

Troy University

Effective January 1, 2007

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Birmingham, Alabama 35298-0001

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or 1 800 292-8868 toll-free

web site:

www.bcbsal.com

54395 & 02523
Dental Plan

02/07

WELCOME

All of us at Blue Cross and Blue Shield of Alabama pledge to you we will provide the best service we can in the administration of your group dental care plan. The following information summarizes your group's benefits. It also summarizes conditions, limitations, and exclusions to those benefits. There are sections explaining eligibility and defining certain words, too. Please be sure to read this information in its entirety.

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 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.

If you have any questions which the person in your company who deals with employee benefits cannot answer, please contact the Blue Cross and Blue Shield of Alabama Customer Service Department.

This booklet contains a summary in English of your plan rights and benefits. If you have questions about your benefits please contact Customer Service at 1 800 292-8868. Simply request a Spanish translator and one will be provided to assist you in understanding your benefits.

Atención por favor - Spanish

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

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SUMMARY OF DENTAL BENEFITS

This table is a summary of benefits and is subject to all other terms and conditions of the Plan:

Maximum Benefit Amounts*	Deductible**
\$1,000 per member each calendar year	\$25 per member each calendar year (three per family)

* Charges applied toward annual and/or lifetime maximums incurred by you or your covered dependents while covered under another Blue Cross and Blue Shield of Alabama contract will be applied toward annual and/or lifetime maximums under this contract.

** The deductible will be applied to claims in the order in which they are processed regardless of the order in which they are received. Once the maximum number of family members specified above has met the full deductible, no additional covered expenses will be applied toward any family member's individual deductible for the rest of the calendar year; however, all charges applied toward individual deductibles until that point are nonrefundable.

We pay benefits toward the Allowable Amount or the dentists actual charge for services. This is the same amount whether you receive services from a Preferred or a Non-Preferred Dentist. There are three differences:

1. All Preferred Dentists agree our payment is payment in full except for your deductible and copayments. If you are covered under another group dental plan, a Preferred Dentist may bill that plan for any difference between the Allowable Amount and his usual charge for a service.
2. Non-Preferred Dentists may charge you the difference between what we pay and their billed amount.
3. Preferred Dentists may not collect their fee for plan benefits from you except for deductibles and copays. They must bill us first except for services which are not plan benefits, such as implants.

Benefit	Copay
Basic Services	20%
Supplemental Services	20%
Periodontic Services	20%

ELIGIBILITY

Who Is Eligible for This Plan?

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

1. you are an employee of your employer and are treated as an employee (as opposed to an independent contractor) by your employer;
2. you work 30 or more hours per week (including vacation and certain leaves of absence that are discussed in the section below dealing with termination of coverage);
3. you are in a category or classification of employees that is covered by the plan;
4. you meet any other eligibility or participation rules established by us or your employer; and,
5. 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.

Is There A Waiting Period Under The Plan?

There is no waiting period under the plan. This means that you may enroll in the plan once you have met the eligibility requirements listed above. Coverage will begin on the date specified below under "When Does Coverage Begin?"

How Do I Apply for the Plan?

Fill out an application form completely and give it to your employer or group. You must name all eligible dependents to be covered on the application. Your employer or group will collect all of the employees' applications and send them to us.

Which of My Dependents Is Eligible?

Your eligible dependents are:

1. your spouse (of the opposite sex);
2. an unmarried child under age 19;
3. an unmarried child age 19 to 24 while a full-time student in a state accredited school, not working full-time and chiefly depending on you for support; and,
4. an incapacitated child who is not able to support himself and who depends on you for support, if the incapacity occurred before age 19 (or 24 if a "full-time student").

The child may be:

1. a natural child,
2. a stepchild residing in the household of the eligible employee,
3. a legally adopted child,
4. a child placed for adoption; or,
5. any other unmarried child for whom the employee has permanent legal custody and who depends solely on the employee for support and regularly and permanently resides with the employee in a parent-child relationship.

A grandchild is only eligible if he or she meets all of the following guidelines: (1) under 19 years of age; (2) unmarried; (3) chiefly dependent on the employee for support; (4) resides in the same household full-time with the employee in a parent-child relationship; and (5) is not employed on a regular full-time basis. The grandchild's parent may not be covered by the employee's contract unless the grandchild has been adopted by the grandparents and the parent meets all of the other conditions to be covered as a dependent. A grandchild may continue coverage under the plan up to age 24 if unmarried and a full-time student in a state accredited school, not working full time, and chiefly dependent upon the employee for support.

When Does Coverage Begin?

Regular Enrollment for Employees:

If you apply within 30 days after the date on which you meet the plan's eligibility requirements (including any applicable waiting periods), your coverage will begin as of the date thereafter specified by your group (generally the first day of the month after you have met the eligibility requirements and applied). If you are a new employee, coverage will not begin earlier than the first day on which you report to active duty. An employee who enrolls under this paragraph is called a "regular enrollee."

Late Enrollment Not Permitted:

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

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, or adoption, you may enroll your spouse and your new dependent as special enrollees 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, or adoption. 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. A dependent who enrolls under this paragraph is called a "special enrollee."

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.

Will The Plan Cover A Child If Required To Do So By Court Order?

If the employer (the plan administrator) receives an order from a court or administrative agency directing the plan to cover a child, the employer 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 employer 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 the employer at the address shown near the end of this summary.

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

1. If we receive a copy of the order within 30 days of the date on which it was entered, along with instructions from the employer to enroll the child pursuant to the terms of the order, coverage will begin as of the date on which the order was entered.
2. 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 employer 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 employer 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 Blue Cross will make benefit payments— other than payments to providers – to the parent or legal guardian who has been awarded custody of the child. Blue Cross 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. Blue Cross will also send claims reports directly to the child's custodial parent or legal guardian.

When Will Coverage Terminate?

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):

1. 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 leave of absence rules below);
2. for spouses, the date of divorce or other termination of marriage;
3. for children, the date a child ceases to be a dependent;
4. for the subscriber and his or her dependents, the date of the subscriber's death;
5. your group fails to pay us the amount due within 30 days after the day due;
6. upon discovery of fraud or intentional misrepresentation of a material fact by you or your group;
7. when none of your group's members still live, reside or work in Alabama; or,
8. on 30 days advance written notice from your group to us.

In all cases 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.

Will I Lose My Coverage During a Leave of Absence?

If your employer 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 employer to determine whether 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 employer 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 employer for information about your rights to continue coverage under the plan.

COBRA COVERAGE

What Is COBRA; Does It Apply to Me?

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.

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 plan administrator (normally your employer) to determine whether this plan is covered by COBRA. Blue Cross is not your plan administrator.

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 employer stops providing dental care through Blue Cross, Blue Cross will stop administering your COBRA benefits. You should contact your employer to determine if you have further rights under COBRA.

What Are My COBRA Rights if I Am a Covered Employee?

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

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.

If the plan provides dental coverage for retired employees, sometimes filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer, 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.

What Are My COBRA Rights if I Am a Covered Spouse?

If you are covered under the plan as a spouse 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:

- your spouse dies;
- your spouse's hours of employment are reduced;
- your spouse's employment ends for any reason other than his or her gross misconduct;
- your spouse becomes enrolled in Medicare; or
- you become divorced from your spouse.

If your spouse cancels your coverage in anticipation of divorce and a divorce later occurs, your 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 spouse canceled your coverage 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). See the discussion below under "Do I Have to Give Notice of any Qualifying Events?" and "What are the Notice Procedures I Have to Use to Notify the Plan of Certain Events?" for more information about your responsibility to give timely notice of your divorce and the procedures for doing so.

What Are My COBRA Rights if I Am a Dependent Child?

If you are covered under the plan as 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 parent-employee dies;
- the parent-employee's hours of employment are reduced;
- the parent-employee's employment ends for any reason other than his or her gross misconduct;
- the parent-employee becomes enrolled in Medicare;
- your parents become divorced; or
- you lose dependent child status under the plan.

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.

How Long will COBRA Last if I Am a Covered Spouse or Dependent Child?

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. For example, if a covered employee becomes enrolled in Medicare 8 months before the date on which his employment terminates, COBRA coverage for his spouse and children can last up to 36 months after the date of Medicare enrollment, which is equal to 28 months after the date of the qualifying event that is termination of employment (36 months minus 8 months).

Do I Have to Give Notice of any Qualifying Events?

Yes.

You will be offered COBRA coverage only after the plan administrator has been notified that a qualifying event has occurred. 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 discussion below under "What are the Notice Procedures I Have to Use to Notify the Plan of Certain Events?" for more information about the notice procedures you must use to give this notice. *If you do not follow these notice procedures or if you do not give the plan administrator notice of your divorce or a child losing dependent status under the plan within the 60-day notice period, you will not be permitted to buy COBRA coverage as a result of divorce or a child losing dependent status.*

When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer if the plan provides retiree dental coverage, or the employee's becoming enrolled in Medicare, the employer must notify the plan administrator of the qualifying event.

Can COBRA Coverage be Extended if I Am Disabled?

Yes. In certain circumstances you can take advantage of a special disability extension.

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 spouses 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 "Can COBRA Coverage be Extended if I have a Second Qualifying Event?" for more information about this.

Do I Have to Give Notice of Social Security's Disability Determination?

Yes.

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 (i) the date of the initial qualifying event, (ii) the date on which coverage would be lost because of the initial qualifying event, or (iii) 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 discussion below under "What are the Notice Procedures I Have to Use to Notify the Plan of Certain Events?" for more information about the notice procedures you must use to give this notice. *If you do not follow these notice procedures or if you do not give the plan administrator notice of Social Security's disability determination within the required notice period, you will not be entitled to this disability extension of COBRA coverage.*

Can COBRA Coverage be Extended if I have a Second Qualifying Event?

Yes. In certain circumstances spouses and children can take advantage of a special second qualifying event extension.

For spouses 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 spouses 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.

Do I Have to Give Notice of Second Qualifying Events?

Yes.

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 discussion below under "What are the Notice Procedures I Have to Use to Notify the Plan of Certain Events?" for more information about the notice procedures you must use to give this notice. *If you do not follow these notice procedures or if you do not give the plan administrator notice of the second qualifying event within the required 60-day notice period, you will not be entitled to an extension of COBRA coverage as a result of the second qualifying event.*

What are the Notice Procedures I Have to Use to Notify the Plan of Certain Events?

Any notices that you give must be in writing. Oral notice, including notice by telephone, is not acceptable. 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 in the last paragraph entitled "Plan Administrator Contact Information" at the end of this booklet. Your notice must state (i) the name of the plan, (ii) the covered employee's name and address, (iii) the name(s) and address(es) of all qualified beneficiary(ies), (iv) the initial qualifying event and the date of the event, and (v), when applicable, the second qualifying event and the date of the event. 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 (toll-free) 1 888 810-6884. 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 in the last paragraph entitled "Plan Administrator Contact Information" at the end of this booklet. Your notice must state (i) the name of the plan, (ii) the covered employee's name and address, (iii) the name(s) and address(es) of all qualified beneficiary(ies), (iv) the qualifying event and the date of the event, (v) the name of the disabled person, (vi) the date the disabled person became disabled, and (vii) the date of Social Security's determination of disability. 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.

Can I Add Newly Acquired Dependents to My COBRA Coverage?

Yes, but only under circumstances permitted under the dental plan. In addition, except as explained below, any new dependents that you add to your coverage will not have independent COBRA rights. That 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. The election should be made on the child's behalf by the child's legal guardian.

I Am Age 65 or Older and about to Retire. Can I Have Medicare and COBRA Coverage at the Same Time?

Yes. If you think you will need both Medicare and COBRA after your retirement, 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 your 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.

Are There Election Rules That Apply to COBRA?

Yes.

After the plan administrator receives timely notice that a qualifying event has occurred, the plan administrator is responsible for (i) notifying you that you have the option to buy COBRA, and (ii), 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 (i) the date you would lose coverage under the plan, or (ii), the date on which the employer 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 employer.

Once the employer 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.

Can My COBRA Coverage Terminate Early?

Yes.

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

- the employer 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 that does not contain any exclusion or limitation on any pre-existing condition you may have or you have sufficient creditable coverage to preclude application of the new plan's pre-existing condition exclusion period to you;

- 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 you are buying COBRA coverage and you become covered under a group dental plan that contains a pre-existing condition limitation or exclusion that *does* apply to you (for example, you do not have enough creditable coverage to preclude application of the new plan's pre-existing condition exclusion period to you), you should discuss the situation with the sponsor of the new plan (usually the new employer) to determine whether it makes sense nonetheless for you to enroll in the new plan while continuing to pay for COBRA coverage at the same time. Since some plans limit the circumstances under which employees and their families may enroll, it is best to consult with the new employer concerning the interaction of COBRA and the new employer's group dental coverage.

Can COBRA Benefits Change?

Yes, as and when benefits under the group dental plan change.

By law, COBRA benefits are required to be the same as those made available to similarly situated active employees. If the employer changes the group coverage, coverage will also change for you.

When Must COBRA Premiums be Paid?

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.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1 866 628-4282. TTD/TTY callers may call toll-free at 1 866 626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.cfm.

What Happens 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.

BENEFIT CONDITIONS

To qualify as plan benefits, dental services and supplies must meet the following:

1. They must be furnished after your coverage becomes effective;
2. We must determine before, during or after services and supplies are furnished that they are dentally necessary;
3. Preferred Dentist benefits must be furnished while you are covered by this plan and the physician must have a Preferred Dentist contract with us;
4. Services and supplies must be furnished when the plan and your coverage both are in effect and fully paid for. No benefits will be provided for services you receive after the plan or your coverage ends, even if they are for a condition which began before the plan or your coverage ends.

DENTAL BENEFITS

Payment of Benefits

We pay Preferred Dentists directly and pay you for services of Non-Preferred Dentists.

Basic Services

1. Dental exams, up to twice per calendar year.
2. Dental x-ray exams:
 - a. Full mouth x-rays, one set during any 36 months in a row;
 - b. Bitewing x-rays, up to twice per calendar year; and
 - c. Other dental x-rays, used to diagnose a specific condition.
3. Tooth sealants on teeth numbers 3, 14, 19 and 30, limited to one application per tooth each 48 months. Benefits are limited to a maximum payment of **\$20 per tooth** and limited to the first permanent molars of children through age 13.
4. Fluoride treatment for children through age 18, twice per calendar year.
5. Space maintainers (not made of precious metals) that replace prematurely lost teeth for children through age 18.

6. Fillings made of silver amalgam and tooth color materials (tooth color materials include composite fillings on the front upper and lower teeth numbers 6-11 and 22-27; payment allowance for composite fillings used on posterior teeth is reduced to the allowance given on amalgam fillings).
7. Routine cleanings, twice per calendar year.
8. Simple tooth extractions.
9. Direct pulp capping, removal of pulp, and root canal treatment.
10. Repairs to removable dentures.
11. Emergency treatment for pain.

Supplemental Services

1. Oral surgery, i.e., tooth extractions and impacted teeth and to treat mouth abscesses of the intra-oral and extra-oral soft tissue.
2. 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.
3. Treatment of the root tip of the tooth including its removal.

Periodontic Services

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

DENTAL BENEFIT LIMITATIONS

Limits to all benefits:

1. Examination and diagnosis no more than twice during any calendar year.
2. Full mouth x-rays will be provided once each 36 months. Bitewings no more than twice during any calendar year.
3. Routine cleaning will be provided no more than twice during any calendar year.
4. Fluoride treatment will be provided to members through age 18 no more than twice during any calendar year.
5. Tooth sealants on teeth numbers 3, 14, 19 and 30, limited to one application per tooth each 48 months. Benefits are limited to a maximum payment of **\$20 per tooth** and limited to the first permanent molars of children through age 13.
6. 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.

7. When there are two ways to treat you and both are plan benefits, we'll pay toward the less expensive one. The dentist may charge you for any excess.

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.

Which plan is primary is decided by the first rule below that applies (note, however, that if the other plan is Medicare the order of benefit determination is determined by the applicable Medicare secondary payer laws):

1. If the other plan has no COB provision, it is primary.
2. Employee/Dependent: The plan covering a patient as an employee, member, or subscriber (that is other than as a dependent) is primary over the plan covering the patient as a dependent. In some cases, depending upon the size of the employer, Medicare secondary payer rules may require us to reverse this order of payment. This can occur when the patient is covered as an inactive or retired employee, is also covered as a dependent of an active employee, and is also covered by Medicare. In this case, the order of benefit determination will be as follows: first, the plan covering the patient as a dependent; second, Medicare; and third, the plan covering the patient as an inactive or retired employee.
3. Dependent Child/Parents Not Separated or Divorced: If both plans cover the patient as a dependent child, 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. If the other plan does not use this "birthday rule" the other plan's rule will be used.
4. Dependent Child/Separated or Divorced Parents: If two or more plans cover the patient as a dependent child of divorced or separated parents, benefits are determined in this order:
 - a. first, the plan of the parent with custody;
 - b. second, the plan of the spouse of the parent with custody;
 - c. third, the plan of the parent without custody; and
 - d. last, the plan of the spouse of the parent without custody.

If the divorced or separated parents have joint legal custody, benefits are determined as if the parents are not separated or divorced (see paragraph 3 above).

If there is a court order that specifically states that one parent must provide for the child's dental expenses or provide dental insurance coverage for the child, benefits are determined in this order:

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

- b. second, the plan of the spouse of the court-ordered parent;
 - c. third, the plan of the non-court-ordered parent; and,
 - d. last, the plan of the spouse of the non-court-ordered parent.
5. **Active/Inactive Employee:** When a patient is covered under one plan as an active employee and under another plan as a retired or inactive employee (e.g., a former employee receiving COBRA benefits), the plan which covers the patient as an active employee is primary over a plan which covers the patient as a laid-off or retired employee. This applies to the employee's dependents as well unless the dependents have other coverage due to their own current or former employment status.
6. **Longer/Shorter Length of Coverage:** If none of the above rules determine the order of payment, the plan covering the patient the longer time is primary.

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.

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've paid plan benefits. This means that you promise to repay us from any money you recover the amount we've 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 aren't 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.

CLAIMS AND APPEALS

The following explains the rules under your group dental plan for filing claims and appeals.

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 handle without an appeal. The phone number to reach our Customer Service Department is on the back of this booklet.

In General

This section of your booklet explains how we process dental claims and how you can appeal a partial or complete denial of a claim.

The following 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 voluntarily process your claim according to ERISA's standards and provide you with the ERISA appeal rights that are discussed in this section of the 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 web site at www.bcbsal.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 dental 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.

Who Gets Paid: Some of the contracts we have with providers of services 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. We need not honor an assignment of your claim to anyone. 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.

Courtesy Pre-Determinations of Treatment Plans: 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.

Member Satisfaction

If you are dissatisfied with our handling of a claim or have any questions or complaints, you may do one or more of the following:

- You may call or write our Customer Service Department. We will help you with questions about your coverage and benefits or investigate any adverse benefit determination you might have received.
- You may file an appeal if you have received an adverse benefit determination.

Your satisfaction is important to us. We will do our utmost to maintain it.

Appeals

In General: 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 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 web site at **www.bcbsal.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 number;
- 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 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 in federal court 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). Voluntary appeals must be in writing, and must be submitted to the following address:

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

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.

GENERAL INFORMATION

Delegation of Discretionary Authority to Blue Cross

The employer 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 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 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. Mail notices to us at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858, with your full name and contract number. We get notice when it arrives at this address.

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 show in your Claim 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 cannot be responsible. We need not do anything to enable them to treat you.

Misrepresentation

If you make any material misrepresentation in applying for coverage, when we learn of this we may terminate your coverage back to your effective date. We need not even refund any payment for your coverage. If your group materially misrepresents its application it will be as though the plan never took effect, and we need not even refund any payment for any member.

PRIVACY AND SECURITY OF YOUR PROTECTED HEALTH INFORMATION

The confidentiality of your personal health information is important to us. Under a new federal law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), plans such as this one are generally required to limit the use and disclosure of your protected health information to treatment, payment, and health care operations and to put in place appropriate safeguards to protect your protected health information. This section of the booklet explains some of HIPAA's requirements. Additional information is contained in the plan's notice of privacy practices. You may request a copy of this notice by contacting your employer's human resources office.

Disclosures of Protected Health Information to the Plan Sponsor: In order for your benefits to be properly administered, the plan needs to share your protected health information with the plan sponsor (your employer). Here are the circumstances under which the plan may disclose your protected health information to the plan sponsor:

- The plan may inform the plan sponsor whether you are enrolled in the plan.
- The plan may disclose summary health information to the plan sponsor. The plan sponsor must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying you.
- The plan may disclose your protected health information to the plan sponsor for plan administrative purposes. This is because employees of the plan sponsor perform some of the administrative functions necessary for the management and operation of the plan.

Here are the restrictions that apply to the plan sponsor's use and disclosure of your protected health information:

- The plan sponsor will only use or disclose your protected health information for plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. See the plan's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.
- If the plan sponsor discloses any of your protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to keep your protected health information as required by the HIPAA regulations.
- The plan sponsor will not use or disclose your protected health information for employment-related actions or decisions or in connection with any other benefit or benefit plan of the plan sponsor.
- The plan sponsor will promptly report to the plan any use or disclosure of your protected health information that is inconsistent with the uses or disclosures allowed in this section of the booklet.
- The plan sponsor will allow you or the plan to inspect and copy any protected health information about you that is in the plan sponsor's custody and control. The HIPAA regulations set forth the rules that you and the plan must follow in this regard. There are some exceptions.
- The plan sponsor will amend, or allow the plan to amend, any portion of your protected health information to the extent permitted or required under the HIPAA regulations.
- With respect to some types of disclosures, the plan sponsor will keep a disclosure log. The disclosure log will go back for six years (but not before April 14, 2003). You have a right to see the disclosure log. The plan sponsor does not have to maintain the log if disclosures are for certain plan related purposes, such as payment of benefits or health care operations.
- The plan sponsor will make its internal practices, books, and records, relating to its use and disclosure of your protected health information available to the plan and to the U.S. Department of Health and Human Services, or its designee.
- The plan sponsor will, if feasible, return or destroy all of your protected health information in the plan sponsor's custody or control that the plan sponsor has received from the plan or from any business associate when the plan sponsor no longer needs your protected health information to administer the plan. If it is not feasible for the plan sponsor to return or destroy your protected health information, the plan sponsor will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

The following classes of employees or other workforce members under the control of the plan sponsor may use or disclose your protected health information in accordance with the HIPAA regulations that have just been explained:

Human Resources

If any of the foregoing employees or workforce members of the plan sponsor use or disclose your protected health information in violation of the rules that are explained above, the employees or workforce members will be subject to disciplinary action and sanctions - which may include termination of employment. If the plan sponsor becomes aware of any violation like this, the plan sponsor will promptly report the violation to the plan and will cooperate with the plan to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to you.

Security of Your Personal Health Information: Here are the restrictions that will apply to the plan sponsor's storage and transmission of your electronic protected health information on and after April 21, 2005 (or, on and after April 21, 2006 if this plan is a small health plan):

- The plan sponsor will have in place appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of your electronic protected health information, as well as to ensure that only those classes of employees or other workforce members of the plan sponsor described above have access to use or disclose your electronic protected health information in accordance with the HIPAA regulations.
- If the plan sponsor discloses any of your electronic protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to have in place the appropriate safeguards as required by the HIPAA regulations.
- The plan sponsor will report to the plan any security incident of which it becomes aware in accordance with the HIPAA regulations.

Our Use and Disclosure of Your Personal Health Information: As a business associate of the plan, we (Blue Cross and Blue Shield of Alabama) have an agreement with the plan that allows us to use your personal health information for treatment, payment, health care operations, and other purposes permitted or required by HIPAA. In addition, by applying for coverage and participating in the plan, you agree that we may obtain, use and release all records about you and your minor dependents that we need to administer the plan or to perform any function authorized or permitted by law. You further direct all persons to release all records to us about you and your minor dependents that we need in order to administer the plan.

Multiple Coverage

If you are covered both by this contract and by a non-group contract we issue, you will be entitled to benefits only under the one that provides the most coverage for you.

Termination of Benefits and Termination of the Plan

1. Blue Cross's obligation to provide benefits under the Plan may be terminated at any time by either the employer or Blue Cross by giving 30 days notice in writing to the other.
2. If the employer fails to pay the amount due within 30 days after it becomes due, Blue Cross's obligation to provide benefits under the Plan will terminate automatically and without notice to you or the employer as of the date due for the payment.
3. The Plan Sponsor may terminate the Plan at any time through action by its authorized officers. In the event of termination of the Plan, all benefits payments will cease as of the effective date of termination, regardless of whether notice of the termination has been provided to you by the employer or Blue Cross.

Changes in Plan

1. Any or all of the provisions of this plan may be amended by the Plan Sponsor at any time and from time to time, by an instrument in writing.
2. No representative or employee of Blue Cross is authorized to amend or vary the terms and conditions of this plan or to make any agreement or promise not specifically contained herein or to waive any provision hereof.

DENTAL BENEFIT EXCLUSIONS

We will **not** provide benefits for the following:

1. 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.
2. Dental services for which you are not charged.
3. Dental services or expenses rendered for any disease, injury or condition arising out of and in the course of employment for which benefits and/or compensation are available in whole or in part under the provisions of any 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 hospital or medical services as such. It applies whether the provider of those services was authorized as required by the law. Finally, it applies whether your employer has insurance coverage for benefits under the law.
4. Dental services with respect to malformations from birth or primarily for appearance.
5. 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.
6. Dental services to the extent coverage is available to the member under any other Blue Cross and Blue Shield contract.
7. Charges for dental care or treatment by a person other than the attending dentist unless the treatment is rendered under the direct supervision of the attending dentist.
8. Gold foil restorations.
9. Charges for your failure to keep a scheduled visit with the dentist.
10. Services or expenses of any kind, if not required by a dentist, or if not dentally necessary.
11. Charges for oral hygiene and dietary information.
12. Charges for plaque control program.
13. Charges for implants.
14. Anesthetic services performed by and billed for by a dentist other than the attending dentist or his assistant.
15. Dental services you receive before your effective date of coverage, or after your effective date of termination.
16. Dental care or treatment not specifically identified as a covered dental expense.

17. 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.
18. 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.
19. 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.
20. 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.
21. Any dental treatment or procedure, drugs, drug usage, equipment, or supplies which are investigational, including services that are part of a clinical trial.
22. Services or expenses for which a claim is not properly submitted.
23. Charges for infection control.
24. Services or expenses for intraoral delivery of or treatment by chemotherapeutic agents.
25. Services or expenses of any kind for complications resulting from services received that are not covered as benefits under this contract.

DEFINITIONS

Allowable Amount: The lesser of the fee for a procedure in the Preferred Dentist Fee Schedule or the amount charged by a dentist who is licensed to practice in Alabama. If services are provided by a dentist who is not licensed to practice in Alabama, the Allowable Amount is the amount of a dentist's charge that Blue Cross will recognize as covered expenses for medically/dentally necessary services provided by this plan.

Application: The subscriber's original application form and any written supplemental application accepted by Blue Cross.

Blue Cross: Blue Cross and Blue Shield of Alabama.

Contract: The Group Dental Benefits contract between your Employer and Blue Cross and Blue Shield of Alabama. The contract is made up of (1) your employer's Group Application for the contract; (2) this Summary Plan Description; and (3) any written change to this Summary Plan Description. Your contract number is listed on your ID card.

Contract Effective Date: The date the Group Dental Benefits contract becomes effective in accordance with the Group Application as accepted by Blue Cross.

Cosmetic Surgery: Any surgical procedure that primarily improves or changes appearance and does not primarily improve physical bodily functions or correct deformities resulting from disease, trauma or congenital anomalies.

Covered Dental Benefits: The amount of benefits we pay to or for you for dental services by a dentist which you incur while covered under this plan.

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

Dependent: See the explanation in the "Eligibility and Enrollment" section.

Effective Date: The date on which the coverage of each individual subscriber and dependent begins as listed in Blue Cross's records.

Eligible Person: Any employee or member of the group or other person who (a) is eligible for coverage under the eligibility standards in the group's application for the contract and (b) has been designated by the group to us as being eligible.

Family Coverage: Coverage for a subscriber and one or more dependents.

Group: The employer, association, or other entity which contracts with Blue Cross and through which you have coverage. The group acts as your agent (and not Blue Cross) in all its actions and conduct relating to the contract or your coverage under it. Examples of matters which the group acts as your agent, and for which Blue Cross is not responsible for its acts or failures to act are: payment for your coverage under the contract; sending or receiving or informing you of applications, notices, correspondence, or other papers concerning the contract or your coverage; and making any statements or failing to inform you about your coverage or the contract.

Group Application: The document in which the employer applies for a group benefits plan from Blue Cross and Blue Shield of Alabama.

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.

Member: A subscriber or eligible dependent who has coverage under the contract. The term member also refers to a former dependent or subscriber who was not terminated for gross misconduct and who is eligible for and covered under COBRA.

Non-Preferred Dentist: A dentist licensed to practice dentistry in Alabama who is not a Preferred Dentist.

Plan: This Summary Plan Description (SPD) describing the benefits of your Employee's Dental Benefits Plan.

Preferred Dentist: A dentist who has an agreement with Blue Cross to provide dental services to members entitled to benefits under the Preferred Dentist Program.

Preferred Dentist Fee Schedule: The schedule of dental procedures and the fee amounts for those dental procedures under the Preferred Dentist Program.

Preferred Dentist Program: A program wherein some dentists have agreements with Blue Cross to furnish certain services for an agreed upon fee schedule to members entitled to benefits under the Preferred Dentist Program.

Subscriber: The employee whose application for coverage under the contract is made and accepted.