



BlueCross BlueShield
of Alabama



Dental Blue[®]



For the plan year beginning January 1, 2023

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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 1-855-350-7444. If needed, simply request a translator and one will be provided to assist you in understanding your benefits.

Atención por favor

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 1-855-350-7444. 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 intended to help you and your covered dependents pay for the cost of dental care. The plan does not pay for all of your dental care. For example, 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 dental coverage. All you have to do is register at AlabamaBlue.com/register. With *myBlueCross*, you have 24 hour access to personalized dental information, PLUS easy-to-use online tools that can help you save time and efficiently manage your dental care:

- Pay your bill online and set up recurring payments.
- Download and print your benefit booklet.
- Request replacement or additional ID cards.
- View all your claim reports in one convenient place.
- Find a dentist.

Nature of Coverage

The plan is not group insurance or COBRA. Since the plan is not group insurance coverage, employers are not permitted to endorse or sponsor the plan (your employer may not pay for or reimburse you for your premiums).

Free Review Period

If for any reason you are not satisfied with the plan, you may return it to us with your identification card within 30 days following your effective date. If you do this, we will refund any fees you have paid for this plan and obtain refunds for any dental benefits that we have paid to you or your dentist.

Policy Year

The policy year of the plan is January 1 through December 31 of each year.

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 cover an expense or service, you and your dentist are responsible for deciding whether you should receive the care or treatment.

If you are in severe pain or your condition is endangering your life, you may obtain emergency care by calling 911 or visiting an emergency room.

Beginning of Coverage

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

Even if you have purchased a family contract, new dependents are not automatically added to the plan. You must submit an application for coverage. If you fail to submit an application, or in some cases, if you submit your application too late, you may not be able to obtain coverage for your family members after the effective date of coverage.

Limitations, Exclusions, and Waiting Periods

In order to maintain the cost of the plan at an overall level that is reasonable for all plan members, the plan contains a number of provisions that limit dental benefits or in some cases subject them to a waiting period. These waiting periods are not reduced by your prior coverage under any plan. Please see the section of this booklet called [Waiting Periods](#). There are also exclusions that you need to pay particular attention to as well. These provisions are found throughout the remainder of this booklet. You need to be aware of the limits, waiting periods, and exclusions to determine if the plan will meet your dental care needs.

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 the state of Alabama. **Preferred Dentists** are in-network dentists in the state of Alabama that contract with Blue Cross and Blue Shield of Alabama for furnishing dental care services at a reduced price. 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.

To locate Alabama in-network dentists, go to AlabamaBlue.com/FindADoctor.

1. Enter a search location by using the zip code or city and state for the area you would like to search.
2. In the search box, you can select the category you would like to search (doctor, hospital dentist, pharmacy, etc.) or keep on “All Categories” to search all. Type in the provider’s name to search or leave blank to see all results.
3. In the “Network or Plan” section, use the drop down menu to select Alabama Preferred Dentists.

Search tip: If your search returns zero results, try expanding the number in the “Distance” drop down.

The plan does not cover any services or supplies you may receive from an out-of-network dentist in the state of Alabama. In that case, you will be responsible for all charges billed to you by the out-of-network dentist. If you receive covered services or supplies from an out-of-network dentist outside the state of Alabama, in most cases, you will have to pay significantly more than what you would pay an in-network dentist because these out-of-network dentists 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 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 an in-network dentist, your dentist will in most cases file claims for you. In other cases, you may be required to pay the dentist 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 and we will give the claim a full and fair review. The provisions of the plan dealing with claims and appeals are found later on in this booklet.

Arbitration

In order to provide for an efficient and fair resolution of disputes, the plan is subject to the arbitration provisions found in the section of your booklet called [General Information](#). When you submitted your application to us, you agreed to be bound by these arbitration provisions.

Changes in the Plan

From time to time it may be necessary for us to change the terms of the plan. When this occurs, we will give you written notice. The rules for changing the terms of the plan are described later in the section called [Plan Changes](#).

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 or course of treatment that began before termination.

Respecting Your Privacy

To administer this plan we need your personal health information from dentists 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 dentists, other insurance companies, 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 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 you and your minor dependents that we need to administer this plan. If you or any dentist refuses to provide records, information or evidence we request within reason, we may deny your benefit payments. You also agree that we may call you at any telephone number provided to us by you, your employer, or any healthcare provider in accordance with applicable law. 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 office:

Blue Cross and Blue Shield of Alabama
Privacy Office
P. O. Box 2643
Birmingham, Alabama 35202-2643
Telephone: 1-800-292-8868

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

Member Rights

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

- Receive information about us, our services, in-network dentists and member rights and responsibilities.
- Be treated with respect and recognition of your dignity and your right to privacy.
- Participate with dentists in making decisions about your dental care.
- A candid discussion of appropriate or dentally necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Voice complaints or appeals about us, or the dental care 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.

Member 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 dentists need in order to provide care.
- Follow plans and instructions for care that you have agreed to with your dentists and verify through the benefit booklet provided to you the coverage or lack thereof under your plan.
- Understand your dental problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

ELIGIBILITY

Your Eligibility for the Plan

You are eligible for the plan if you are at least 19 years old and a resident of the state of Alabama.

Your Eligible Dependents

Your eligible dependents are:

- Your spouse if he or she is a resident of the state of Alabama;
- Your married or unmarried child up to their 26th birthday; 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 their 26th birthday.

The child may be your 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 cover your grandchild only if you are eligible to claim your grandchild as a dependent on your federal income tax return.

Timely Payment of Premiums

Initial Payment of Premiums For Annual Open Enrollment Period

Your initial payment of premiums during the annual open enrollment period must be made no later than your scheduled effective date of coverage. If we do not receive your initial payment of premiums on time, your scheduled effective date of coverage under the plan will be canceled and you will have no coverage under the plan.

Initial Payment of Premiums For Special Open Enrollment Period

In most cases, your initial payment of premiums during a special open enrollment period must be made no later than your scheduled effective date of coverage. In some cases (such as retroactive coverage in the case of birth and other circumstances), your initial payment of premiums during these special open enrollment periods must be made no later than 30 days from the date of your premium statement date. If we do not receive your initial payment of premiums on time, your scheduled effective date of coverage under the plan will be canceled and you will have no coverage under the plan.

Subsequent Monthly Payment of Premiums

After you make your initial payment for plan coverage, you must make timely periodic payments for each subsequent month.

Each of your monthly periodic payments is due on the 1st day of the month for that monthly coverage period. There is a grace period of 30 days for all monthly premium payments after the initial premium payment. If you fail to pay in full a monthly payment before the end of the grace period for that coverage period, your coverage under the plan will be canceled as of the last day of the month before that monthly coverage period. Failure to timely pay premium payments is not a special open enrollment event for later coverage under the plan.

Beginning of Coverage

Your Initial Enrollment

If we accept your application, you will receive an identification card. Your coverage begins on the effective date shown on your identification card provided that you timely pay your initial premiums before your scheduled effective date of coverage. If you fail to timely pay your initial premiums in full, your coverage will be canceled as of the effective date.

No Annual Open Enrollment Period for Dependents

There is no open enrollment period under the plan for adding a spouse or dependent to your plan. You may, however, add a spouse or dependent to your plan under limited circumstances described below. In addition, if you are covering yourself under the plan, you will first have to convert your coverage to family coverage and pay any additional premiums.

Special Enrollment Period for Dependents Losing Other Coverage

A dependent (1) who does not enroll during your initial enrollment because the eligible dependent has other coverage, (2) whose other coverage was either COBRA coverage that was exhausted or other dental coverage which ended due to "loss of eligibility" (as described below) or failure of the employer to pay toward that coverage, and (3) who requests enrollment within 60 days of the exhaustion or termination of coverage, may enroll in the plan. Coverage will be effective no later than the first day of the first month beginning after the date the request for special enrollment is received (assuming you timely pay your premiums in full).

Loss of eligibility with respect to a special enrollment period includes loss of coverage as a result of legal separation, divorce, cessation of dependent status, cessation of pediatric dental coverage, death, termination of employment, reduction in the number of hours of employment, failure of your employer to offer dental coverage to you, and any loss of eligibility that is measured by reference to any of these events, but does not include loss of coverage due to failure to timely pay premiums or termination of coverage for fraud or intentional misrepresentation of a material fact.

An eligible individual or dependent whose other coverage has a non-calendar year plan or policy year may also enroll in the plan at the end of the other coverage's plan year if coverage is requested within 60 days of the end of the other coverage's plan year. Coverage will be effective no later than the first day of the first calendar month beginning after the date the request for special enrollment is received.

Special Enrollment Period for Newly Acquired Dependents

If you 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 as special enrollees provided that you request enrollment within 60 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 (assuming you timely pay your premiums in full). In the case of a dependent acquired through marriage, the effective date will be no later than the first day of the first month beginning after the date the request for special enrollment is received (assuming you timely pay your premiums in full).

If you are required to provide dental coverage to a dependent through a qualified medical child support order or other court order, you may enroll this dependent as a special enrollee provided that you request enrollment within 60 days of the date of the court order. The effective date of coverage will be the date of the court order (assuming you timely pay your premiums in full).

Special Enrollment Period Related to Advance Payments of Premium Tax Credit and Cost Sharing Reductions

A dependent who is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost sharing reductions under the Affordable Care Act, regardless of whether such dependent is already enrolled in a qualified health plan, may enroll in the plan provided the request for special enrollment is received within 60 days of the event. Coverage will be effective no later than the first day of the calendar month following receipt of the request for special enrollment (assuming you timely pay your premiums in full).

Other Special Enrollment Periods

A dependent who is an Indian (as defined by section 4 of the Indian Health Care Improvement Act) may enroll in the plan at any time (but no more than once per calendar month). Coverage will be effective no later than the first day of the calendar month following receipt of the request for special enrollment (assuming you timely pay your premiums in full).

A dependent who becomes eligible for the plan because of a permanent move into the state of Alabama may enroll in the plan provided that you request special enrollment within 60 days. Coverage will be effective no later than the first day of the calendar month following receipt of the request for special enrollment (assuming you timely pay your premiums in full). If you purchased the plan through the health insurance marketplace, the time period to make a request for this special open enrollment right and the effective date of coverage will be determined by the health insurance marketplace.

A dependent who was not previously a citizen, national, or lawfully present individual that gains such status may enroll in the plan provided that you request special enrollment within 60 days. Coverage will be effective no later than the first day of the calendar month following receipt of the request for special enrollment (assuming you timely pay your premiums in full).

A dependent who the health insurance marketplace determines is eligible for a special enrollment period because of (1) unintentional, inadvertent or erroneous enrollment in another plan; (2) another plan under which the employee or dependent was enrolled that substantially violated a material provision of that plan; or (3) other exceptional circumstances may also enroll in the plan provided that you request special enrollment within 60 days. Coverage will be effective no later than the first day of the calendar month following receipt of the request for special enrollment (assuming you timely pay your premiums in full).

Termination of Coverage

Plan coverage ends for you and your dependents when the first of the following happens:

1. You fail to pay all applicable fees for coverage before the effective date of your coverage, in which case coverage for you and your dependents will be canceled as of the effective date of coverage;
2. You fail to pay subsequent fees for coverage within the applicable grace period as explained above in this booklet in the subsection called [Timely Payment of Premiums](#);
3. You are no longer a resident of the state of Alabama;
4. For spouses, the first day of the month following divorce or other termination of marriage;
5. For children, the first day of the month following the date a child ceases to be a dependent;
6. For all covered dependents, the first day of the month following the date of the contract holder's death;
7. For any member, the date of his or her death;
8. Upon discovery of fraud or intentional misrepresentation of a material fact; or,

9. Upon termination of the plan as explained later in this booklet in the section called [General Information](#).

All the dates of termination assume that payment for coverage 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.

Limited Continuation of Coverage Rights Under the Plan

Attention: We will not provide a separate notice to you at the time of termination of coverage telling you about your continuation of coverage rights. You are responsible for remembering that these options are available.

1. If you are covered under the plan as a dependent child and you lose dependent status, you may apply for your own plan. If you submit your application within 60 days of losing coverage and if we accept your application, we will count your coverage under your prior plan when applying your new plan's waiting periods (described in the [Waiting Periods](#) section below).
2. Upon divorce, other termination of marriage, or death of the contract holder, covered family members may elect to continue coverage (usually under a new plan number) if we are properly notified within 60 days of the event. If we receive timely notice, we will count your coverage under your prior plan when applying your new plan's waiting periods (described in the [Waiting Periods](#) section below).
3. If the contract holder establishes residency outside of the state of Alabama and thereby loses coverage under the plan, any covered family members who remain residents of the state of Alabama may elect to continue coverage if we are properly notified within 60 days of the event. If we receive timely notice, we will count your coverage under your prior plan when applying your new plan's waiting periods (described in the [Waiting Periods](#) section below).

Attention: Because this plan is not a group insurance plan, it does not provide benefits under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1986). The only continuation of coverage rights are those outlined in this section of the plan.

Limitation on Effect of Certain Amendments

Except as otherwise required by law, no amendment or change to this section of the booklet ([Eligibility](#)) will result in the disenrollment, loss of eligibility, or early termination of eligibility of a member properly enrolled under the terms of the plan as of the effective date of the amendment.

BENEFIT EXCLUSION PERIODS (WAITING PERIODS)

Exclusion Period for Basic Dental Services

For the first 180 days you are covered by this plan there are no plan benefits for Basic Dental Services. This is referred to as a benefit exclusion period. The entire 180-day benefit exclusion period must be served before any benefits for Basic Dental Services are available under the plan. However, if you were covered under a group dental plan administered or insured by us with no more than a sixty-three (63) day break in dental coverage prior to the effective date of coverage under this plan, you will be given credit under this Basic Dental Services benefit exclusion period for any time served for any Basic Dental Services benefit exclusion periods

under the prior group plan.

Exclusion Period for Major Dental Services

For the first 365 days you are covered under this plan there are no plan benefits for Major Dental Services. The entire 365-day benefit exclusion period must be served before any benefits for Major Dental Services are available under the plan. However, if you were covered under a group dental plan administered or insured by us with no more than a sixty-three (63) day break in dental coverage prior to the effective date of coverage under this plan, you will be given credit under this Major Dental Services benefit exclusion period for any time served for any Major Dental Services benefit exclusion periods under the prior group plan.

Limitation on Effect of Certain Amendments

Except as otherwise required by law, no amendment or change to this section of the booklet ([Benefit Exclusion Periods](#)) will result in an extension of the benefit periods described above for any member covered under the plan and currently serving such benefit exclusion period as of the effective date of the amendment. For example, if you are serving your 365-day benefit exclusion period for Major Services and we amend the plan to increase the benefit exclusion period from 365 days to 730 days (2 years), that change would not apply to you or any other member of your family currently serving the benefit exclusion period. It would apply to any members of your family properly added to the plan after the effective date of the amendment.

COST SHARING

Calendar Year Deductible	\$50 per member
Calendar Year Maximum Benefits	\$1,000 per member

Calendar Year Deductible

The calendar year deductible is specified in the table above. The calendar year deductible under the plan is the amount you must pay for dental expenses covered by the plan before your dental care benefits begin. The calendar year deductible is applied on a per member per calendar year basis. The calendar year deductible will be applied to claims in the order in which they are processed regardless of the order in which they are received.

Calendar Year Maximum Benefits

The calendar year maximum benefits are specified in the table above. The calendar year maximum benefit for each member under the plan is the maximum amount the plan will pay for dental expenses covered by the plan. The calendar year maximum benefits is applied on a per member per calendar year basis. The calendar year maximum benefits will be applied to claims in the order in which they are processed regardless of the order in which they are received. Once the calendar year maximum benefits are reached, you will no longer receive any benefits under the plan for the remainder of that calendar year.

Other Cost Sharing Provisions

The plan may also 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 outside of the state of Alabama, you may be responsible for paying the dentist's charges in excess of the allowable amount.
- **Actual full charges of out-of-network dentists in the state of Alabama.** If you see an out-of-network dentist in the state of Alabama, the plan provides no coverage for such services. You will be responsible for payment of the full amount of the dentist's actual charges.

DENTAL BENEFITS

The plan's in-network dental network is the **Preferred Dentist** network. We pay benefits toward the lesser of the allowable amount or the dentist's actual charge for services whether you receive services from in-network dentists or from out-of-network dentists outside the state of Alabama; however, the following are some notable differences:

- All in-network dentists agree our payment is payment in full for covered services except for your deductible, coinsurance and amounts exceeding the calendar year maximum benefits when applicable. If you are covered under another dental plan, an in-network dentist may bill that plan for any difference between the allowable amount and his usual charge for a service.
- 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 included in plan benefits.
- There is no coverage under the plan for services provided by out-of-network dentists in the state of Alabama. You will be responsible for payment of the full amount of the dentist's actual charges.
- There is coverage under the plan for out-of-network dentists outside the state of Alabama but they may charge you the difference between the allowable amount and their billed charges in addition to your deductible, coinsurance, and amounts exceeding the calendar year maximum benefits when applicable.

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.

Diagnostic and Preventive Dental Benefits

SERVICE	PLAN PAYS
Diagnostic and preventive services	100% of the allowable amount, subject to the calendar year deductible

- 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 a maximum payment of \$20 per tooth and limited to the first permanent molars of children through age 13.
- Fluoride treatment for members up to their 19th birthday, twice per calendar year.
- Routine cleanings, twice per calendar year.
- Space maintainers (not made of precious metals) that replace prematurely lost teeth for members up to their 19th birthday.

Basic Dental Benefits

SERVICE	PLAN PAYS
<p>Basic services</p> <p>Note: A 180 day benefit exclusion may apply. For more information, see the Benefit Exclusion Period section of this booklet.</p>	<p>75% of the allowable amount, subject to the calendar year deductible</p>

- 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 (excluding surgical treatment and/or removal of the root tip of the tooth).
- Repairs to crowns, inlays, onlays, fixed partial dentures and removable dentures.
- Emergency treatment for pain.

Major Dental Benefits

SERVICE	PLAN PAYS
<p>Major services</p> <p>Note: A 365 day benefit exclusion may apply. For more information, see the Benefit Exclusion Period section of this booklet.</p>	<p>50% of the allowable amount, subject to the calendar year deductible</p>

- Oral surgery, i.e., to diagnose and treat mouth cysts and abscesses and for tooth extractions and impacted teeth.
- 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.
- Surgical treatment and/or removal of the root tip of the tooth.
- Periodontic exams twice per calendar year.
- 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.

DENTAL BENEFIT LIMITATIONS

Limits to all benefits:

- Examination and diagnosis no more than twice during any calendar year.
- Full mouth X-rays will be provided once each 36 months; bitewings no more than twice during any calendar year.
- Routine cleaning will be provided no more than twice during any calendar year.
- Fluoride treatment will be provided to members up to their 19th birthday, no more than twice during any calendar year.
- 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.
- We do not cover major services such as dentures, partials, fixed or removable prosthesis or major restorations on the same arch within five years of the original service.
- 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.

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.

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.

Services or expenses we determine are not **dentally necessary** or for which do not meet generally accepted standards of dental practice. This means dental procedures that are considered strictly cosmetic in nature including but not limited to charges for personalization or characterization of prosthetic appliances are not covered. This also means that precision attachments, precious metal bases and other specialized techniques are not covered.

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.

Services or expenses of any kind rendered by an **out-of-network** dentist in the state of Alabama.

P

Charges for dental care or treatment by a **person** other than the attending dentist unless the treatment is rendered under the direct supervision of the attending dentist.

Charges for **plaque control program**.

R

Services of a dentist rendered to a member who is **related** to the dentist by blood or marriage or who regularly resides in the dentist's household.

W

Dental services or expenses in cases covered in whole or in part by **workers' compensation** or employers' liability laws, state or federal. This applies whether you fail to file a claim under that law. It applies whether the law is enforced against or assumed by the employer. It applies whether the law provides for dental services as such. Finally, it applies whether your employer has insurance coverage for benefits under the law.

COORDINATION OF BENEFITS (COB)

We coordinate the benefits under the plan with other group and non-group dental plans.

When a person is covered by two or more plans, the determination of which plan is primary is decided by the first rule below that applies:

1. If the other plan has no COB provision or a COB provision that is inconsistent in substance with the COB provisions of this plan, the other plan is primary.
2. **Group Dental Plan:** If the other plan is a group dental plan (for example, a plan sponsored by an employer for its employees and their eligible dependents) the benefits of the other plan are determined before the benefits of this plan. This rule applies regardless of whether the other plan covers the patient as an employee, retiree, COBRA beneficiary, contract holder, or eligible dependent of any of the foregoing.
3. **Non-Group Dental Plan:** If the other plan is a non-group dental plan, the following rules apply:
 - a. The benefits of the plan which covers the person as an applicant, contract holder, or policyholder (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.
 - b. **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. The term "birthday" refers only to month and day in a calendar year and does not include the year in which the individual is born.
 - c. **Dependent Child/Separated or Divorced Parents:** If two or more plans cover the patient as a dependent child of parents who are divorced, separated, or no longer living together (regardless of whether they have ever been married), benefits are determined in this order.

If there is no court decree allocating responsibility for the child's healthcare expenses or healthcare coverage, the order of benefits for the child are determined as follows:

1. First, the plan of the custodial parent;
2. Second, the plan of the spouse of the custodial parent;
3. Third, the plan of the non-custodial parent; and,
4. Last, the plan of the spouse of the non-custodial parent.

The term "custodial parent" means a parent awarded custody of a child by a court decree. 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.

If a court decree states that a parent is responsible for the dependent child's healthcare expenses or healthcare coverage and the plan of that parent has actual knowledge of those terms, the plan of the court-ordered parent is primary.

If a court decree states that both parents are responsible for the dependent child's healthcare expenses or healthcare coverage, benefits are determined as if the parents are not separated or divorced (see paragraph 3.b. above).

If the court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the dependent child, benefits are determined as if the parents are not separated or divorced (see paragraph 3.b. above).

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 under paragraph 3.b. or 3.c. above, as applicable, as if those individuals were the parents of the child.

- d. 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.
- e. Equal Division: If none of the above rules determine the order of payment, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

If this plan is primary, it shall pay benefits as if the secondary plan did not exist. 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 dental care 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 by 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 dental care coverage. In some cases, 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.

For purposes of these coordination of benefits rules, except as set forth below or where a statute requires a different definition, the term "allowable expense" means any dental care expenses, 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 dentist 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. For example, if this plan does not provide benefits for vision care or other similar type of coverage or benefit, then it will have no secondary liability with respect to such coverage or benefit.

Except as otherwise required by law, no amendment or change to this section of the booklet ([Coordination of Benefits](#)) will apply to claims incurred before the effective date of the amendment.

Right to Receive and Release Needed Information

Certain facts about dental coverage and services are needed to apply these COB rules and to determine benefits payment 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 need not 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 those rules and determine benefits payable.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, this plan may pay that amount to the organization that made that payment. The amount will then be treated as though it were a benefit paid under this plan. This plan 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.

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 this plan's 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, or we retain our own attorney to appear in any court (including bankruptcy court), our reimbursement or subrogation recovery under this section will not be decreased by any attorney's fee for your attorney or under the common fund theory.

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

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 handle without an appeal. The phone number to reach our Customer Service Department is on the back of this 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 obtain the form by calling our Customer Service Department. You can also go to 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 dentist.

In order for us to treat a submission by you or your dentist 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 dentists are aware of our claim filing requirements and will file claims for you. If your dentist 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, and we will send you the proper type of 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 dentist 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, we might need additional information to determine whether the claim is payable.

The most common example of this is X-rays. If we need 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 dentist. If we do this, we will send you a copy of our request. However, you will remain responsible for getting us 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: We encourage, but do not require, you or your dentist to submit a treatment plan to us for a courtesy pre-determination. If you ask for a courtesy pre-determination, 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. In order to request a courtesy pre-determination, you or your dentist should call our Customer Service Department.

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 we obtained advice from a healthcare 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

The rules in this section of the booklet allow you or your authorized representative to appeal any denial of a claim. Please note that if you call or write us without following the rules 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.

In all cases, 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, 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 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:

1. The patient's name;
2. The patient's contract number;
3. Sufficient information to reasonably identify the claim or claims being appealed, such as date of service, dentist 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,

4. 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

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 healthcare professional who has appropriate expertise. If we consulted a healthcare 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 dentist 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 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 These Mandatory Plan Administrative Appeals

Remedies: If you 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 claim a voluntary appeal (discussed below); or,
- You may file a claim for arbitration, as explained under the section of this booklet dealing with arbitration.

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.

Alabama Department of Insurance

If you have general insurance questions or if you are dissatisfied with an appeal decision from Blue Cross and Blue Shield of Alabama, you have the right to contact the Alabama Department of Insurance. For insurance questions, contact the DOI by phone at 334-241-4141. The mailing address is P.O. Box 303351, Montgomery, Alabama 36130-3351. The website is www.aldoi.gov.

Limitation on Effect of Certain Amendments

Except as otherwise required by law, no amendment or change to this section of the booklet ([Claims and Appeals](#)) will apply to claims incurred before the effective date of the amendment.

GENERAL INFORMATION

Discretionary Authority to Blue Cross

We have 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 the administration of the plan. Whenever we make reasonable decisions that are neither arbitrary nor capricious, our decisions will be determinative, subject only to your right of review under the plan and thereafter to arbitration to determine whether our decision was arbitrary or capricious.

Arbitration

IN CONSIDERATION OF COVERAGE UNDER THE PLAN AND PAYMENT OF PREMIUMS, YOU (AND WE) AGREE THAT ANY ONE OR MORE OF THE FOLLOWING CLAIMS SHALL BE RESOLVED BY FINAL AND BINDING ARBITRATION:

- **ANY CLAIM THAT ARISES OUT OF OR RELATES TO THE PLAN;**
- **ANY CLAIM THAT INVOLVES ANY RELATIONSHIPS THAT RESULT FROM OR RELATE IN ANY WAY TO THE PLAN (INCLUDING CLAIMS INVOLVING PERSONS OR ORGANIZATIONS WHO ARE NOT PARTIES TO THE PLAN);**
- **ANY CLAIM THAT ALLEGES ANY CONDUCT BY YOU OR US, REGARDLESS OF WHETHER RELATED TO THE PLAN; OR,**
- **ANY CLAIM THAT CONCERNS THE VALIDITY, ENFORCEABILITY, SCOPE, OR ANY OTHER ASPECT OF THIS ARBITRATION PROVISION.**

THIS ARBITRATION AGREEMENT IS INTENDED TO HAVE THE BROADEST SCOPE PERMISSIBLE BY LAW, AND INCLUDES ANY AND ALL CLAIMS, WHETHER IN PLAN, TORT, OR OTHERWISE, WHETHER ARISING BEFORE, ON, OR AFTER THE DATE OF COVERAGE UNDER THE PLAN, AND INCLUDING WITHOUT LIMITATION ANY STATUTORY, COMMON LAW, INTENTIONAL TORT, OR EQUITABLE CLAIMS.

THE ARBITRATOR SHALL APPLY GOVERNING FEDERAL LAW, SUCH AS THE FEDERAL ARBITRATION ACT (FAA) AND, TO THE EXTENT FEDERAL LAW IS NOT APPLICABLE, STATE LAW. THE ARBITRATOR SHALL APPLY ALL APPLICABLE STATUTES OF LIMITATIONS AND ANY CLAIMS OF PRIVILEGE RECOGNIZED BY LAW.

THE CLAIMANT IS RESPONSIBLE FOR STARTING THE ARBITRATION PROCEEDINGS BY NOTIFYING THE OTHER PARTY IN WRITING OF THE ARBITRATION DEMAND. IF THE CONTRACT HOLDER OR MEMBER IS THE CLAIMANT, THE WRITTEN ARBITRATION DEMAND SHOULD BE SENT TO THE

FOLLOWING ADDRESS:

**BLUE CROSS AND BLUE SHIELD OF ALABAMA
LEGAL DEPARTMENT
450 RIVERCHASE PARKWAY EAST
BIRMINGHAM, AL 35244**

THE ARBITRATION SHALL BE CONDUCTED BEFORE A SINGLE ARBITRATOR WHO SHALL BE CHOSEN BY THE JOINT AGREEMENT OF THE PARTIES, WITH THE SELECTION TO OCCUR ORDINARILY WITHIN ONE MONTH FROM THE RECEIPT OF THE DEMAND FOR ARBITRATION. IF THE PARTIES CANNOT AGREE ON AN ARBITRATOR, THEY SHALL OBTAIN A LIST OF SEVEN ARBITRATORS FROM THE AMERICAN ARBITRATION ASSOCIATION. THE LIST SHALL BE REDUCED TO ONE ARBITRATOR BY ALTERNATIVE STRIKES, WITH THE CLAIMANT STRIKING FIRST. ALL PARTIES SHALL BE ENTITLED PRIOR TO THE ARBITRATION HEARING TO THE PRODUCTION OF DOCUMENTS RELEVANT TO THE CLAIMANT'S INDIVIDUAL CLAIM AND DEFENSES AND TO THE DEPOSITIONS OF THE KEY WITNESSES. THE ARBITRATION HEARING SHALL ORDINARILY COMMENCE WITHIN FOUR MONTHS OF THE SELECTION OF THE ARBITRATOR UNLESS THE PARTIES AGREE OTHERWISE.

ALL DISPUTES CONCERNING ARBITRATION PROCEDURES SHALL BE RESOLVED BY THE ARBITRATOR.

WE WILL BEAR ALL COSTS OF ARBITRATION OTHER THAN YOUR COSTS OF REPRESENTATION. BUT IF YOU INITIATE THE ARBITRATION, AND IF THE ARBITRATOR FINDS THAT THE DISPUTE IS WITHOUT SUBSTANTIAL JUSTIFICATION, THE ARBITRATOR HAS THE AUTHORITY TO ORDER THAT THE COST OF THE ARBITRATION PROCEEDINGS BE BORNE BY YOU. THE ARBITRATION WILL OCCUR IN THE COUNTY IN WHICH YOU RESIDE UNLESS THE PARTIES AGREE TO A DIFFERENT LOCATION. PRIOR TO THE ARBITRATION, IF ALL PARTIES CONSENT TO MEDIATE THE CLAIM, THE CLAIM WILL BE REFERRED TO A SEPARATE MEDIATOR, BUT ARBITRATION WILL FOLLOW IF NO SETTLEMENT IS REACHED.

THE ARBITRATOR SHALL BE EMPOWERED TO GRANT WHATEVER RELIEF WOULD BE AVAILABLE IN COURT UNDER LAW OR EQUITY, EXCEPT AS EXPRESSLY LIMITED BY THE CONTRACT. THE ARBITRATOR'S DECISION SHALL BE IN WRITING, SHALL CONTAIN FINDINGS OF FACT AND CONCLUSIONS OF LAW, AND SHALL SPECIFY THE TYPE OF ANY DAMAGES OR RELIEF AWARDED.

IN ALL CASES, THE ARBITRATOR'S DECISION SHALL BE FINAL AND BINDING, EXCEPT THAT IT MAY BE REVIEWED IN COURT TO THE LIMITED EXTENT PERMITTED BY THE FAA AND THIS PARAGRAPH. MOREOVER, IF THE AMOUNT IN CONTROVERSY EXCEEDS \$50,000, ON APPEAL BY EITHER PARTY, THE COURT SHALL ALSO REVIEW THE ARBITRATOR'S DECISION USING THE STANDARD OF APPELLATE REVIEW APPLICABLE WHENEVER A COURT

REVIEWS THE DECISION OF A TRIAL COURT SITTING WITHOUT A JURY. THE FOLLOWING RULES SHALL APPLY WHEN DETERMINING THE AMOUNT IN CONTROVERSY: (1) ALL CLAIMS OF ALL CLAIMANTS IN THE PROCEEDING SHALL BE AGGREGATED, AND (2), CLAIMS FOR UNSPECIFIED AMOUNTS, SUCH AS EMOTIONAL DISTRESS AND PUNITIVE DAMAGES, SHALL BE DEEMED TO EXCEED \$50,000.

THIS PLAN IS MADE PURSUANT TO A TRANSACTION INVOLVING INTERSTATE COMMERCE, AND IS GOVERNED BY THE FAA. IF ANY PORTION OF THIS ARBITRATION PROVISION IS DEEMED INVALID OR UNENFORCEABLE, THE REMAINING PORTIONS SHALL CONTINUE IN FULL FORCE AND EFFECT. EXCEPT AS OTHERWISE REQUIRED BY LAW, NO AMENDMENT OR CHANGE TO THE ARBITRATION PROVISIONS ABOVE WILL APPLY TO CLAIMS INCURRED BEFORE THE EFFECTIVE DATE OF THE AMENDMENT.

Correcting Payments

While we try to pay all claims quickly and correctly, we do make mistakes. If we pay you or a dentist 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 dentist. If we deduct it from an amount paid to you, it will show in your claim report.

Plan Termination

If we decide to discontinue offering this product, we may elect to terminate your plan (which will terminate your coverage and the coverage and all of your dependents) by giving you at least 90 days prior written notice. If we do this, and if we offer other dental products in the individual market, we will give you the option to purchase any of these other products.

Plan Changes

1. Except as other portions of this booklet expressly limit our right to amend the plan, we may change, add to, or remove any term of the plan or alter coverage under the plan. We will give you written notice of any such changes at least 30 days before the effective date of the changes. The changes will apply to all benefits for services you receive on or after the effective date of the changes (except as expressly limited by other portions of this booklet). If you submit payment for coverage to us after the effective date of the changes, your payment will be considered your acceptance of the benefit plan changes. Any changes we make will apply on a uniform basis to all policyholders who have purchased this same type contract as you.
2. The written notice of changes referred to above must be signed by one of our officers in order to be effective. None of our representatives, officers, employees, or agents can make any plan changes orally, as by telephone, or in any other way except in a signed writing as described in this paragraph.
3. By giving 30-days' notice in writing to you, we may change the amount of your premium. Your payment of the new premium will be considered acceptance by you of the new premium.

Responsibility for Dentists

We are not responsible for what dentists 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 commit fraud or make any intentional misrepresentation of material fact 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.

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.

No Assignment

As discussed in more detail in the [Claims and Appeals](#) section of this benefit booklet, most dentists are aware of our claim filing requirements and will file claims for you. If your dentist does not file your claim for you, you should call our Customer Service Department and ask for a claim form. However, regardless of who files a claim for benefits under the plan, we will not honor an assignment by you of payment of your claim to anyone. What this means is that we will pay covered benefits to you or your in-network dentist (as required by our contract with your in-network dentist) – even if you have assigned payment of your claim to someone else. With out-of-network providers, we may choose whether to pay you or the provider. When we pay you or your dentist, 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.

DEFINITIONS

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

Allowable Amount: The lesser of Blue Cross and Blue Shield of Alabama's negotiated amount with an in-network dentist 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 dentally necessary services provided by the 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 dentist of services; and,
- Not "investigational."

Health Insurance Marketplace: The exchange established by the Affordable Care Act in the state of Alabama in which individuals and their families may purchase individual health plans and stand-alone dental plans.

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 dentists 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 dentists.

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



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