

Millsource

Dental

Effective January 1, 2015

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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 our Customer Service Department at 1-800-292-8868. If needed, simply request a Spanish translator and one will be provided to assist you in understanding your benefits.

Las siguientes disposiciones de este folleto contienen un resumen en inglés de sus derechos y beneficios bajo el plan. Si usted tiene preguntas acerca de sus beneficios, por favor póngase en contacto con nuestro Departamento de Servicio al Cliente al 1-800-292-8868. Si es necesario, basta con solicitar un traductor de español y se le proporcionará uno para ayudarle a entender sus beneficios.

Purpose of the Plan

The plan is a rider to your employer-sponsored group health plan. The plan is intended to help you and your covered dependents pay for the costs of dental care. The plan does not pay for all of your dental care. For example, you may be required to contribute through payroll deduction before you obtain coverage under the plan. You may also be required to pay deductibles and coinsurance.

Using *myBlueCross* to Get More Information

By being a member of the plan, you get exclusive access to **myBlueCross** – an online service only for members. Use it to easily manage your healthcare coverage. All you have to do is register at www.AlabamaBlue.com/register. With **myBlueCross**, you have 24-hour access to personalized healthcare information, PLUS easy-to-use online tools that can help you save time and efficiently manage your healthcare:

- Pay your bill online and set up recurring payments.
- Download and print your benefit booklet or Summary of Benefits and Coverage.
- Request replacement or additional ID cards.
- View all your claim reports in one convenient place.
- Find a doctor.
- Track your health progress.
- Take a health assessment quiz.
- Get fitness, nutrition, and wellness tips.
- Get prescription drug information.

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 plan does not provide benefits, you and your provider may decide that care and treatment are necessary. You and your provider are responsible for making this decision.

Beginning of Coverage

The section of this booklet called [Eligibility](#) will tell you what is required for you to be covered under the plan and when your coverage begins.

Limitations and Exclusions

The plan 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 this plan.

Dental Necessity

The plan 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 plan 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 for furnishing dental care services at a reduced price. Preferred Dentists are in-network dentists in the state of Alabama. To locate in-network dentists for the plan, go to www.AlabamaBlue.com. Assuming the services are covered, you will normally only be responsible for out-of-pocket costs such as deductibles and coinsurance when using in-network dentists.

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

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 plan. 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. The provisions of the plan dealing with claims or appeals are found further on in this booklet.

Termination of Coverage

The section below called [Eligibility](#) tells you when coverage will terminate under the plan. If coverage terminates, no benefits will be provided thereafter, even if for a condition that began before the plan or your coverage termination. In some cases you will have the opportunity to buy COBRA coverage after your group coverage terminates. COBRA coverage is explained in detail later in this booklet.

Respecting Your Privacy

To administer this plan we need your medical information from physicians, hospitals and others. To decide if your claim should be paid or denied or whether other parties are legally responsible for some or all of your expenses, we need records from healthcare providers and other plan administrators. By applying for coverage and participating in this plan, you agree that we may obtain, use and release all records about you and your minor dependents that we need in order to administer this plan or to perform any function authorized or permitted by law. You further direct all other persons to release all records to us about your minor dependents that we need to administer the plan. If you or any provider refuses to provide records, information or evidence we request within reason, we may deny any more payments to the one refusing. Additionally, we may use or disclose your personal health information for treatment, payment or healthcare operations, or as permitted or authorized by law pursuant to the privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We have prepared a privacy notice that explains our obligations and your rights under the HIPAA privacy regulations. To request a copy of our notice or to receive more information about our privacy practices or your rights, please contact us at the following address:

Blue Cross and Blue Shield of Alabama Privacy Office
P.O. Box 2643
Birmingham, Alabama 35202-2643

You may also go to www.AlabamaBlue.com for a copy of our privacy notice.

Your Rights

As a member of the plan, you have the right to:

- Receive information about us, our services, in-network providers, and your rights and responsibilities.
- Be treated with respect and recognition of your dignity and your right to privacy.
- Participate with providers in making decisions about your healthcare.
- A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Voice complaints or appeals about us, or the healthcare the plan provides.
- Make recommendations regarding our member rights and responsibilities policy.

If you would like to voice a complaint, please call the Customer Service Department number on the back of your ID card.

Your Responsibilities

As a member of the plan, you have the responsibility to:

- Supply information (to the extent possible) that we need for payment of your care and your providers need in order to provide care.
- Follow plans and instructions for care that you have agreed to with your providers and verify through the benefit booklet provided to you the coverage or lack thereof under your plan.

- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

ELIGIBILITY

Eligibility for the Plan

You are eligible to enroll in this plan if all of the following requirements are satisfied:

- You are an employee and are treated as such by your group. Examples of persons who are not employees include independent contractors, board members, and consultants;
- Your group has determined that you work on average 30 or more hours per week (including vacation and certain leaves of absence that are discussed in the section dealing with termination of coverage) in accordance with the Affordable Care Act;
- You are in a category or classification of employees that is covered by the plan;
- You meet any additional eligibility or participation rules established by your group; and,
- You satisfy any applicable waiting period, as explained below.

You must continue to meet these eligibility conditions for the duration of your participation in the plan.

Enrollment Waiting Periods

There may be a waiting period under the plan, as determined by your group. You should contact your group to determine if this is the case. Your group will also tell you the length of any applicable waiting period. Under federal law, any waiting period established by your group cannot be longer than 90 days.

Coverage will begin on the date specified below under [Beginning of Coverage](#), but in no event later than the 91st day in which you first meet the eligibility or participation rules established by your group (other than any applicable waiting period).

Applying for Plan Coverage

Fill out an application form completely and give it to your group. You must name all eligible dependents to be covered on the application. Your group will collect all of the employees' applications and send them to us. Some employers provide for electronic online enrollment. Check with your group to see if this option is available.

Eligible Dependents

Your eligible dependents are:

- Your spouse;
- A married or unmarried child up to age 26; and,
- An unmarried, incapacitated child who (1) is age 26 and over; (2) is not able to support himself; and (3) depends on you for support, if the incapacity occurred before age 26.

The child may be the employee's natural child; stepchild; legally adopted child; child placed for adoption; or eligible foster child. An eligible foster child is a child that is placed with you by an authorized placement agency or by court order.

You may not cover your grandchild unless your grandchild is your adopted child, a child placed for adoption, or your eligible foster child.

Beginning of Coverage

Late Enrollment Not Permitted

If you do not enroll as a regular enrollee, you may not enroll in the plan.

Regular Enrollment

If you apply within 30 days after the date on which you meet the plan's eligibility requirements (including any applicable waiting periods established by your group), your coverage will begin as of the date thereafter specified by your group but in no event later than the 91st day in which you first meet the eligibility requirements established by your group (other than any applicable waiting periods). If you are a new employee, coverage will not begin earlier than the first day on which you report to active duty.

Special Enrollment Period for Newly Acquired Dependents

If you are already enrolled and have a new dependent as a result of marriage, birth, placement for adoption, adoption, or placement as an eligible foster child, you may enroll your spouse and your new dependent provided that you request enrollment within 30 days of the event. The effective date of coverage will be the date of birth, placement for adoption, adoption, or placement as an eligible foster child. In the case of a dependent acquired through marriage, the effective date will be no later than the first day of the first calendar month beginning after the date the plan receives the request for special enrollment.

If we accept your application, you will receive an identification card. If we decline your application, all the law requires us to do is refund any fees paid.

Qualified Medical Child Support Orders

If the group (the plan administrator) receives an order from a court or administrative agency directing the plan to cover a child, the group will determine whether the order is a Qualified Medical Child Support Order (QMCSO). A QMCSO is a qualified order from a court or administrative agency directing the plan to cover the employee's child regardless of whether the employee has enrolled the child for coverage. The group has adopted procedures for determining whether such an order is a QMCSO. You have a right to obtain a copy of those procedures free of charge by contacting your group.

The plan will cover an employee's child if required to do so by a QMCSO. If the group determines that an order is a QMCSO, we will enroll the child for coverage effective as of a date specified by the group, but not earlier than the later of the following:

- If we receive a copy of the order within 30 days of the date on which it was entered, along with instructions from the group to enroll the child pursuant to the terms of the order, coverage will begin as of the date on which the order was entered.
- If we receive a copy of the order later than 30 days after the date on which it was entered, along with instructions from the group to enroll the child pursuant to the terms of the order, coverage will begin as of the date on which we receive the order. We will not provide retroactive coverage in this instance.

Coverage may continue for the period specified in the order up to the time the child ceases to satisfy the definition of an eligible dependent. If the employee is required to pay extra to cover the child, the group may increase the employee's payroll deductions. During the period the child is covered under the plan as a result of a QMCSO, all plan provisions and limits remain in effect with respect to the child's coverage except as otherwise required by federal law.

While the QMCSO is in effect we will make benefit payments – other than payments to providers – to the parent or legal guardian who has been awarded custody of the child. We will also provide sufficient information and forms to the child's custodial parent or legal guardian to allow the child to enroll in the plan. We will also send claims reports directly to the child's custodial parent or legal guardian.

Termination of Coverage

Plan coverage ends as a result of the first to occur of the following (generally, coverage will continue to the end of the month in which the event occurs):

- The date on which the employee fails to satisfy the conditions for eligibility to participate in the plan, such as termination of employment or reduction in hours (except during vacation or as otherwise provided in the [Leaves of Absence](#) rules below);
- For spouses, the date of divorce or other termination of marriage;
- For children, the date a child ceases to be a dependent;
- For the employee and his or her dependents, the date of the employee's death;
- Your group fails to pay us the amount due within 30 days after the day due;
- Upon discovery of fraud or intentional misrepresentation of a material fact by you or your group;
- Any time your group fails to comply with the contribution or participation rules in the plan documents;
- When none of your group's members still live, reside or work in Alabama; or,
- On 30-days advance written notice from your group to us.

In all cases except the last item above, the termination occurs automatically and without notice. All the dates of termination assume that payment for coverage for you and all other employees in the proper amount has been made to that date. If it has not, termination will occur back to the date for which coverage was last paid.

Leaves of Absence

If your group is covered by the Family and Medical Leave Act of 1993 (FMLA), you may retain your coverage under the plan during an FMLA leave, provided that you continue to pay your premiums. In general, the FMLA applies to employers who employ 50 or more employees. You should contact your group to determine whether a leave qualifies as FMLA leave.

You may also continue your coverage under the plan for up to 30 days during an employer-approved leave of absence, including sick leave. Contact your group to determine whether such leaves of absence are offered. If your leave of absence also qualifies as FMLA leave, your 30-day leave time runs concurrently with your FMLA leave. This means that you will not be permitted to continue coverage during your 30-day leave time in addition to your FMLA leave.

If you are on military leave covered by the Uniformed Services Employment and Reemployment Rights Act of 1994, you should see your group for information about your rights to continue coverage under the plan.

COST SHARING

Calendar Year Deductible	\$50 (does not apply to diagnostic and preventive services)
Calendar Year Out-of-Pocket Maximum for In-Network Benefits for Children Up to Age 19	\$XX6,350 (\$12,700 aggregate per family) (This is a combined maximum for applicable in-network cost-sharing for health and dental services for children up to age 19)
Calendar Year Maximum Benefits for Adults (ages 19 and over)	\$1,250

Calendar Year Out-of-Pocket Maximum for In-Network 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 health plan 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 (ages 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 plan 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 plan'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	80%

- 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 teeth numbers 3, 14, 19 and 30, limited to one application per tooth each 48 months. Benefits are limited to the first permanent molars of children through age 13.
- 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	80%

- 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	80%

- 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	80%

- 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 \$1,250 (maximum does not apply to medically necessary orthodontic services for children up to age 19)	50%, subject to the same per member deductible as other dental services

Orthodontic benefits are provided for the initial and subsequent treatment and installation of orthodontic equipment for dependent children up to age 26 .

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:

- 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.

COORDINATION OF BENEFITS (COB)

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 section.

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 group, Medicare secondary payer rules may require us to reverse this order of payment. This can occur when the patient is covered as an inactive or retired employee, is also covered as a dependent of an active employee, and is also covered by Medicare. In this case, the order of benefit determination will be as follows: first, the plan covering the patient as a dependent; second, Medicare; and third, the plan covering the patient as an inactive or retired employee.

Dependent Child – Parents Not Separated or Divorced: If both plans cover the patient as a dependent child of parents who are married or living together (regardless of whether they have ever been married), the plan of the parent whose birthday falls earlier in the year will be primary. If the parents have the same birthday, the plan covering the patient longer is primary.

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

1. If there is no court decree allocating responsibility for the child's dental care expenses or dental care coverage, the order of benefits for the child are as follows:
 - a. first, the plan of the custodial parent;
 - b. second, the plan covering the custodial parent's spouse;
 - c. third, the plan covering the non-custodial parent; and,
 - d. last, the plan covering the non-custodial parent's spouse.
2. If a court decree states that a parent is responsible for the dependent child's dental care expenses or dental care coverage and the plan of that parent has actual knowledge of those terms, the plan of the court-ordered parent is primary.

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

- a. first, the plan of the spouse of the court-ordered parent;
- b. second, the plan of the non-court-ordered parent; and,
- c. third, the plan of the spouse of the non-court-ordered parent.

If a court decree states that both parents are responsible for the dependent child's dental care expenses or dental care coverage, the provisions of "Dependent Child – Parents Not Separated or Divorced" (the "birthday rule") above shall determine the order of benefits.

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

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

Active Employee or Retired or Laid-Off Employee:

1. The plan that covers a person as an active employee (that is, an employee who is neither laid off nor retired) or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.
2. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.
3. This rule does not apply if the rule in the paragraph "Employee/Dependent" above can determine the order of benefits. For example, if a retired employee is covered under his or her own plan as a retiree and is also covered as a dependent under an active spouse's plan, the retiree plan will be primary and the spouse's active plan will be secondary.

COBRA or State Continuation Coverage:

1. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.
2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
3. This rule does not apply if the rule in the paragraph "Employee/Dependent" above can determine the order of benefits. For example, if a former employee is receiving COBRA benefits under his former employer's plan (the "COBRA plan") and is also covered as a dependent under an active spouse's plan, the COBRA plan will be primary and the spouse's active plan will be secondary. Similarly, if a divorced spouse is receiving COBRA benefits under his or her former spouse's plan (the "COBRA plan") and is also covered as a dependent under a new spouse's plan, the COBRA plan will be primary and the new spouse's plan will be secondary.

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

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

Determination of Amount of Payment

1. If this plan is primary, it shall pay benefits as if the secondary plan did not exist.
2. If our records indicate this plan is secondary, we will not process your claims until you have filed them with the primary plan and the primary plan has made its benefit determination.

If this plan is a secondary plan on a claim, should it wish to coordinate benefits (that is, pay benefits as a secondary plan rather than as a primary plan 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 the amount of any reduction in benefits under a primary plan because (a) the covered person failed to comply with the primary plan's provisions concerning second surgical opinions or precertification of admissions or services, or (b), the covered person had a lower benefit because he or she did not use an in-network dentist.

Birthdate: The term “birthdate” refers only to month and day in a calendar year and does not include the year in which the individual is born.

Custodial Parent: The term “custodial parent” means:

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

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

Noncompliant Plan: The term “noncompliant plan” means a plan with 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 regulation; or,

- All plans that cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

Secondary Plan: The term “secondary plan” means a plan that is not a primary plan.

Right to Receive and Release Needed Information

Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. We are not required to tell or get the consent of any person to do this. Each person claiming benefits under this plan must give us any facts we need to apply these COB rules and to determine benefits payable as a result of these rules.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons it has paid to or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Special Rules for Coordination with Medicare

Except where otherwise required by federal law, the plan will pay benefits on a secondary basis to Medicare or will pay no benefits at all for services or supplies that are included within the scope of Medicare's coverage, depending upon, among other things, the size of your group, whether your group is a member of an association, and the type of coordination method used by your group. For example, if this plan is secondary to Medicare under federal law, this plan will pay no benefits for services or supplies that are included within the scope of Medicare's coverage if you fail to enroll in Medicare when eligible.

SUBROGATION

Right of Subrogation

If we pay or provide any benefits for you under this plan, we are subrogated to all rights of recovery which you have in contract, tort, or otherwise against any person or organization for the amount of benefits we have paid or provided. That means that we may use your right to recover money from that other person or organization.

Right of Reimbursement

Besides the right of subrogation, we have a separate right to be reimbursed or repaid from any money

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

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

Right to Recovery

You agree to furnish us promptly all information which you have concerning your rights of recovery or recoveries from other persons or organizations and to fully assist and cooperate with us in protecting and obtaining our reimbursement and subrogation rights in accordance with this section.

You or your attorney will notify us before filing any suit or settling any claim so as to enable us to participate in the suit or settlement to protect and enforce our rights under this section. If you do notify us so that we are able to and do recover the amount of our benefit payments for you, we will share proportionately with you in any attorney's fees charged you by your attorney for obtaining the recovery. If you do not give us that notice, our reimbursement or subrogation recovery under this section will not be decreased by any attorney's fee for your attorney.

You further agree not to allow our reimbursement and subrogation rights under this plan to be limited or harmed by any other acts or failures to act on your part. It is understood and agreed that if you do, we may suspend or terminate payment or provision of any further benefits for you under the plan.

DENTAL BENEFIT EXCLUSIONS

We will not provide benefits for the following:

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 malalignment of teeth. This does not apply to covered orthodontic services.

B

Dental services to the extent coverage is available to the member under any other **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 Blue Cross has not been received by Blue Cross, or (b) for which a claim is received by Blue Cross later than 24 months after the date services were performed.

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

Services or expenses for treatment of injury sustained in the commission of a **crime** (except for treatment of injury as a result of a medical condition or 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** control.

Any dental treatment or procedure, drugs, drug usage, equipment, or supplies which are **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 **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.

CLAIMS AND APPEALS

This section of your booklet explains how we process dental claims and how you can appeal a partial or complete denial of a claim. Remember that you may always call our Customer Service Department for help if you have a question or problem that you would like us to fix without an appeal.

The claims and appeal procedures are designed to comply with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA). Even if your plan is not covered by ERISA, we will process your claim according to ERISA's standards and provide you with the ERISA appeal rights that are discussed in this section of your booklet.

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. We have developed a form that you must use if you wish to designate an authorized representative. You can get the form by calling our Customer Service Department. You can also go to our Internet website at www.AlabamaBlue.com and ask us to mail you a copy of the form. If a person is not properly designated as your authorized representative, we will not be able to deal with him or her in connection with the exercise of your rights under this section of your booklet.

Claims

What Constitutes a Claim: For you to obtain benefits after dental services have been rendered, we must receive a properly completed and filed claim from you or your provider.

In order for us to treat a submission by you or your provider as a claim, it must be submitted on a properly completed standardized claim form or, in the case of electronically filed claims, must provide us with the data elements that we specify in advance. Most providers are aware of our claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call our Customer Service Department and ask for a claim form. Tell us the type of service or supply for which you wish to file a claim (for example, hospital, physician, or pharmacy), and we will send you the proper type of claim form. When you receive the form, complete it, attach an itemized bill, and send it to us at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858. Claims must be submitted and received by us within 24 months after the service takes place to be eligible for benefits.

If we receive a submission that does not qualify as a claim, we will notify you or your provider of the additional information we need. Once we receive that information, we will process the submission as a claim.

Processing of Claims: Even if we have received all of the information that we need in order to treat a submission as a claim, from time to time we might need additional information in order to determine whether the claim is payable. The most common example of this is X-rays. If we need this sort of additional information, we will ask you to furnish it to us, and we will suspend further processing of your claim until the information is received. You will have 90 days to provide the information to us. In order to expedite our receipt of the information, we may request it directly from your provider. If we do this, we will send you a copy of our request. However, you will remain responsible for seeing that we get the information on time.

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

In some cases, we may ask for additional time to process your claim. If you do not wish to give us additional time, we will go ahead and process your claim based on the information we have. 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 us for a courtesy pre-determination of benefits. If you ask for a courtesy pre-determination of a treatment plan, we will do our best to provide you with a timely response. If we decide that we cannot provide you with a courtesy pre-determination (for example, we cannot get the information we need to make an informed decision), we will let you know. In either case, courtesy pre-determinations are not claims under the plan. When we process requests for courtesy pre-determinations, we are not bound by the time frames and standards that apply to claims.

Your Right To Information

You have the right, upon request, to receive copies of any documents that we relied on in reaching our decision and any documents that were submitted, considered, or generated by us in the course of reaching our decision. You also have the right to receive copies of any internal rules, guidelines, or protocols that we may have relied upon in reaching our decision. If our decision was based on a medical or scientific determination (such as dental necessity), you may also request that we provide you with a statement explaining our application of those medical and scientific principles to you. If we obtained advice from a health care professional (regardless of whether we relied on that advice), you may request that we give you the name of that person. Any request that you make for information under this paragraph must be in writing. We will not charge you for any information that you request under this paragraph.

Appeals

If you are dissatisfied with our adverse benefit determination of a claim, you may file an appeal with us. You cannot file a claim for benefits under the plan in federal or state court (or in arbitration if provided by

your plan) unless you exhaust these administrative remedies.

The rules in this section of the booklet allow you or your authorized representative to appeal any adverse benefit determination. An adverse benefit determination means any determination we make with respect to a claim that results in your owing any money to your provider other than copayments you make, or are required to make, to your provider.

You have 180 days following our adverse benefit determination within which to submit an appeal.

How to File an Appeal: If you wish to file an appeal of an adverse benefit determination relating to a claim we recommend that you use a form that we have developed for this purpose. The form will help you provide us with the information that we need to consider your appeal. To get the form, you may call our Customer Service Department. You may also go to our Internet website at www.AlabamaBlue.com. Once there, you may ask us to send a copy of the form to you.

If you choose not to use our appeal form, you may send us a letter. Your letter must contain at least the following information:

- The patient's name;
- The patient's contract;
- Sufficient information to reasonably identify the claim or claims being appealed, such as date of service, provider name, procedure (if known), and claim number (if available). (The best way to satisfy this requirement is to include a copy of your Claims Report with your appeal.); and,
- A statement that you are filing an appeal.

You must send your appeal to the following address:

Blue Cross and Blue Shield of Alabama
Attention: Customer Service Department – Appeals
P.O. Box 12185
Birmingham, Alabama 35202-2185

Please note that if you call or write us without following the rules just described for filing an appeal, we will not treat your inquiry as an appeal. We will, of course, do everything we can to resolve your questions or concerns.

Conduct of the Appeal: We will assign your appeal to one or more persons within our organization who are neither the persons who made the initial determination nor subordinates of those persons. If resolution of your appeal requires us to make a medical judgment (such as whether services or supplies are dentally necessary), we will consult a health care professional who has appropriate expertise. If we consulted a health care professional during our initial decision, we will not consult that same person or a subordinate of that person during our consideration of your appeal.

If we need more information, we will ask you to provide it to us. In some cases we may ask your provider to furnish that information directly to us. If we do this, we will send you a copy of our request. However, you will remain responsible for seeing that we get the information. If we do not get the information, it may be necessary for us to deny your appeal.

We will consider your appeal fully and fairly.

We will notify you of our decision within 60 days of the date on which you filed your appeal.

In some cases, we may ask for additional time to process your appeal. If you do not wish to give us additional time, we will go ahead and decide your appeal based on the information we have. This may result in a denial of your appeal.

If You Are Dissatisfied After Exhausting Your Mandatory Plan Administrative Remedies: If you have filed an appeal and are dissatisfied with our response, you may do one or more of the following:

- You may ask our Customer Service Department for further help;

- You may file a voluntary appeal (discussed below); or
- You may file a lawsuit under Section 502(a) of ERISA or in the forum specified in your plan if your claim is not a claim for benefits under Section 502(a) of ERISA.

Voluntary Appeals: If we have given you our appeal decision and you are still dissatisfied, you may file a second appeal (called a voluntary appeal). You should file your appeal in writing by sending a letter to the same address you used when you submitted your first appeal.

Your written appeal must state that you are filing a voluntary appeal.

If you file a voluntary appeal, we will not assert in court a failure to exhaust administrative remedies if you fail to exhaust the voluntary appeal. We will also agree that any defense based upon timeliness or statutes of limitations will be tolled during the time that your voluntary appeal is pending. In addition, we will not impose any fees or costs on you as part of your voluntary appeal.

You may ask us to provide you with more information about voluntary appeals. This additional information will allow you to make an informed judgment about whether to request a voluntary appeal.

COBRA COVERAGE

COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, Title X). If COBRA applies, you may be able to temporarily continue coverage under the plan beyond the point at which coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA coverage may be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of a qualifying event. You are not entitled to buy COBRA coverage if you are employed as a nonresident alien who received no U.S. source income, nor may your family members buy COBRA.

Not all group dental plans are covered by COBRA. As a general rule, COBRA applies to all employer sponsored group dental plans (other than church plans) if the employer employed 20 or more full or part-time employees on at least 50% of its typical business days during the preceding calendar year. In determining the number of employees of an employer for purposes of COBRA, certain related corporations (parent/subsidiary and brother/sister corporations) must be treated as one employer. Special rules may also apply if the employer participates in an association plan.

You must contact your employer to determine whether this plan is covered by COBRA. Blue Cross is not your plan administrator.

By law, COBRA benefits are required to be the same as those made available to similarly situated active employees. If the group changes the plan coverage, coverage will also change for you. You will have to pay for COBRA coverage. Your cost will equal the full cost of the coverage plus a two percent administrative fee. Your cost may change over time, as the cost of benefits under the plan changes. If the group stops providing dental care through Blue Cross, Blue Cross will stop administering your COBRA benefits. You should contact your group to determine if you have further rights under COBRA.

COBRA Rights for Covered Employees

If you are a covered employee, you will become a qualified beneficiary if you lose coverage under the 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 your gross misconduct.

COBRA coverage will continue for up to a total of 18 months from the date of your termination of employment or reduction in hours, assuming you pay your premiums on time. If, apart from COBRA, your group continues to provide coverage to you after your termination of employment or reduction in hours (regardless of whether such extended coverage is permitted under the terms of the plan), the

extended coverage you receive will ordinarily reduce the time period over which you may buy COBRA benefits.

If you are on a leave of absence covered by the Family and Medical Leave Act of 1993 (FMLA), and you do not return to work, you will be given the opportunity to buy COBRA coverage. The period of your COBRA coverage will begin when you fail to return to work following the expiration of your FMLA leave or you inform your group that you do not intend to return to work, whichever occurs first.

If the plan provides dental coverage for retired employees, sometimes filing a proceeding in bankruptcy under Title 11 of the United States Bankruptcy Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the group, and the bankruptcy results in the loss of coverage of any covered retired employee, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage.

COBRA Rights for a Covered Spouse or Dependent Children

If you are covered under the plan as a spouse or a dependent child of a covered employee, you will become a qualified beneficiary if you would otherwise lose coverage under the plan as a result of any of the following events:

- The covered employee dies;
- The covered employee's hours of employment are reduced;
- The covered employee's employment ends for any reason other than his or her gross misconduct;
- The covered employee becomes enrolled in Medicare;
- Divorce of the covered employee and spouse; or,
- For a dependent child, the dependent child loses dependent child status under the plan.

When the qualifying event is a divorce or a child losing dependent status under the plan, you must timely notify the plan administrator of the qualifying event. You must provide this notice within 60 days of the event or within 60 days of the date on which coverage would be lost because of the event, whichever is later. See the section called [Notice Procedures](#) for more information about the notice procedures you must use to give this notice.

If you are a covered spouse or dependent child, the period of COBRA coverage will generally last up to a total of 18 months in the case of a termination of employment or reduction in hours and up to a total of 36 months in the case of other qualifying events, provided that premiums are paid on time. If, however, the covered employee became enrolled in Medicare before the end of his or her employment or reduction in hours, COBRA coverage for the covered spouse and dependent children will continue for up to 36 months from the date of Medicare enrollment or 18 months from the date of termination of employment or reduction in hours, whichever period ends last.

If you are a child of the covered employee or former employee and you are receiving benefits under the plan pursuant to a qualified medical child support order, you are entitled to the same rights under COBRA as a dependent child of the covered employee.

If your coverage is canceled in anticipation of divorce and a divorce later occurs, the divorce may be a qualifying event even though you actually lost coverage under the plan earlier. If you timely notify the plan administrator of your divorce and can establish that your coverage was canceled in anticipation of divorce, COBRA coverage may be available to you beginning on the date of your divorce (but not for the period between the date your coverage ended and the date of the divorce).

Extension of COBRA for Disability

If you or a covered member of your family is or becomes disabled under Title II (OASDI) or Title XVI (SSI)

of the Social Security Act and you timely notify the plan administrator, the 18-month period of COBRA coverage for the disabled person may be extended to up to 11 additional months (for a total of up to 29 months) or the date the disabled person becomes covered by Medicare, whichever occurs sooner. This 29-month period also applies to any non-disabled family members who are receiving COBRA coverage, regardless of whether the disabled individual elects the 29-month period for him or herself. The 29-month period will run from the date of the termination of employment or reduction in hours. For this disability extension to apply, the disability must have started at some time before the 60th day of COBRA coverage and must last at least until the end of the 18-month period of COBRA coverage.

The cost for COBRA coverage after the 18th month will be 150% of the full cost of coverage under the plan, assuming that the disabled person elects to be covered under the disability extension. If the only persons who elect the disability extension are non-disabled family members, the cost of coverage will remain at 102% of the full cost of coverage.

For a spouse and children, the disability extension may be further extended to 36 months if another qualifying event (death, divorce, enrollment in Medicare, or loss of dependent status) occurs during the 29-month period. See the following discussion under "Extensions of COBRA for Second Qualifying Events" for more information about this.

For this disability extension of COBRA coverage to apply, you must give the plan administrator timely notice of Social Security's disability determination before the end of the 18-month period of COBRA coverage and within 60 days after the later of (1) the date of the initial qualifying event, (2) the date on which coverage would be lost because of the initial qualifying event, or (3) the date of Social Security's determination. You must also notify the plan administrator within 30 days of any revocation of Social Security disability benefits. See the section called [Notice Procedures](#) for more information about the notice procedures you must use to give this notice.

Extensions of COBRA for Second Qualifying Events

For a spouse and children receiving COBRA coverage, the 18-month period may be extended to 36 months if another qualifying event occurs during the 18-month period, if you give the plan administrator timely notice of the second qualifying event. The 36-month period will run from the date of the termination of employment or reduction in hours.

This extension is available to a spouse and children receiving COBRA coverage if the covered employee or former employee dies, becomes enrolled in Medicare, or gets divorced, or if the child stops being eligible under the plan as a dependent child, *but only if the event would have caused the spouse or child to lose coverage under the plan had the first qualifying event not occurred.* For example, if a covered employee is terminated from employment, elects family coverage under COBRA, and then later enrolls in Medicare, this second event will rarely be a second qualifying event that would entitle the spouse and children to extended COBRA coverage. This is so because, for almost all plans that are subject to COBRA, this event would not cause the spouse or dependent children to lose coverage under the plan if the covered employee had not been terminated from employment.

For this 18-month extension to apply, you must give the plan administrator timely notice of the second qualifying event within 60 days after the event occurs or within 60 days after the date on which coverage would be lost because of the event, whichever is later. See the section called [Notice Procedures](#) for more information about the notice procedures you must use to give this notice.

Notice Procedures

If you do not follow these notice procedures or if you do not give the plan administrator notice within the required 60-day notice period, you will not be entitled to COBRA or an extension of COBRA as a result of an initial qualifying event of divorce or loss of dependent child status, a second qualifying event or Social Security's disability determination.

Any notices of initial qualifying events of divorce or loss of dependent child status, second qualifying

events or Social Security disability determinations that you give must be in writing. Your notice must be received by the plan administrator or its designee no later than the last day of the required 60-day notice period unless you mail it. If mailed, your notice must be postmarked no later than the last day of the required 60-day notice period.

For your notice of an initial qualifying event that is a divorce or a child losing dependent status under the plan and for your notice of a second qualifying event, you must mail or hand-deliver your notice to the plan administrator at the address listed under [Administrative Information](#) in the [Statement of ERISA Rights](#) section. If the initial or second qualifying event is a divorce, your notice must include a copy of the divorce decree. For your convenience, you may ask the plan administrator for a free copy of the Notice by Qualified Beneficiaries form that you may use to give your notice.

For your notice of Social Security's disability determination, if you are instructed to send your COBRA premiums to Blue Cross, you must mail or hand-deliver your notice to Blue Cross at the following address: Blue Cross and Blue Shield of Alabama, Attention: Customer Accounts, 450 Riverchase Parkway East, Birmingham, Alabama 35298-0001, or fax your notice to Blue Cross at 205-220-6884 or 1-888-810-6884 (toll-free). If you do not send your COBRA premiums to Blue Cross, you must mail or hand-deliver your notice to the plan administrator at the address listed under [Administrative Information](#) in the [Statement of ERISA Rights](#) section. Your notice must also include a copy of Social Security's disability determination. For your convenience, you may ask the plan administrator for a free copy of the Notice by Qualified Beneficiaries form that you may use to give your notice.

Adding New Dependents to COBRA Coverage

You may add new dependents to your COBRA coverage under the circumstances permitted under the plan. Except as explained below, any new dependents that you add to your COBRA coverage will not have independent COBRA rights. This means, for example, that if you die, they will not be able to continue coverage.

If you are the covered employee and you acquire a child by birth or placement for adoption while you are receiving COBRA coverage, then your new child will have independent COBRA rights. This means that if you die, for example, your child may elect to continue receiving COBRA benefits for up to 36 months from the date on which your COBRA benefits began.

If your new child is disabled within the 60-day period beginning on the date of birth or placement of adoption, the child may elect coverage under the disability extension if you timely notify the plan administrator of Social Security's disability determination as explained above.

Medicare and COBRA Coverage

If you think you will need both Medicare and dental coverage through COBRA after your retirement or other qualifying event under COBRA, you should enroll in Medicare on or before the date on which you make your election to buy COBRA coverage. If you do this, COBRA coverage for your dependents will continue for a period of 18 months from the date of your retirement or 36 months from the date of your Medicare enrollment, whichever period ends last. Your COBRA coverage will continue for a period of 18 months from the date of retirement. If you do not enroll in Medicare on or before the date on which you make your election to buy COBRA coverage, your COBRA benefits will end when your Medicare coverage begins. Your covered dependents will have the opportunity to continue their own COBRA coverage.

If you do not want both Medicare and COBRA for yourself, your covered family members will still have the option to buy COBRA when you retire.

Electing COBRA

After the plan administrator receives timely notice that a qualifying event has occurred, the plan

administrator is responsible for (1) notifying you that you have the option to buy COBRA, and (2), sending you an application to buy COBRA coverage.

You have 60 days within which to elect to buy COBRA coverage. The 60-day period begins to run from the later of (1) the date you would lose coverage under the plan, or (2), the date on which the group notifies you that you have the option to buy COBRA coverage. Each qualified beneficiary has an independent right to elect COBRA coverage. You may elect COBRA coverage on behalf of your spouse, and parents may elect COBRA coverage on behalf of their children. An election to buy COBRA coverage will be considered made on the date sent back to the group.

Once the group has notified us that your coverage under the plan has ceased, we will retroactively terminate your coverage and rescind payment of all claims incurred after the date coverage ceased. If you elect to buy COBRA during the 60-day election period, and if your premiums are paid on time, we will retroactively reinstate your coverage and process claims incurred during the 60-day election period.

Because there may be a lag between the time your coverage under the plan ends and the time we learn of your loss of coverage, it is possible that we may pay claims incurred during the 60-day election period. If this happens, you should not assume that you have coverage under the plan. The only way your coverage will continue is if you elect to buy COBRA and pay your premiums on time.

COBRA Premiums

Your first COBRA premium payment must be made no later than 45 days after you elect COBRA coverage. That payment must include all premiums owed from the date on which COBRA coverage began. This means that your first premium could be larger than the monthly premium that you will be required to pay going forward. You are responsible for making sure the amount of your first payment is correct. You may contact the plan administrator to confirm the correct amount of your first payment.

After you make your first payment for COBRA coverage, you must make periodic payments for each subsequent coverage period. Each of these periodic payments is due on the first day of the month for that coverage period. There is a grace period of 30-days for all premium payments after the first payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, any claim you submit for benefits will be suspended as of the first day of the coverage period and then processed by the plan only when the periodic payment is received. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to COBRA coverage under the plan.

Payment of your COBRA premiums is deemed made on the day sent.

Early Termination of COBRA

Your COBRA coverage will terminate early if any of the following events occur:

- The group no longer provides group dental coverage to any of its employees;
- You do not pay the premium for your continuation coverage on time;
- After electing COBRA coverage, you become covered under another group dental plan;
- After electing COBRA coverage, you become enrolled in Medicare; or,
- You are covered under the additional 11-month disability extension and there has been a final determination that the disabled person is no longer disabled for Social Security purposes.

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.

If your group stops providing dental care through Blue Cross, you will cease to receive any benefits through us for any and all claims incurred after the effective date of termination of our contract with the group. This is true even if we have been billing your COBRA premiums prior to the date of termination.

It is the responsibility of your group, not Blue Cross, to notify you of this termination. You must contact your group directly to determine what arrangements, if any, your group has made for the continuation of your COBRA benefits.

When COBRA Coverage Ends

If you exhaust your COBRA coverage or you stop paying for it, then you will not have any further coverage under the group dental plan.

If you have any further questions about COBRA or if you change marital status, or you or your spouse or child changes address, please contact your plan administrator. Additional information about COBRA can also be found at the web site of the Employee Benefits Security Administration of the United States Department of Labor.

GENERAL INFORMATION

Delegation of Discretionary Authority to Blue Cross

The group has delegated to us the discretionary responsibility and authority to determine claims under the plan, to construe, interpret, and administer the plan, and to perform every other act necessary or appropriate in connection with our provision of benefits and/or administrative services under the plan.

Whenever we make reasonable determinations that are neither arbitrary nor capricious in our administration of the plan, those determinations will be final and binding on you, subject only to your right of review under the plan (including, when applicable, arbitration) and thereafter to judicial review to determine whether our determination was arbitrary or capricious.

Notice

We give you notice when we mail it or send it electronically to you or your group at the latest address we have. You and your group are assumed to receive notice three days after we mail it. Your group is your agent to receive notices from us about the plan. The group is responsible for giving you all notices from us. We are not responsible if your group fails to do so.

Unless otherwise specified in this booklet, if you are required to provide notice to us, you should do so in writing, including your full name and contract number, and mail the notice to us at 450 Riverchase Parkway East, P.O. Box 995, Birmingham, Alabama 35298-0001.

Correcting Payments

While we try to pay all claims quickly and correctly, we do make mistakes. If we pay you or a provider in error, the payee must repay us. If he does not, we may deduct the amount paid in error from any future amount paid to you or the provider. If we deduct it from an amount paid to you, it will be reflected in your claims report.

Responsibility for Providers

We are not responsible for what providers do or fail to do. If they refuse to treat you or give you poor or dangerous care, we are not responsible. We need not do anything to enable them to treat you.

Misrepresentation

If you commit fraud or make any intentional material misrepresentation in applying for coverage, when we learn of this we may terminate your coverage back to the effective date on which your coverage began as listed in our records. We need not refund any payment for your coverage. If your group commits fraud or makes an intentional material misrepresentation in its application, it will be as though the plan never took effect, and we need not refund any payment for any member.

Governing Law

The law governing the plan and all rights and obligations related to the plan shall be ERISA, to the extent applicable. To the extent ERISA is not applicable, the plan and all rights and obligations related to the plan shall be governed by, and construed in accordance with, the laws of the state of Alabama, without regard to any conflicts of law principles or other laws that would result in the applicability of other state laws to the plan.

Termination of Benefits and Termination of the Plan

Our obligation to provide or administer benefits under the plan may be terminated at any time by either the group or us by giving written notice to the other as provided for in the contract. The fiduciary obligation, if any, to notify you of this termination belongs to the group, not to us.

If the group fails to pay us the amounts due under the contract within the time period specified therein, our obligation to provide or administer benefits under the plan will terminate automatically and without notice to you or the group as of the date due for payment. The fiduciary obligation, if any, to notify you of this termination belongs to the group, not to us.

Subject to any conditions or restrictions in our contract with the group, the group may terminate the plan at any time through action by its authorized officers. In the event of termination of the plan, all benefit payments by us will cease as of the effective date of termination, regardless of whether notice of the termination has been provided to you by the group or us. The fiduciary obligation, if any, to notify you of this termination belongs to the group, not to us.

If for any reason our services are terminated under the contract, you will cease to receive any benefits by us for any and all claims incurred after the effective date of termination. In some cases, this may mean retroactive cancellation by us of your plan benefits. This is true for active contract holders, retirees, COBRA beneficiaries and dependents of either. Any fiduciary obligation to notify you of our termination belongs to the group, not to us.

Changes in the Plan

By giving a 30-day notice to the group, we may amend any and all provisions of the plan or the amount of fees that you or your group must pay for coverage under the plan. The fiduciary obligation to notify you of these changes belongs to the group, not us. The plan amendment will be effective whether or not the group has notified you of the amendment. Payment of premiums by the group after the effective date of the amendment will constitute acceptance by you and the group of the changes.

Except as otherwise provided in the contract, no representative or employee of Blue Cross is authorized to amend or vary the terms and conditions of the plan or to make any agreement or promise not specifically contained in the plan documents or to waive any provision of the plan documents. This means, in part, that no representative, employee, or agent of Blue Cross may make any changes to the plan over the telephone or verbally.

No Assignment

We will not honor an assignment of your claim to anyone. Some of the contracts we have with providers of services, such as hospitals, require us to pay benefits directly to the providers. With other claims we may choose whether to pay you or the provider. If you or the provider owes us money we may deduct the amount owed from the benefit paid. When we pay or deduct the amount owed from you or the provider, this completes our obligation to you under the plan. Upon your death or incompetence, or if you are a minor, we may pay your estate, your guardian or any relative we believe is due to be paid. This, too, completes our plan obligation to you.

Alabama Insurance Fraud Investigation Unit and Criminal Prevention Act

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

DEFINITIONS

Affordable Care Act: The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Educational Reconciliation Act, and its implementing rules and regulations.

Allowable Amount: The amount of a dentist's charge that Blue Cross will recognize as covered expenses for medically/dentally necessary services provided by the plan. 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 dentist's 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 providers may bill the member for charges in excess of the allowable amount.

Blue Cross: Blue Cross and Blue Shield of Alabama, except where the context designates otherwise.

Care Coordination: Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's/Subscriber's/Covered Person's/Employee's healthcare needs across the continuum of care.

Care Coordinator Fee: A fixed amount paid by a payer/Blue Cross and/or Blue Shield Plan to providers periodically for Care Coordination under a Value-Based Program.

Contract: Unless the context requires otherwise, the terms "contract" and "plan" are used interchangeably. The contract includes our financial agreement or administrative services agreement with the group.

Dentally Necessary or Dental Necessity: Services or supplies which are necessary to treat your illness, injury, or symptom. To be dentally necessary, services or supplies must be determined by Blue Cross 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 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: Any healthcare provider when licensed and acting within the scope of that license or certification at the time and place you are treated or receive services.

Group: The employer or other organization that has contracted with us to provide or administer group dental benefits pursuant to the plan.

In-Network Dentist: A dentist who has an agreement with Blue Cross and Blue Shield of Alabama to provide dental services to members entitled to benefits under the plan.

Investigational: Any treatment, procedure, facility, equipment, drugs, drug usage, or supplies that either we have not recognized as having scientifically established dental value, or that does not meet generally accepted standards of dental practice. When possible, we develop written criteria (called dental criteria) concerning services or supplies that we consider to be investigational. We base these criteria on peer-reviewed literature, recognized standards of dental practice, and technology assessments. We put these dental criteria in policies that we make available to the dental community and our members. We do this so that you and your providers will know in advance, when possible, what we will pay for. If a service or supply is considered investigational according to one of our published dental criteria policies, we will not pay for it. If the investigational nature of a service or supply is not addressed by one of our published dental criteria policies, we 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 dental outcomes;
- The technology must improve the net dental 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 we make determinations about the investigational nature of a service or supply we are 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 dental providers.

Medically Necessary Orthodontic Services: Dentally necessary orthodontia is covered for the treatment of congenital or hereditary conditions which result in craniofacial abnormalities which would require medically necessary surgical correction (as determined by the plan) due to problems related to swallowing, chewing, speaking, breathing, OR for acute injury to the teeth from an external force which cannot be stabilized by any other method. This treatment may be placed prior to and/or following the corrective surgery. Dentally necessary orthodontia as defined by this plan does not include realigning teeth, closing gaps between teeth, or the movement of teeth for cosmesis.

Member: You or your eligible dependent who has coverage under the plan.

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

Plan: The plan is the group dental benefit plan of the group, as amended from time to time. The plan documents consist of the following:

- This benefit booklet, as amended;
- Our contract with the group, as amended;
- Any benefit matrices upon which we have relied with respect to the administration of the plan; and,
- Any draft benefit booklets that we are treating as operative. By “operative,” we mean that we have provided a draft of the booklet to the group that will serve as the primary, but not the sole, instrument upon which we base our administration of the plan, without regard to whether the group finalizes the booklet or distributes it to the plan's members.

If there is any conflict between any of the foregoing documents, we will resolve that conflict in a manner that best reflects the intent of the group and us as of the date on which claims were incurred. Unless the

context requires otherwise, the terms "plan" and "contract" have the same meaning.

Plan Administrator: The group that sponsors the plan and is responsible for its overall administration. If the plan is covered under ERISA, the group referred to in this definition is the "administrator" and "sponsor" of the plan within the meaning of section 3(16) of ERISA.

Provider Incentive: An additional amount of compensation paid to a healthcare provider by a payer/Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular group/population of covered persons.

Value-Based Program (VBP): An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

We, Us, Our: Blue Cross and Blue Shield of Alabama.

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

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation, to the extent applicable to the plan.

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Dental Plan Coverage

Continue dental care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this booklet plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your group, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan administrator and do not receive them within 30 days, you may file suit in a Federal court (unless your plan has a binding arbitration clause). In such a case, the court may require the plan administrator, which is not Blue Cross, to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court after you have exhausted your administrative remedies under the plan. In addition, if you disagree with the plan administrator's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Administrative Information

The following information is provided pursuant to the requirements of ERISA:

- The plan's official name is: Millsource Group Dental Care Plan.
- The plan sponsor and plan administrator is the employer. The employer is responsible for discharging all obligations that ERISA and its regulations impose upon plan sponsors and plan administrators, such as delivering summary plan descriptions, annual reports, and COBRA notices when required by law.
- The plan number assigned by the plan sponsor is: 501.
- The IRS Employer Identification Number (EIN) of the sponsor is: 63-0400153.
- The plan provides dental benefits as administered under an agreement between Blue Cross and Blue Shield of Alabama and the group. Blue Cross has complete discretion to interpret and administer the provisions of the plan. The administrative functions performed by Blue Cross include paying claims, determining medical necessity, etc. The plan benefits are underwritten.
- The agent for legal process is the group.
- The records of the dental plan are kept on the basis of a plan year which begins on January 1st and ends on the following December 31st.
- The group currently intends to continue the plan as described herein, but reserves the right, in its discretion, to amend, reduce or terminate the plan and coverage at any time for active employees, retirees, former employees, and all dependents.

- This is an employer-employee shared cost plan. The sources of the contributions to this plan are currently the group and the employee in relative amounts as determined by the group from time to time. While the group may change its level of contribution at any time, the group must always contribute at least a portion of the employee's premiums. Any information concerning what is to be paid by the employee in the future will be furnished by the group in writing and will constitute a part of this plan. Your contribution is determined by the group based on the plan's experience and other factors.
- Plan Administrator Contact Information:

Please mail or hand-deliver all COBRA notices to your plan administrator at the following address:

Attention: Employee Benefits (COBRA)
Millsource
80 Shelby Street
Montevallo, Alabama 35115-4089

450 Riverchase Parkway East
P.O. Box 995
Birmingham, Alabama 35298-0001

Customer Service Department:

1-800-292-8868 toll-free

Website:

www.AlabamaBlue.com

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Dental Plan

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