

LGHIP Optional Insurance Plan



Dental – Vision

Administered by
Southland National Insurance Corporation

POST OFFICE BOX 1250 • TUSCALOOSA, ALABAMA 35403 • TELEPHONE 866-327-6674

www.southlandnationallghip.com

Version published 06/01/07

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INTRODUCTION

This summary of health care benefits available to you through the Local Government Health Insurance Plan (LGHIP) Voluntary Insurance Coverage Plan is designed to help you understand your coverage. All terms, conditions and limitations are not covered here. All benefits are subject to the terms, conditions and limitations of the contract or contracts between the State Employees' Insurance Board (SEIB) and Southland National Insurance Corporation (Southland) 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.

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

The LGHIP Voluntary Coverage Insurance Plan offers a package of two plans of insurance (Dental - Vision) that are administered by Southland National Insurance Corporation (Southland).

The initial plan begins July 1, 2007 and runs through December 31, 2007. Subsequent Plan Years will begin on January 1 and through December 31.

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

GENERAL INFORMATION

Eligible Participants

All participants who are eligible for coverage through the Local Government Health Insurance Program are eligible to participate in the Southland National Voluntary Plan.

Eligible Dependent

The term “dependent” includes the following individuals subject to appropriate documentation (marriage certificate, birth certificate, court decree, etc.):

1. Your spouse (excludes divorced or common law spouse).
2. An unmarried child under age 19, only if the child is:
 - a. your son or daughter
 - b. a child legally adopted by you (including any probationary period during which the child is required to live with you)
 - c. your stepchild
 - d. your grandchild, niece or nephew for whom the court has granted you legal custody (provided the child is not eligible for any other group health insurance benefits).
3. Children ages 19 through 25 who are full-time unmarried students attending an accredited institution. Annual student verification from the institution must be filed with the SEIB.
4. An incapacitated dependent will be considered for coverage to any age provided dependent:
 - a. is unmarried,
 - b. is permanently mentally or physically disabled or incapacitated,

- c. is so incapacitated as to be incapable of self-sustaining employment,
- d. is dependent upon the subscriber for 50% or more support,
- e. is otherwise eligible for coverage as a dependent except for age, and
- f. the condition must have occurred prior to the dependent’s 19th birthday (unless already covered by the SEIB as a student, in which case the condition must have occurred prior to the dependent’s 26th birthday).

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

To apply, contact the SEIB to obtain an Incapacitated Dependent Certification Form. Final approval of incapacitation will be determined by Medical Review. Proof of disability must be provided to the SEIB within 60 days from the date the child would cease to be covered because of age.

NOTE: The SEIB reserves the right to periodically re-certify incapacitation.

Initial Participation

Enrollment - there will be an initial enrollment period beginning April 1, 2007 and continuing through April 30. Eligible employees, elected officers, retirees and dependents who make application during this period will have an effective date of July 1, 2007.

Cancellation – Participants enrolled effective July 1, 2007 may cancel Southland participation during 2007 Open Enrollment, effective for January 1, 2008.

Family Coverage Enrollment

A participating employee, elected officer or retiree in the Southland National Voluntary Plan may apply for family coverage during the initial enrollment period in the month of April for coverage becoming effective July 1.

Before dependents are added to family coverage, the SEIB must receive appropriate documentation (marriage certificate, birth certificate, court decree, etc.). If documentation is not received with a Southland Enrollment Form, the SEIB will send a notice to the employee to submit the documentation within 30 days. If documentation is not received by the SEIB within 60 days, the SEIB has the right to disallow the request to add dependent coverage.

New employees may elect to have dependent coverage begin on the date their coverage begins. If dependent coverage is not elected at the time the new employee becomes covered, they may enroll for dependent coverage within 60 days of a qualifying event (marriage, birth or adoption), and the effective date of coverage will be the first day of the next month after the Change Form is received in the SEIB office.

Open Enrollment

There shall be an Annual Open Enrollment held in November (for coverage to be effective January 1) of each year to allow active eligible employees not currently participating in the insurance program a chance to enroll.

If an employee wishes to add family coverage to an existing individual plan during open enrollment, a change form (Form LG08) must be filled out.

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

Cancellation of Dependent/Family Coverage

Employees who enroll with a July 1, 2007 effective date of coverage: may cancel dependent/ family coverage during Open Enrollment for a January 1, 2008 effective date.

Employees who enroll after July 1, 2007 may cancel during Open Enrollment for a January 1, 2007 effective date of coverage.

Dropping dependent coverage requires a qualifying event outside Open Enrollment. Coverage will be cancelled at the end of the month of the qualifying event. The SEIB may require proof of qualifying event.

Leave Without Pay/Military Leave

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

GENERAL PROVISIONS

Privacy of Your Protected Health Information:

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

Use and Disclosure of Your Personal Health Information:

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

Responsibility for Actions of Providers of Services:

Southland and the SEIB will not be responsible for any acts or omissions, whether negligent, intentional, or otherwise, by any institution, facility, or individual provider in furnishing or not furnishing any services, care, treatment, or supplies to you. Southland and SEIB will not be responsible if any provider of service fails or refuses to admit you to a facility, or treat you, or provide services to

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

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

Obtaining, Use and Release of Information:

By submitting your application for coverage or any claims for benefits you authorize Southland to obtain from all providers, hospitals, facilities, other providers of service, and all other persons or institutions having information concerning you, all records which in its judgment are necessary or desirable for processing your claim, performing our contractual duties or complying with any law. You also authorize providers of health services, and any other person or organization, to furnish to Southland any such records or information it requests. And you authorize Southland to use and release to other persons or organizations any such records and information as considered necessary or desirable in its judgment. Neither Southland or any provider or other person or organization will be liable for obtaining, furnishing, using, or releasing any such records or information.

Responsibility of Members and Providers to Furnish Information:

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

- A claim for the benefits must be properly submitted to and received by Southland.
- A provider, hospital, or other provider that has furnished or prescribed any

services or supplies to a member must provide the records, information, and evidence Southland requests in connection with benefits claimed or paid for the services or supplies.

- A member who receives services or supplies for which benefits are claimed must provide the records, information and evidence Southland requests.

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

Applicable State Law: This is administered in the State of Alabama and will be governed by the law of Alabama to the extent that state law is applicable.

I.D. Card: Will be provided by Southland National.

Claim Forms: Claim forms may be obtained from Southland and may also be downloaded from the SEIB website at <http://www.alseib.org>.

Claims Administrator: The Claims Administrator for the LGHIP Voluntary Insurance Coverage Plan is Southland National Insurance Corporation - P.O. Box 1250 - Tuscaloosa, Alabama 35403. Toll-free telephone number is: 1.866.327.6674.

Payment and Claim Filing Limitations: All claims must be submitted in writing and such writing must be received by Southland **no later than 365 days** following the date covered expenses are incurred. If a claim is not submitted and received by Southland within this period, the claim for that benefit will not be paid. Claim forms must be completed, with proper documentation and certification

from the health care provider, upon submission. Failure to provide a completed claim form may cause delays in claims processing and may be cause for the denial of the claim.

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

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

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

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

Incorrect Benefit Payments: Every effort is made to promptly and correctly process claims. If payments are made to you in error, or to a provider who furnished services or supplies to you, and Southland later determines that an error has been made, you or the provider will be required to repay any overpayment. If repayment is not made, Southland may deduct the amount of the overpayment from any future payment to you or the provider. If this action is taken, Southland will notify you in writing.

Fraudulent Claims: Any person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information or conceals for the purpose of misleading information concerning any

fact material thereto, commits a fraudulent insurance act which is a crime. In addition to any disciplinary action already in place, any employee or retiree knowingly and willfully submitting false information to the SEIB will be required to

repay all claims and other expenses incurred by the LGHIP Voluntary Insurance Coverage Plan related to the false or misleading information, plus interest.

DENTAL AND VISION PLAN BENEFITS WILL BE SECONDARY TO ALL OTHER COVERAGES AVAILABLE TO ANY CLAIMANT. THE TOTAL AMOUNT THAT IS PAYABLE UNDER ALL PLANS WILL NOT BE MORE THAN 100% OF THE MAXIMUM ALLOWABLE EXPENSES.

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

1.866.327.6674

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

1. To appeal, the insured must submit a request for review, in writing, to Southland within sixty (60) days from the date any writing is received by the insured from Southland denying payment of a claim. This request must contain the specific reasons the insured contends claim denial was improper. Within the same time period, insured may submit any other evidence which insured contends supports his or her position.
2. Southland will review the claim; any written requests or other evidence received from the insured and advise the insured of its final determination.
3. If the insured is still of the opinion that claim denial is improper, insured may obtain a judicial review of Southland's decision by the Circuit Court of Montgomery, Alabama.

SEIB Appeal Process

General Information: Members of the LGHIP Voluntary Insurance Coverage Plan have a right to question the decisions of the SEIB. Issues involving eligibility and enrollment should be addressed directly with the SEIB. Before addressing an issue involving a benefit claim with the SEIB, however, you should exhaust all administrative procedures with the claims administrator, Southland.

Informal Review: If you still feel that an enrollment or eligibility ruling was not appropriate or that the Plan's benefits were incorrectly applied (after exhausting the Administrative process with the

Claims Administrator), you should then contact the SEIB for an Informal Review. In many cases the problem can be handled over the phone through the Informal Review process without the need for a formal review or appeal. Should you still feel that the enrollment or eligibility ruling was not appropriate or that the Plan's benefits were not properly applied, you may file a request for an Administrative Review.

All requests for Administrative Review must be submitted on Form LG06. Forms are available through the SEIB office. Receipt of your Administrative Review will be acknowledged by returning a copy of the received form to you. Oral arguments will not be considered once the Administrative Review process has begun unless approved by the SEIB.

Administrative Review: A request must be received in the SEIB office within 60 days following receipt of the final notice of a partial or total denial of your claim from the claims administrator. A copy of the decision of the claims administrator must be attached to the Administrative Review request form. Upon receipt of the completed form, the Administrative Review Committee will review the grievance usually within sixty (60) days. The Administrative Review Committee shall issue a decision in writing to all parties involved in the grievance.

Note: Decisions of the claims administrator will be reviewed to determine if the review was conducted in a fair and equitable manner. Medical decisions will not be questioned.

Formal Appeal: If you do not agree with the response to your Administrative Review, you may file a Formal Appeal before the Board of Directors. Requests for a Formal Appeal must be received in

the SEIB office within 60 days following the date of the Administrative Review decision.

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

Generally, a decision will be issued within ninety (90) days following receipt of the request form. The number of days may be extended by notice from the SEIB. The decision by the Board is the final step in

the administrative proceedings and will exhaust all administrative remedies.

Items That Will Not Be Reviewed Under the Administrative Review or Formal Appeal Process:

- Investigational Related Services;
- Custodial Care;
- Allowed Amounts.

If you have not received a decision or notice of extension of the Administrative Review or Formal Appeal within 90 days, you may consider your request denied.

CONTINUATION OF GROUP HEALTH COVERAGE (COBRA)

Introduction

The Public Health Service Act [42 USC Sections 300bb-1 through 300bb-8] requires that the SEIB offer employees and their families the opportunity for a temporary extension of health coverage (called “continuation coverage”) at group rates in certain instances where coverage under the plan would otherwise end. COBRA coverage can be particularly important for several reasons:

1. It will allow you to continue group health care coverage beyond the point at which you would ordinarily lose it.
2. It may prevent you from incurring a break in coverage (persons with 63-day breaks in creditable coverage may be required to satisfy preexisting condition exclusion periods if they obtain health coverage elsewhere).
3. It could allow you to qualify for coverage under the Alabama Health Insurance Program (AHIP). See the AHIP section for more information about this.

This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of this law. ***You and your spouse should take the time to read this notice carefully.***

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of coverage under the LGHIP Voluntary Insurance Coverage Plan when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed under the section entitled “Qualified

Beneficiaries” below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. You, your spouse and your dependent children could become qualified beneficiaries if coverage under the LGHIP Voluntary Insurance Coverage Plan is lost because of a qualifying event. Under the LGHIP Voluntary Insurance Coverage Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage.

Qualified Beneficiaries

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

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the LGHIP Voluntary Insurance Coverage Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than gross misconduct.

If you are the spouse of an employee, you

will become a qualified beneficiary if you lose your coverage under the LGHIP Voluntary Insurance Coverage Plan because either one of the following qualifying events happens:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the LGHIP Voluntary Insurance Coverage Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the LGHIP Voluntary Insurance Coverage Plan as a “dependent child.”

Coverage Available

If you choose continuation coverage, the SEIB is required to offer you coverage

that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members.

When Your Employer Should Notify the SEIB

COBRA continuation coverage will be offered to qualified beneficiaries only after the SEIB has been notified that a qualifying event has occurred. Your employer is responsible for notifying the SEIB of the following qualifying events:

- end of employment,
- reduction of hours of employment or
- death of an employee.

When You Should Notify the SEIB

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

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

Written notice must be given to the SEIB within 60 days of the date of the event or the date, in which coverage would end under the LGHIP Voluntary Insurance Coverage Plan because of the event, whichever is later. All notices should be sent to the address listed under “SEIB Contact Information” at the end of this section.

Election Period

When the SEIB is notified that a qualifying event has happened, COBRA continuation coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. In addition, a Covered employee may elect

COBRA continuation coverage on behalf of his or her spouse and either covered parent may elect COBRA continuation coverage on behalf of their children.

If you do not choose continuation coverage, your group health insurance will end.

Length of Coverage

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

- Death of the employee,
- Divorce or legal separation, or
- Dependent child loses eligibility as a “dependent child” under LGHIP Voluntary Insurance Coverage Plan.

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

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

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

- **Disability** – if you or anyone in your family covered under LGHIP Voluntary Insurance Coverage Plan is determined by the Social Security Administration to be disabled and you notify the SEIB within 30 days of the determination, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage. The disability would have to have started before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of contin-

uation coverage. (You must provide a copy of the Social Security Administration determination to the SEIB at the address listed under “SEIB Contact Information” at the end of this section.)

- **Second Qualifying Event** – if your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage. You must notify the SEIB within 30 days of the second qualifying event. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage when one of the following qualifying events occurs:
 - Employee or former employee dies,
 - Employee or former employee gets divorced or legally separated or
 - If dependent child loses eligibility as a “dependent child” under LGHIP Voluntary Insurance Coverage Plan.

For the extension to apply, the above listed events must have caused the spouse or dependent child to lose coverage under the LGHIP Voluntary Insurance Coverage Plan had the first qualifying event not occurred.

Family and Medical Leave Act

If you are on a leave of absence covered by the Family and Medical Leave Act of 1993 (FMLA), and you do not return to work, you will be given the opportunity to elect COBRA continuation coverage. The period of your COBRA continuation coverage will begin when you fail to return to work following the expiration of your FMLA leave or you inform your employ-

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

Premium Payment

If you qualify for continuation coverage, you will be required to pay the group's premium plus 2% administrative fee, directly to the SEIB. Members who are disabled under Title II or Title XVI of the Social Security Act when a qualifying event occurs, will be required to pay 150% of the group's premium for the 19th through the 29th month of coverage or the month that begins more than 30 days after the date is determined that you are no longer disabled under Title II or Title XVI of the Social Security Act, whichever comes first. (If the only persons who elect the disability extension are non-disabled family members, the cost of coverage will remain at 102% of the full cost of coverage.) Your coverage will be canceled if you fail to pay the entire amount in a timely manner.

Your initial premium payment must be received by the SEIB within 45 days from your date of election. All subsequent premiums are due on the first day of the month of coverage. There is a 30-day grace period.

Termination of Continuation Coverage

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

1. SEIB no longer provides group health coverage.
2. The premium for your continuation coverage is not paid on time.
3. You become covered by another group plan, unless the plan contains any exclusions or limitations with respect to any preexisting condition you or your covered dependents may have.

4. You become entitled to Medicare.
5. You extend coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled.

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

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

Keep the SEIB Informed of Address Changes

In order to protect your family's rights, you should keep the SEIB informed of any changes in the address of family members. You should also keep a copy for your records of any notices you send to the SEIB.

If You Have Any Questions

Questions concerning your COBRA continuation coverage rights may be addressed by calling the SEIB at 1-866.853.2225 or 334.833.5911 or by mail at the contact listed below. For more information about your COBRA rights, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area.

DentaNet

a Southland National network of Participating
Dentists that benefit LGHIP members

**ARE YOU USING THE
NETWORK?**



DentaNet



is a Southland National network of Participating Dentists that benefit LGHIP members

Here are the top 3 reasons to use one of our participating dentists:

1. THEY SAVE YOU MONEY

2. THEY SAVE LGHIP MONEY

3. THEY SAVE YOU & LGHIP MONEY

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

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



FACT:

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

FACT:

DentaNet is one of the largest dental networks in the State of Alabama

FACT:

By using DentaNet providers, LGHIP members save money.

QUESTION: ARE YOU SAVING MONEY?

If you participate in the LGHIP Dental Plan, you probably purchased dental insurance to save money.

DentaNet providers are all over the state. To find a participating DentaNet provider in your area, visit **www.southlandnationallghip.com** or call us, toll-free, at **1-866-327-6674** today.

You'll be glad you did.

Why You Should Use The “DentaNet” Network of Dentists...

DentaNet, the dental network provided by Southland National offers LGHIP members and their families the largest independent statewide network of preferred dentists. Although members can choose any dentist they like, using a DentaNet dentist saves LGHIP members money.

DentaNet dentists do not balance bill LGHIP members the difference between the DentaNet negotiated fee schedule and what they normally charge. Additionally, services that require a co-pay, are also based on the DentaNet negotiated fee schedule...so LGHIP members will save all the way around.

**Visit “www.southlandnationallghip.com”
to find a network dentist near you and start saving today.**



Note: In order to obtain the DentaNet network savings described above, you must have LGHIP Dental Plan coverage.

SEIB Contact Information

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

State Employees' Insurance Board
COBRA Section
500 RSA Tower/201 Monroe Street
Post Office Box 304900
Montgomery, AL 36130-4900

The Alabama Health Insurance Plan

If you exhaust your COBRA coverage, you may qualify for coverage through the Alabama Health Insurance Plan (AHIP). For more information about AHIP, call the SEIB at 1.877.619.2447.

DENTAL BENEFITS PROGRAM

Plan Summary*

Dental Benefit Schedule

	Plan I (Employee Only)	Plan II (Employee & Full Family)
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Maximum benefits applicable Per person per plan year:	\$1,250.00	\$1,000.00
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Diagnostic & Preventive Services: Based on Reasonable & Customary Charges

Deductible	None	None
Oral Examinations	100%	100%
Cleaning of Teeth	100%	100%
Fluoride Applications for children	None	100%
Space Maintainers for children ¹	None	Limited
X-Rays	100%	100%
Emergency Office Visits	100%	100%
Sealants	None	100%

Basic & Major Services: Based on Reasonable & Customary Charges

Deductible ²	None	\$25.00
Fillings	80%	60%
General Anesthetics	80%	60%
Oral Surgery ³	80%	60%
Periodontics	80%	60%
Endodontics	80%	60%
Dentures ⁴	80%	60%
Bridgework ⁴	80%	60%
Crowns	80%	60%

NO ORTHODONTIC BENEFITS

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| <p>¹ Space maintainers limited to \$125.00 per unit</p> <p>² Deductibles are applied per person, per plan year with a maximum of three (3) per Family</p> <p>³ Oral surgery excludes any procedures covered under a Group Medical Program</p> <p>⁴ No benefits are provided for replacement of teeth removed before coverage is effective</p> <p>* Expenses are incurred at the preparation date and not the installation, service, or "seating" date.</p> <p>* Benefits are not provided for temporary partials.</p> |
|---|

COVERED DENTAL EXPENSES

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

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

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

REASONABLE AND CUSTOMARY CHARGES

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

- The **Usual Fee** which the individual dentist in Alabama most frequently charges the majority of his patients for service rendered;
- The **Prevailing Range of Fees** charged in the same areas by dentists in Alabama of similar training and experience for service rendered; and
- **Circumstances or Complications** requiring additional time, skill and experience.

DIAGNOSTIC AND PREVENTIVE EXPENSES

This plan will pay all reasonable and customary charges for:

Oral Examinations and Office Visits.

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

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

Topical Application of Fluoride.

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

Space Maintainers.

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

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

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

OTHER COVERED DENTAL EXPENSES

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

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

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

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

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

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

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

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

- The existing denture or bridgework was provided while coverage under this plan was in effect, the existing denture or bridgework is at least five (5) years old and cannot be made serviceable; or
- The replacement or addition of teeth is required to replace one or more natural teeth extracted or accidentally lost while insured.

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

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

PRE-DETERMINATION OF BENEFITS

Before beginning a course of treatment for which dentists' charges are expected to be \$150.00 or more, a description of the proposed course of treatment and charges to be made should be filed on the claim form with Southland.

Southland will then determine the estimated benefits payable for Covered Dental Expenses expected to be incurred and advise the employee and the dentist before treatment begins. Services must be completed within a reasonable length of time from date predetermination was processed.

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

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

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

In the event there is no claim for a predetermination of benefits, the benefit will be

paid based upon the information submitted to Southland at the time of the claim.

ALTERNATE PROCEDURES

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

COORDINATION OF DENTAL BENEFITS

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

DENTANET BENEFITS

The dental coverage administered by Southland National will offer a dental network to members and dependents enrolled in the dental plan. Under the Southland dental network, known as "DentaNet", MEMBERS HAVE THE OPPORTUNITY TO USE THE NETWORK DENTISTS BUT STILL HAVE THE FREEDOM TO USE ANY DENTIST.

DentaNet dentists cannot balance bill you for the difference between the negotiated fee schedule and what they normally charge. On services requiring you to pay a coinsurance fee, the coinsurance payment will be based on a negotiated fee. SEIB and its members save money when DentaNet dentists are used.

DENTAL EXCLUSIONS

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

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

28. Pulp capping or acid etching as a separate procedure.
29. Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes.
30. Periodontal cleaning aids or devices.
31. Specific charges for infection control and/or protection supplies, including but not limited to, gloves, masks, gowns, shoes or other items.
32. Microscopic bacteriological examinations.
33. Antimicrobial irrigation.
34. Temporomandibular joint (TMJ) disorders.
35. Benefits are not provided for temporary partials.
36. Expenses for which the individual is not required to make payment, including but not limited to, reductions or readjustments to the charges made by the health care provider.
37. All claims not submitted in writing, not completed, without the requisite certification of the health care provider, or received by Southland more than 365 days following the claim incurrence.
38. Services of a dentist who is related to the member by blood or marriage or who regularly resides in the same household.
39. Hospital expenses for dental work performed in the hospital.

Vision Program
Coverage and Maximum Benefits

Examination actual charges not to exceed:	40.00
Lenses not to exceed:	
Single Vision	50.00
Bifocals	75.00
Trifocals	100.00
Lenticular	125.00
Contacts	100.00
Frames	60.00

* Plan provides either contacts or lenses and frames, but not both in any plan year.

** It is the responsibility of the member to submit a claim for either lenses or contacts and the payment will be made based on the date the claim is received.

LIMITATIONS

Examinations: One in any Plan Year.

Lenses: One new prescription or replacement in any Plan Year. Benefits are not available under the plan for both lenses and contacts in the same Plan Year.

Contacts: One new prescription or replacement in any Plan Year. Plan provides either contacts or lenses and frames, but not both in any Plan Year.

Frames: One new or replacement in any Plan Year.

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

- * case history
- * external examination of the eye and adnexa
- * determination of refractive status
- * ophthalmoscopy
- * application of pharmaceutical agents

for diagnostic purposes when indicated and allowed by state law

- * tonometry test for glaucoma when indicated
- * binocular measure
- * summary findings and recommendations
- * prescribing corrective lenses, if needed

DEFINITIONS

Bifocal Lenses: Lenses containing 2 foci (points of convergence of rays of light), usually arranged with the focus for distance above and a smaller segment for near focus below.

Trifocal Lenses: Lenses containing 3 foci, usually arranged with the focus for distance above, for intermediate distance in the middle, and for near vision below.

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

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

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

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

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

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

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

EXCLUSIONS

Vision Care Plan benefits will not be provided for certain charges, including but not limited to charges for:

1. Expenses incurred by or on account of an individual prior to such persons effective date of coverage under the plan;
2. Services or supplies for which coverage is provided or available under the

Local Government Health Insurance Program, or by Workers' Compensation Laws, or by any Safety Lens program;

3. Drugs or any other medication;
4. Any medical or surgical treatments;
5. Special or unusual treatment such as orthoptics, vision training, sub-normal vision aids, aniseikonia lenses or tonography;
6. Services or supplies not prescribed by a licensed physician, optometrist, or ophthalmologist, and lenses which do not require a prescription;
7. Service or supplies which are experimental in nature or are not approved by the American Ophthalmology Association;
8. The extra charge for oversized, photo sensitive, or anti-reflective lenses, whether or not medically necessary;
9. Sun glasses, including lenses and frames;
10. Follow-up visits, fitting fees, dispensing fees, coating or care kits;
11. Expenses for which the individual is not required to make payment, including but not limited to, reductions or readjustments to the charges made by the health care provider;
12. All claims not submitted in writing, not completed, with the requisite certification of the health care provider or received by Southland more than 365 days following the claim occurrence.
13. Services of a physician who is related to the member by blood or marriage or who regularly resides in the same household.

COORDINATION OF VISION BENEFITS

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

STATE EMPLOYEES' INSURANCE BOARD

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