Local Government Dental Benefit Plan

Local Government Plan

Effective January 1, 2014

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

INTRODUCTION

This summary of dental benefits available is designed to help you understand your coverage. This booklet supplements the Local Government Health Insurance Plan booklet. Both booklets 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 booklets. All benefits are subject to the terms, conditions and limitations of the contract or contracts between the State Employees Insurance Board (SEIB) and Blue Cross Blue Shield of Alabama or other third party administrators that the SEIB may contract with that it deems is necessary to carry out its statutory obligations. Copies of all contracts are kept on file at the SEIB office and are available for review. The SEIB shall have absolute discretion and authority to interpret the terms and conditions of the plan and reserves the right to change the terms and conditions and/or end the plan at any time and for any reason.

Local Government Health Insurance Plan
Dental Benefits
Administered By:

State Employees' Insurance Board
Post Office Box 304900
Montgomery, Alabama 36130-4900
Phone: (334) 263.8326
Toll-Free: 1.866.836.9137
Website: www.alseib.org

Claims Administrator

Blue Cross 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: www.bcbsal.com

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OVERVIEW OF THE PLAN

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

Atención por favor

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

Purpose of the Plan

The dental benefits offered through the Local Government Health Insurance Plan (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 and coinsurance.

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

Blue Cross and Blue Shield of Alabama's home page on the Internet is www.bcbsal.com. If you visit, you will see a section of our home page called ***my*BlueCross**. Registering for ***my*BlueCross** is easy and secure. 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.

Definitions

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

Receipt of Dental Care

Even if the 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.

Limitations and Exclusions

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

Dental Necessity

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

In-Network Benefits

One way in which the LGHIP tries to manage dental care costs and provide enhanced dental benefits is through negotiated discounts with in-network dentists. In-network dentists are dentists that contract with Blue Cross and Blue Shield of Alabama (directly or indirectly) for furnishing dental care services at a reduced price. Preferred Dentists are in-network dentists in the state of Alabama. National Dental Network (Dentemax) are in-network dentists located outside the state of Alabama. To locate in-network dentists for the LGHIP, go to www.bcbsal.com. Assuming the services are covered, you will normally only be responsible for out-of-pocket costs such as deductibles and coinsurance when using in-network dentists.

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

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

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

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 us for reimbursement under the terms of the LGHIP. If we deny a claim in whole or in part, you may file an appeal with us. We will give you a full and fair review.

Termination of Coverage

If coverage terminates, no benefits will be provided thereafter, 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.

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 & 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 for 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 for 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.	

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

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 Blue Cross as an approved provider for the type of service or supply being furnished. Call Blue Cross Customer Services if you have any question whether your provider is recognized by Blue Cross as an approved provider for the services or supplies you plan on receiving.

- Services and supplies must be furnished when the LGHIP and your coverage are both in effect and fully paid for. 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.

COST SHARING

Calendar Year Deductible	**$25** **(Does not apply to diagnostic and preventive services.)**
Calendar Year Out-of-Pocket Maximum for In-Network Benefits for children up to age 19 only	**$6,250 per member** **$12,500 aggregate per family** **(This is a combined maximum applicable in-network cost-sharing for health and dental services for children up to age 19 only.)**
Calendar Year Maximum Benefits for Adults (ages 19 and over)	**$1,500** **(does not apply to orthodontic services)**

Calendar Year Out-of-Pocket Maximum for In-Network Dental Services for Children Up to Age 19

The calendar year out-of-pocket maximum for in-network dental services for children up to age 19 is specified in the table above. Cost-sharing amounts for in-network services incurred under the health and dental plan are combined for children up to age 19. (Please refer to the LGHIP document for a description of applicable cost-sharing amounts for health services.) Only in-network cost-sharing amounts (calendar year deductible and coinsurance) for covered services for children up to age 19 apply to the calendar year out-of-pocket maximum.

Once the calendar year out-of-pocket maximum has been reached, children up to age 19 will no longer be subject to in-network cost-sharing for affected in-network covered health and dental services for the remainder of the calendar year (we will pay 100% of the allowable amount for the remainder of the calendar year).

Calendar Year Maximum Benefits

Charges applied toward annual and/or lifetime maximums incurred by you or your covered dependents age 19 and over while covered under another Blue Cross dental contract issued through your same employer or group will be applied toward the annual and/or lifetime maximums under this contract.

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

DENTAL BENEFITS

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

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

SERVICE	BENEFIT
Basic – Diagnostic and Preventive Services	100%

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

SERVICE	BENEFIT
Basic – Restorative Services	50%

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

SERVICE	BENEFIT
Supplemental Services	**50%**

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

SERVICE	BENEFIT
Prosthetic Services	**50%**

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

Limits on prosthetic services:

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

SERVICE	BENEFIT
Periodontic Services	**50%**

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

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

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

Exclusions and limitations on orthodontic benefits:

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

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 1st permanent molars, teeth numbers 3, 14, 19 and 30, limited to two application per tooth per benefit period. Benefits are limited to a maximum payment of **$20 per tooth** and limited to children under age 19.
- If you change dentists while being treated, or if two or more dentists do one procedure, we'll pay no more than if one dentist did all the work.
- When there are two ways to treat you and both would otherwise be plan benefits, we'll pay toward the less expensive one. The dentist may charge you for any excess.
- Prosthetic – Gold, baked porcelain restorations, veneers, crowns and jackets – If a tooth can be restored with a material such as amalgam, we'll pay toward that procedure even if a more expensive means is used.
- Prosthetic – Payment will be made toward eliminating oral disease and replacing missing teeth.

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.**

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

C

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

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

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

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

D

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

E

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

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

F

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

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

G **Gold** foil restorations.

I Charges for **implants**.

Charges for **infection c**ontrol.

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

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.

FILING A CLAIM

The following explains the rules under the LGHIP for filing dental claims with Blue Cross.

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

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

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

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

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

How to File Claims
When you use your benefits, a claim must be filed before payment can be made. The 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) in excess of $500, a Request for Pre-Determination of Benefits should be filed by the dentist on a dental claim form. The treatment plan along with pre-operative radiographs should be submitted to BCBS.

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

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

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

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

Receipt and Processing Claims
Claims for dental benefits are always post-service.

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

Post-Service Claims

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

In order for BCBS to treat a submission by you or your provider as a post-service claim, it must be submitted on a properly completed standardized claim form or, in the case of electronically filed claims, must provide BCBS with the data elements that BCBS specifies in advance. Most providers are aware of BCBS's claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call the BCBS customer service department and ask for a claim form. 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 12 months after the service takes place to be eligible for benefits.

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

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

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

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

Courtesy Pre-Determinations of Treatment Plan: We encourage, but do not require, you or your provider to submit a treatment plan to BCBS for a courtesy pre-determination of benefits. If you ask for a courtesy pre-determination of a treatment plan, BCBS will do its best to provide you with a timely response. If BCBS decides that it cannot provide you with a courtesy pre-determination (for example, we cannot get the

information BCBS needs to make an informed decision), BCBS will let you know. In either case, courtesy pre-determinations are not claims under the LGHIP. When BCBS processes requests for courtesy pre-determinations, BCBS is not bound by the time frames and standards that apply to claims.

DEFINITIONS

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

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

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

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

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

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

Effective Date: The date on which the coverage of each individual member begins as listed in the SEIB 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 generally accepted standards of medical practice. When possible, BCBS will develop written criteria (called medical criteria) concerning services or supplies that BCBS considers to be investigational. BCBS bases these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. BCBS puts these medical criteria in policies that BCBS makes available to the medical community and our members. BCBS does this so that you and your providers will know in advance, when possible, what BCBS will pay for. If a service or supply is considered investigational according to one of BCBS's published medical criteria policies, BCBS will not pay for it. If the investigational nature of a service or supply is not addressed by one of BCBS's published medical criteria policies, BCBS will consider it to be non-investigational only if the following requirements are met:

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

- The improvement must be attainable outside the investigational setting.

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

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

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

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

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

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

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

Local Government Dental Benefit Plan
Administered By:

State Employees' Insurance Board
Post Office Box 304900
Montgomery, Alabama 36130-4900

Phone: 334.263.8326
Toll-Free: 1.866.836.9137
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