LGHIP Voluntary Insurance Plan Summary of Benefits

Dental — Vision

Effective January 1, 2021

SOUTHLAND
BENEFIT SOLUTIONS

Important: This is a Summary of Benefits. Members should refer to the LGHIP Voluntary Insurance Plan booklet for detailed information and limitations.

Voluntary Coverages

The Local Government Health Insurance Plan Voluntary Insurance Plan offers two types of coverages. Claims administration is provided through Southland Benefit Solutions.

An eligible employee or retiree may enroll for individual coverage at any time by submitting a Southland enrollment form (LG07) to the unit's payroll clerk. Once the form has been approved by the LGHIB, coverage in the LGHIP Voluntary Insurance coverage(s) selected will begin the first day of the second month after enrollment. Participants must remain in the LGHIP Voluntary Insurance Plan for at least twelve months. If enrollment is effective on any day other than January 1, coverage will remain in effect through the end of the next full plan year.

Eligible participants may enroll for either individual or family coverage. Members enrolled in family coverage cannot change to individual coverage outside the open enrollment period unless all dependent(s) become ineligible due to age, death or divorce.

Vision Care Plan

The vision care plan's vision benefits are detailed in the chart below. This vision care plan is not a network plan; therefore, members are able to utilize any eye care professional and receive the same level of benefits.

Vision Plan Summary

Vision Allowances	Benefit
Eye Exam	$75
AND	
Frames	$75
Lenses - Single Vision	$80
Lenses - Bifocal	$105
Lenses - Trifocal	$150
Lenses - Lenticular	$175
OR	
Refractive Surgery *(Per Eye)*	$150
OR	
Contacts	$150

Limitations

Examinations: One in any plan year.

Only one of the following in a plan year:

- Contacts – One new prescription or replacement, or
- Frames and Lenses: One new or replacement frame and one new lens prescription or replacement, or
- Refractive Surgery: One surgery per eye.

Dental Plan

This plan covers diagnostic and preventative services, as well as basic and major dental services.

Diagnostic and preventative services are not subject to a deductible and are covered at 100% (based on reasonable and customary charges) and includes oral examinations, cleaning of teeth, fluoride applications for insured children to age 19, space maintainers, x-rays, and emergency office visits. Routine cleaning visits are limited to two visits per plan year.

Basic and major services are covered at 80% for individual coverage and 60% for family coverage (based on reasonable and customary charges) and includes fillings, general anesthetics, oral surgery not covered under a Group Medical Program, periodontics, endodontics, dentures, bridgework, and crowns. There is a $25 deductible for family coverage for basic and major services, which is applied per person, per plan year with a maximum of three per family.

The dental plan administered by Southland offers a dental network program known as "DentaNet". Under the DentaNet program members have the opportunity to use network dentists to save money. However, members enrolled in the dental plan still have the freedom to use any dentist they choose.

All dental services are subject to a maximum of $1,250 per year for individual coverage and $1,000 per-person-per-year for family coverage. Dental coverage does not cover pre-existing dentures or bridgework and does not provide orthodontia benefits. The dental coverage does not cover the replacement of natural teeth removed before a member's coverage is effective. This plan does not cover temporary partials, implants and temporary crowns.

Dental Plan Summary

	Employee Only	Family Plan
Benefits per person per year	$1,250	$1,000
Deductible – Preventative & Diagnostic	$0	$0
Deductible- Basic & Major	$0	$25
Preventative Services- Exams, Cleanings, X-Rays, Emergency Visits	100%	100%
Basic & Major Services- Fillings, Oral Surgery, Periodontics, Endodontics, Dentures, Crowns, General Anesthetics	80%	60%

Why you should use the "DentaNet" network of dentists:

DentaNet, Southland's dental network, offers local government employees and their families the largest independent statewide network of preferred dentists. Although members can choose any dentist they like, using a DentaNet dentist saves you money.

Member savings are obtained in both of the following ways:

- DentaNet dentists do not balance bill members the difference between the DentaNet negotiated fee schedule and what they normally charge.
- Services that require a copay are based on the DentaNet negotiated fee schedule.

Visit www.southlandbenefit.com to find a network dentist near you and start saving today.

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

General Information

Claims Administrator: The Claims Administrator for the LGHIP Voluntary Insurance Plan is Southland Benefit Solutions, P.O. Box 1250, Tuscaloosa, Alabama 35403, 1-866-327-6674.

Plan Year: The Plan Year is January 1 through December 31.

Coordination of Benefits: Benefits are coordinated under the dental and vision plans. Dental benefits will be paid according to the Coordination of Dental Benefits rules listed in the LGHIP Voluntary Insurance Plan. If an enrolled member is covered under more than one group plan or is entitled to any other source, the total amount that is payable under all plans will not be more than 100% of the maximum allowable expenses.

Dental and vision benefits exclude expenses for which the individual is not required to make payment, including but not limited to, reductions or readjustments to the charges made by the health care provider.

Insurance Commences: Insurance commences upon final approval by the Local Government Health Insurance Board.

I.D. Card: Southland Benefit Solutions will provide an ID card as quickly after enrollment as possible.

Claim Forms: Claim forms can be downloaded from the Southland website, www.southlandbenefit.com.

Payment and Claim Filing Limitation: All claims must be submitted in writing and must be received by the Administrator no later than 365 days following the date covered expenses are incurred. If a claim is not submitted and received by the Claims Administrator within this period, the claim for that benefit will not be paid.

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