic services:

- Partial dentures – If a removable partial denture can restore the upper or lower dental arch satisfactorily, we will pay as though it were supplied even if you chose a more expensive means.

- Precision attachments – There are no benefits for precision attachments.

- Dentures – We pay only toward standard dentures.

- Replacement of existing dentures, fixed bridgework, veneers, or crowns – We pay toward replacing an existing denture, fixed bridgework, veneer, or crown only if the old one 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.

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.

ONLY FOR CHILDREN UNDER AGE 19	
SERVICE	**BENEFIT**
Orthodontic Services	Covered at 50% of the Preferred Dental Fee Schedule subject to a $25 annual deductible. No maximum dollar limit for medically necessary services for members under age 19, and all other services are limited to a separate lifetime maximum of $1,000 per person. Coverage only available to dependent children under age of 19.

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 will only be paid for months that you have orthodontic coverage. There are no benefits for orthodontic services for you or your dependents before coverage is in effect. If you started orthodontic services before this coverage began and complete them while covered, we will prorate the benefits for the services you get while covered.

- Any charge for the replacement and/or repair of any appliance furnished under the treatment plan shall not be paid.

- Applicable benefits apply through the end of the month in which the member turns 19.

Chapter 8
Dental Benefit Limitations

Limits to all benefits:

- Examination and diagnosis no more than twice during any calendar year.
- Full mouth X-rays will be provided once each 36 months; bitewings no more than twice during any calendar year.
- Routine cleaning will be provided no more than twice during any calendar year.
- Fluoride treatment will be provided to members through age 18 no more than twice during any calendar year.
- Tooth sealants on first permanent molars, teeth numbers 3, 14, 19 and 30, limited to two applications per tooth per benefit period. Benefits are limited to a maximum payment of $20 per tooth and limited to children under age 19.
- If you change dentists while being treated, or if two or more dentists do one procedure, we will pay no more than if one dentist did all the work.
- When there are two ways to treat you and both would otherwise be plan benefits, we will pay toward the less expensive one. The dentist may charge you for any excess.
- Prosthetic – Gold, baked porcelain restorations, veneers, crowns, and jackets – If a tooth can be restored with a material such as amalgam, we will 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 9
Dental Benefit Exclusions

The following benefits will not be provided:

A

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

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

B

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

C

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

Services or expenses for intraoral delivery of or treatment by **chemotherapeutic agents**.

Services or expenses for which a **claim** is not properly submitted.

Services or expenses of any kind either (a) for which a **claim** submitted for a member in the form prescribed by BCBS has not been received by BCBS, or (b) for which a claim is received by BCBS later than 365 days after the date services were performed.

Services or expenses of any kind for **complications** resulting from services received that are not covered 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.

E

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

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

F

Charges to use any **facility** such as a hospital in which dental services are rendered, regardless if 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 supplies 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 provide or pay 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 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 10
Filing a Claim

The following explains the rules under the LGHIP for filing dental claims 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, there are certain services that 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 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, become incompetent or are a minor, BCBS pays your estate, your guardian or any relative that, in its judgment, is entitled to the payment. Payment of benefits to one of these people will satisfy its obligation to you.

How to File Claims

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

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

Your dental plan includes a provision for pre-determination of benefits for bridgework, crowns, onlays and inlays and osseous surgery. The purpose of pre-determination of benefits is to assure you and the dentist that the proposed dental treatment is covered. 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) more than $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 visit BCBS's website at AlabamaBlue.com and request 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.

In order for BCBS to treat a submission by you or your provider as a post-service claim, it must be submitted on a properly completed standardized claim form or, in the case of electronically filed claims, must provide BCBS with the data elements that BCBS specifies in advance. Most providers are aware of BCBS's claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call the BCBS customer service department and ask for a claim form. When you receive the form, complete it, attach an itemized bill, and send it to BCBS at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858. Claims must be submitted and received by BCBS within 365 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 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 more information is needed, BCBS will ask you to furnish it, and will suspend further processing of your claim until it 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 (for example, 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 LGHIP. When BCBS processes requests for courtesy pre- determinations, BCBS is not bound by the time frames and standards that apply to claims.

Chapter 11
Coordination of Dental Benefits

Coordination of Benefits (COB) is a provision designed to help manage the cost of dental care by avoiding duplication of benefits when a person is covered by two or more benefit plans. COB provisions determine which plan is primary and which is secondary.

A primary plan is one whose benefits for a person's dental care coverage must be determined first without taking the existence of any other plan into consideration.

A secondary plan is one which takes into consideration the benefits of the primary plan before determining benefits available under its plan.

Some COB terms have defined meanings. These terms are set forth at the end of this COB Chapter.

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 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:

- 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:
    - first, the plan of the custodial parent;
    - second, the plan covering the custodial parent's spouse;
    - third, the plan covering the non-custodial parent; and
    - last, the plan covering the non-custodial parent's spouse.

- 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:
  - first, the plan of the spouse of the court-ordered parent;
  - second, the plan of the non-court-ordered parent; and
  - 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.

- 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

- 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.

- 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.

COBRA

- 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.

- 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.

- 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 is the primary plan and the plan that covered the person for the shorter period is the secondary plan.

Equal Division: If the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all 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

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

- 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.

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

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

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

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

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

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

Chapter 12
Definitions

Allowable Amount: The amount of a dentist's charge that BCBS will recognize as covered expenses for medically/dentally necessary services provided by the LGHIP. This amount is 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 more than the allowable amount.

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

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

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

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

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

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

Investigational: Any treatment, procedure, facility, equipment, drugs, drug usage, or supplies that either BCBS has not recognized as having scientifically established medical value, or that does not meet accepted standards of medical practice. When possible, BCBS will develop written criteria (called medical criteria) concerning services or supplies that BCBS considers to be investigational. BCBS bases these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. BCBS puts these medical criteria in policies that BCBS makes available to the medical community and our members. BCBS does this so that you and your providers will know in advance, when possible, what BCBS will pay for. If a service or supply is considered investigational according to one of BCBS's published medical criteria policies, BCBS will not pay for it. If the investigational nature of a service or supply is not addressed by one of BCBS's published medical criteria policies, BCBS will consider it to be non-investigational only if the following requirements are met:

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

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

Local Government Health Insurance Board (LGHIB): The State agency charged with the administration of the dental benefit plan for local government employees and their dependents. This agency is also referred to as the LGHIB.

Local Government Health Insurance Plan (LGHIP): A self-insured benefit plan administered by the Local Government Health Insurance Board.

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

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

We, Us, Our: BCBS, the LGHIP or the LGHIB as shown by the context.

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

Local Government Health Insurance Plan
Dental Benefits Administered By:

Local Government Health Insurance Board
Post Office Box 304900
Montgomery, Alabama 36130-4900

Phone: 1-334-263-8326
Toll-Free: 1-866-836-9137
Website: LGHIP.org

Claims Administrator

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

Customer Service: 1-800-321-4391
Rapid Response: 1-800-248-5123
Fraud Hot Line: 1-800-824-4391
Website: AlabamaBlue.com

Group Numbers: 30000, 97000
MKT232-2211