LGHIP Voluntary Insurance Plan

Dental – Vision - Cancer

Effective January 1, 2026

STATE OF ALABAMA
LOCAL GOVERNMENT HEALTH INSURANCE BOARD
P.O. Box 304901
MONTGOMERY, ALABAMA 36130
334-851-6802 | 1-866-836-9137
LOCAL GOVERNMENT HEALTH INSURANCE BOARD
VOLUNTARY INSURANCE PLAN
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

The Local Government Health Insurance Board Voluntary Insurance Plan (the "Plan") considers personal information to be confidential. The Plan protects the privacy of that information in accordance with applicable privacy laws, as well as its own privacy policies.

The Plan's Responsibilities

The Plan is required by a federal law to keep your health information private, to give you notice of the Plan's legal duties and privacy practices, and to inform you about:

- the Plan's uses and disclosures of your protected health information;
- your privacy rights with respect to your protected health information;
- the Plan's obligations with respect to your protected health information;
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- the person or office to contact for further information about the Plan's privacy practices.

Effective Date of Notice: This notice is effective as of January 1, 2026.

How the Plan May Use and Disclose Health Information

This section of the notice describes uses and disclosures that the Plan may make of your health information for certain purposes without first obtaining your permission as well as instances in which we may request your written permission to use or disclose your health information. The Plan also requires its business associates to protect the privacy of your health information through written agreements.

Uses and disclosures related to payment, health care operations and treatment. The Plan and its business associates may use your health information without your permission to carry out payment or health care operations. The Plan may also disclose health information to the Plan Sponsor, the State of Alabama, for purposes related to payment or health care operations.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, review for medical necessity and appropriateness of care and utilization review and preauthorizations). For example, the Plan may tell an insurer what percentage of a bill will be paid by the Plan.

Health care operations include but are not limited to underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts, disease management, case management, conducting or arrangement for medical review, legal services and auditing functions, including fraud and abuse programs, business planning and development, business management and general administrative activities. However, the Plan will not use genetic protected health information for underwriting purposes. It also includes quality assessment and improvement and reviewing competence or qualifications of health care professionals. For example, the Plan may use medical benefit claims information to conduct a review of the accuracy of how benefit claims are being paid.

The Plan will only disclose the minimum information necessary with respect to the amount of health information used or disclosed for these purposes. In other words, only information relating to the task being performed will be used or disclosed. Information not required for the task will not be used or disclosed.

The Plan may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other uses and disclosures that do not require your written authorization. The Plan may disclose your health information:

- To persons and entities that provide services to the Plan and assure the Plan they will protect the information;
- If it constitutes summary health information, and it is used only for modifying, amending or terminating a group health plan or obtaining premium bids from health plans providing coverage under the group health plan;
- If it constitutes de-identified information;
- If it relates to workers' compensation programs;
- If it is for judicial and administrative proceedings;
- If it is about decedents;
- If it is for law enforcement purposes;
- If it is for public health activities;
- If it is for health oversight activities;
- If it is about victims of abuse, neglect or domestic violence;
- If it is for cadaveric organ, eye or tissue donation purposes;
- If it is for certain limited research purposes;
- If it is to avert a serious threat to health or safety;
- If it is for specialized government functions;
- If it is for limited marketing activities.

Additional disclosures to others without your written authorization. The Plan may disclose your health information to a relative, a friend or any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, the Plan may confirm whether a claim has been received and paid. You have the right to request that this kind of disclosure be limited or stopped by contacting the Plan's Privacy Officer at 334-851-6802.

Uses and Disclosures Requiring Your Written Authorization. In all situations other than those described above, the Plan will ask for your written authorization before using or disclosing your health information. If you have given the Plan an authorization, you may revoke it at any time, if the Plan has not already acted on it. If you have questions regarding authorizations, contact the Plan's Privacy Officer at 334-851-6802.

How the Plan Will Treat Certain SUD Treatment Information

The Plan is not a federally assisted substance use disorder diagnosis, treatment or referral program that is covered by 42 CFR Part 2 (a "Part 2 Program") and does not create and does not typically maintain any records that are subject to 42 CFR Part 2. If the Plan does receive any Part 2 Program records pursuant to your written consent for claim administration and payment, the records will only be used and disclosed in accordance with HIPAA and your consent. In no event will the Plan use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings against you, unless authorized by your written consent or a court order accompanied by a subpoena or other legal requirement compelling disclosure after you received notice and an opportunity to respond.

Your Privacy Rights

This section of the notice describes your rights with respect to your health information and a brief description of how you may exercise these rights.

Notice of Breach. You have a right to notice of a breach of unsecured PHI.

Restrict Uses and Disclosures. You have the right to request that the Plan restricts uses and disclosure of your health information for activities related to payment, health care operations and treatment. The Plan will consider, but may not agree to, such requests. (Exception: The Plan must grant a restriction on PHI disclosed to a health plan for payment or health care operations purposes if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.)

Alternative Communication. The Plan will accommodate reasonable requests to communicate with you at a certain location or in a certain way. For example, if you are covered as an adult dependent, you may want the Plan to send health information to a different address than that of the Employee.

Inspect or Copy Health Information. You have a right to inspect or obtain a copy of health information that is contained in a "designated record set" – records used in making enrollment, payment, claims adjudication, and other decisions. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

You may request your records in an electronic format. The Plan may provide you with a summary of the health information if you agree in advance to the summary. You may also be asked to pay a fee of $1.00 per page based on the Plan's copying, mailing, and other preparation costs.

Amend Health Information. You have the right to request an amendment to health information that is in a "designated record set." You must provide a statement to support the request. The Plan may deny your request to amend your health information if the Plan did not create the health information, if the information is not part of the Plan's records, if the information was not available for inspection or the information is accurate and complete.

Accounting of Certain Disclosures. You have the right to receive a list of certain disclosures of your health information. The accounting will not include: (1) disclosures made for purposes of treatment, payment or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosure for national security purpose; and (6) disclosures incident to other permissible disclosures.

You may receive information about disclosures of your health information going back for six (6) years from the date of your request. You may make one (1) request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You will be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to Access Electronic Records. You may request access to electronic copies of your health information, or you may request in writing or electronically that another person receive an electronic copy of these records. The electronic protected health information will be provided in a mutually agreed-upon format, and you may be charged for the cost of any electronic media (such as a USB flash drive) used to provide an electronic copy.

Right to a Copy of Privacy Notice. You have the right to receive a paper copy of this notice upon request, even if you agreed to receive the notice electronically.

Complaints. You may complain to the Plan or the Secretary of HHS if you believe your privacy rights have been violated. To file a complaint with the Plan, contact the Plan's Privacy Officer at 334-851-6802. You will not be penalized for filing a complaint.

How to exercise your rights in this notice

To exercise your rights listed in this notice, you should contact the Plan's Privacy Officer at 334-851-6802.

This Notice is Subject to Change

The terms of this notice and the Plan's privacy policies may be changed at any time. If changes are made, the new terms and policies will then apply to all health information maintained by the Plan. If any material changes are made, the Plan will distribute a new notice to participants and beneficiaries.

Your Questions and Comments

If you have questions regarding this notice, please contact the Plan's Privacy Officer at 334-851-6802.

Revision 8-2025

Discrimination is Against the Law

The Local Government Health Insurance Board (LGHIB) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The LGHIB does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The LGHIB:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact 1-855-216-3144 or TTY: 711.

If you believe that the LGHIB has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Section 1557 Coordinator, P.O. Box 304901, Montgomery, Alabama, 36130; Direct: (334) 851-6802; Email: 1557Grievance@lghip.org. You can file a grievance by mail, email or in person. If you need help filing a grievance, the Section 1557 Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-Language Interpreter Services

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-216-3144 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-216-3144 (TTY: 711). 번으로 전화해 주십시오

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-216-3144 (TTY: 711)。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-216-3144 (TTY: 711).

Arabic: هاتف الصم والبكم: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-216-3144 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-216-3144 (TTY: 711).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-216-3144 (ATS : 711).

Gujarati: સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-216-3144 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-216-3144 (TTY: 711).

Hindi: ध्यान दें: यदि आप हिंदी बोलते, भाषा सहायता सेवाओं, नि: शुल्क, आप के लिए उपलब्ध हैं। कॉल । 1-855-216-3144 कॉल (TTY: 711)।

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-216-3144 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-216-3144 (TTY: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-216-3144 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-216-3144 (TTY: 711) irtibat numaralarını arayın..

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます 1-855-216-3144 (TTY: 711) まで、お電話にてご連絡ください

Table of Contents

Chapter 1
Introduction

This summary of health care benefits available to you through the Local Government Health Insurance Plan Voluntary Insurance Coverage Plan (hereinafter referred to as “the Plan”) is designed to help you understand your coverage. All terms, conditions and limitations are not covered here. All benefits are subject to the terms, conditions and limitations of the contract between Local Gov Health and Wellness (Local Gov) and Southland Benefit Solutions (Southland). Local Gov shall have absolute discretion and authority to interpret the terms and conditions of the Plan and reserves the right to change the terms and conditions and/or end the Plan at any time and for any reason. Participation in this Plan is completely voluntary, based on elections you make for yourself and your dependents in the time and manner described below.

The Plan offers three types of coverage: dental, vision, and cancer which can be purchased individually or together. The benefits are administered by Southland.

The Plan year begins on January 1 and runs through December 31.

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

Chapter 2
General Information

Eligible Employees and Retirees

An employee who receives a W-2, is in an employee/ employer relationship and regularly works 30 hours or more per week. All eligible employees who are eligible for coverage through the Local Government Health Insurance Plan (LGHIP) are eligible to participate in this plan.

Non-Medicare and Medicare Retirees enrolled in LGHIP health coverage may also enroll in the Southland Plan. Retirees not enrolled in LGHIP health coverage are not eligible to enroll in the Southland Plan. Should a retiree cancel their LGHIP health insurance coverage through the LGHIP, their Southland coverage will be canceled as well.

Note: Under the LGHIP rules, temporary, seasonal, intermittent and emergency employees are not eligible; however, for units with 50 or more employees, any employee in these categories may be eligible if they work, on average, 30 hours per week or 130 hours per month. For more information, see the ACA Exception Section under Ineligible Participants.

Eligible Dependents

Eligible dependents are listed below. A participant may cover their spouse or other dependents if they are covered, or if they are eligible for coverage, as an eligible employee.

The term “dependent” includes the following individuals:

- The participant’s spouse (excludes a divorced spouse)

- A child under age 26, only if the child is:
    - The participant’s son or daughter
    - A child legally adopted by the participant or their spouse
    - The participant’s stepchild

- A dependent, under age 19, for whom the participant, or his or her spouse, has legal and physical custody granted by a court of competent jurisdiction.

- An incapacitated child* over age 25 will be considered for coverage provided the child is:
    - unmarried,
    - permanently mentally or physically disabled or incapacitated,
    - incapable of self-sustaining employment,
    - dependent upon the participant for 50% or more financial support,
    - otherwise eligible for coverage as a dependent child except for age,
    - had the condition prior to the child’s 26th birthday, and

- not eligible for any other group insurance benefits.

*The above requirements must be met to be eligible for coverage as an incapacitated child. Local Gov will decide whether an application for incapacitated status will be accepted, and final approval of incapacitation will be determined by medical review conducted by BCBS. Local Gov reserves the right to periodically recertify incapacitation. Neither a reduction in work capacity nor inability to find employment is, of itself, evidence of eligibility. If a mentally or physically incapacitated child is employed, the extent of their earning capacity will be evaluated.

Dependents who are eligible under multiple employees can only be enrolled in one Local Gov contract. For example, if a dependent is eligible under a parent's coverage and is also eligible under their spouse's coverage, the dependent must choose one to enroll in and cannot be enrolled in both.

Ineligible Participants

An employee of a unit who: (a) does not receive a W-2, is not in an employee/employer relationship, or does not regularly work 30 or more hours per week; or (b) is a temporary, part-time, seasonal, intermittent, emergency, or contract employee.

Affordable Care Act (ACA) Exception

Under the ACA, you may be eligible for coverage if you are a temporary, seasonal, intermittent, or emergency employee otherwise ineligible for coverage under the LGHIP's enrollment rules but your unit is subject to the ACA because it has 50 or more full-time employees (or full-time equivalents) in the prior calendar year and you average working more than 30 hours a week, or 130 hours in a month, during the unit's measurement period. If your unit is subject to the ACA and you believe that you qualify for coverage even though you are a temporary, part-time, seasonal, intermittent, or emergency employee, your unit must verify that:

- your unit is subject to the ACA;
- you average working more than 30 hours a week, or 130 hours a month, during the unit's measurement period.

In addition, your unit must provide the following information by completing the ACA Verification Form (LG23):

- start and end date of the measurement, administrative, and stability period; and
- the number of hours the employee averaged during the measurement period

If you are eligible pursuant to the ACA provisions, you must enroll in the LGHIP or submit a Declination of Coverage form with acceptable proof of other coverage.

Ineligible Dependents

An individual who does not meet the definition of an eligible dependent under the LGHIP rules. Examples include, but are not limited to:

- An ex-spouse or ex-stepchildren, regardless of what the divorce decree may state
- Children aged 26 and older
- Foster children
- Incapacitated children aged 26 and older who do not meet the Incapacitated Child eligibility requirements
- A child of a dependent child
- A participant's child, if the participant has been relieved of their parental rights and responsibilities
- A daughter-in-law or son-in-law
- Grandchildren or other individuals related to the participant by blood or marriage for which the participant does not have legal and physical custody
- Grandchildren, nieces, or nephews aged 19 and older regardless of whether the participant has legal custody
- Grandparents
- Parents
- A fiancé or live-in girlfriend or boyfriend

Employee Enrollment

Eligible employees may enroll in coverage within 30 days of employment or during open enrollment. New employees' coverage will be effective according to the unit's effective date of coverage for health insurance.

Effective Date of Coverage of New Eligible Employees

Depending upon the election made by your unit, your coverage will begin either on (1) your date of hire or the date you became an eligible employee; (2) the first day of the second month following your date of hire or the date you became an eligible employee; or (3) if you are eligible pursuant to the ACA, the first day of the stability period.

Probationary Period for New Eligible Employees

Some units have a probationary period applicable to employees' effective date of LGHIP coverage. If your unit has such a probationary period, the effective date your unit has elected for coverage will begin once the probationary period has ended.

Dependent Enrollment

You may apply for family coverage at your initial enrollment by submitting a Southland Enrollment form (LG07) or, if an eligible dependent qualifies for special enrollment, by submitting a Southland Change and Cancellation form (LG08) within 60 days of the

qualifying event, or during annual open enrollment. See the Special Enrollment and Open Enrollment sections for more information.

Appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.) must be submitted to Local Gov.

Enrolling an Incapacitated Child

To apply, contact Local Gov to obtain an Incapacitated Child Certification form. A completed Incapacitated Child Certification form and proof of incapacity must be provided to Local Gov no more than 60 days after the dependent's 26th birthday. If the form and proof of incapacity is not submitted within the required time, your child is not eligible for future enrollment except in the following two situations:

- If you are a new participant and you request coverage for your incapacitated child within 60 days of employment; or

- When your incapacitated child is covered under your spouse's employer group health insurance for at least 18 consecutive months and:
    - your spouse loses the other coverage because:
        - the employer ceases operations, or
        - of termination of employment or reduction of hours of employment, or
        - the employer stopped contributing to coverage
    - a New Dependent form is submitted to Local Gov within 60 days of the incapacitated child's loss of other coverage, and
    - Medical review approved incapacitation status.

In these two situations, child must meet all of the Incapacitated Child eligibility requirements.

Open Enrollment

An annual open enrollment period is held in November during which you may add dependents or family coverage by submitting a Southland Change and Cancellation form (form LG08) to Local Gov. All changes during open enrollment will be effective January 1 of the following plan year. If you do not want to make changes during open enrollment, no paperwork is necessary.

Special Enrollment

Special enrollment allows eligible employees and dependents who previously declined Southland Voluntary Benefits to enroll in coverage upon the loss of other coverage, and participants may add new dependents due to certain qualifying events (marriage, birth, etc.) Special enrollment rights arise regardless of the LGHIP's open enrollment period. You must request enrollment and provide proof of the qualifying event within 60 days of the event

triggering the special enrollment. The effective date will be the date the other coverage was lost or the date of the qualifying event.

If proof of the qualifying event is not submitted within 60 days of the qualifying event, the request will be denied.

Cancellation of Dependent / Family Coverage

You may only drop dependent/family coverage upon the occurrence of a qualifying event or during annual open enrollment. Proof of the qualifying event must be provided if dropping dependent(s) outside of open enrollment. If you request a dependent to be dropped outside of open enrollment, you must complete a Southland Change and Cancellation form (LG08) and submit it to Local Gov within 60 days of the event. The effective date of cancellation will be the last day of the month after the qualifying event, or January 1 if submitted during open enrollment.

Qualifying events to cancel family coverage or drop a dependent from coverage include, but are not limited to:

- Divorce;
- Loss of custody;
- Commencement of dependent employment;
- Dependent's employer has a different open enrollment than LGHIP;
- Medicare/Medicaid entitlement;
- Dependent change of residence; or
- Dependent no longer qualifies for LGHIP coverage.

When Coverage Terminates

You or your dependents' coverage will terminate on the last day of the month after the following events:

- Death
- Employment termination;
- Leave without pay
- Retirement
- Elected official's term of office ends;
- When premium payments cease;
- When your unit withdraws from the LGHIP;
- If you are eligible pursuant to the ACA, coverage terminates on the last day of the month after the end of the applicable stability period if you do not average 30/130 or more hours per week/month during a subsequent measurement period.

In you change from full-time to part-time employment, coverage will end on the last day of the month after the unit notifies Local Gov of the change.

In addition to the above, coverage terminates for your dependent on the last day of the month in which your dependent ceases to be an eligible dependent.

In many cases, you and your dependents will have the option to choose COBRA continuation coverage. (See COBRA Chapter for more information)

If you perform an act or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, coverage may be terminated retroactively to the date of the act or omission. Local Gov may recover the amount of any claims paid in error due to the act or omission.

Chapter 3
General Provisions

Privacy of Your Protected Health Information

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

Use and Disclosure of Your Protected Health Information

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

Responsibility for Actions of Providers of Services

Southland and Local Gov will not be responsible for any acts or omissions, whether negligent, intentional, or otherwise, by any institution, facility, or individual provider in furnishing or not furnishing any services, care, treatment, or supplies to you. Southland and Local Gov will not be responsible if any provider of service fails or refuses to admit you to a facility, or treat you, or provide services to you. Southland and Local Gov are not required to do anything to enable providers to furnish services, supplies, or facilities to you.

Misrepresentation

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

Obtaining, Use and Release of Information

By submitting your application for coverage or any claims for benefits, you authorize Southland to obtain from all providers, hospitals, facilities, other providers of service, and all other persons or institutions having information concerning you, all records which in its judgment are necessary or desirable for processing your claim, performing our contractual duties, or complying with any law. You also authorize providers of health services, and any other person or organization, to furnish to Southland any such records or information it requests.

Further, you authorize Southland to use and release to other persons or organizations any such records and information as considered necessary or desirable in its judgment. Neither Southland nor any provider, other person or organization will be liable for obtaining, furnishing, using, or releasing any such records or information.

Responsibility of Members and Providers to Furnish Information

By applying for coverage or a claim for benefits, you agree that in order to be eligible for benefits:

- A claim for the benefits must be properly submitted to and received by Southland.
- A provider, hospital, or other provider that has furnished or prescribed any services or supplies to a member must provide the records, information, and evidence Southland requests in connection with benefits claimed or paid.
- A member who receives services or supplies for which benefits are claimed must provide the records, information and evidence Southland requests.

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

Applicable State Law

The Plan is administered in the State of Alabama and will be governed by the law of Alabama to the extent that state law is applicable.

I.D. Card

Southland will provide an identification card.

Claim Forms

Claim forms may be obtained from Southland (www.SouthlandLGHIP.com) and may also be downloaded from Local Gov's website www.lghip.org.

Claims Administrator

The claims administrator for the Plan is:

Southland Benefit Solutions
P.O. Box 1250
Tuscaloosa, Alabama 35403
205-951-4455

Payment and Claim Filing Limitations

All claims must be submitted in writing and such writing must be received by Southland **no later than 365 days** following the date covered expenses are incurred. If a claim is not

submitted and received by Southland within this period, the claim for that benefit will not be paid.

Claim forms must be completed, with proper documentation and certification from the health care provider, upon submission. Failure to provide a completed claim form may cause delays in claims processing and may be cause for the denial of the claim.

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

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

THE TOTAL AMOUNT THAT IS PAYABLE UNDER ALL PLANS WILL NOT BE MORE THAN 100% OF THE MAXIMUM ALLOWABLE EXPENSES.

Incorrect Benefit Payments

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

Fraudulent Claims

Any person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime. In addition to any disciplinary action already in place, any employee or retiree knowingly and willfully submitting false information to Local Gov will be required to repay all claims and other expenses incurred by the Plan related to the false or misleading information, plus interest.

Customer Service

If you have questions about your coverage, or need additional information about how to file claims, you should contact Southland. Southland Customer Service, located in Tuscaloosa, is open for phone inquiries from 8:00 a.m. to 5:00 p.m. Monday through Friday. The phone number is 1-205-951-4455.

Chapter 4
Continuation of Group Health Coverage (COBRA)

Introduction

The Public Health Service Act [42 USC Sections 300bb-1 through 300bb-8] requires that Local Gov offer covered employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plan would otherwise end. COBRA coverage can be particularly important because it will allow you to continue this Plan's coverage beyond the point at which you would ordinarily lose it.

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

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of coverage under the Plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed under the section entitled Qualified Beneficiaries below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage.

Who is a Qualified Beneficiary?

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

COBRA Rights for Covered Employees

If you are a covered employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events occurs:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than 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 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 Local Gov that you do not intend to return to work, whichever occurs first.

COBRA Rights for a Covered Spouse and Dependent Children

If you are the spouse of a covered employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events occurs:

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

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events occurs:

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

What Coverage is Available?

If you choose COBRA continuation coverage, Local Gov is required to offer you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members.

When is COBRA Coverage Available?

COBRA continuation coverage will be offered to qualified beneficiaries only after Local Gov has been notified that a qualifying event has occurred.

When Should Your Unit Notify Local Gov?

Your employer is responsible for notifying Local Gov of the following qualifying events:

- End of employment
- Reduction of hours of employment or
- Death of an employee

When Should You Notify Local Gov?

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

- Divorce
- Legal separation, or
- A child losing dependent status.

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

How is COBRA Coverage Provided?

When Local Gov is notified that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. In addition, a covered employee may elect COBRA continuation coverage on behalf of his or her spouse and either covered parent may elect COBRA continuation coverage on behalf of their children.

If you do not choose continuation coverage, your coverage under the Plan will end.

After Local Gov receives timely notice that a qualifying event has occurred, Local Gov will (1) notify you that you have the option to buy COBRA, and (2) send you a COBRA election notice.

You have 60 days within which to elect to buy COBRA coverage. The 60-day period begins to run from the later of (1) the date you would lose coverage under the Plan, or (2), the date on which Local Gov 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 the election notice is sent back to Local Gov.

Once Local Gov has been notified of your qualifying event, your coverage under the Plan will be retroactively terminated and payment of all claims incurred after the date coverage

ceased will be rescinded. If you elect to buy COBRA during the 60-day election period, and if your premiums are paid on time, Local Gov 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, the Plan 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 coverage and pay your premiums on time.

What will be the Length of COBRA Coverage?

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

- Death of the employee,
- Divorce or legal separation, or
- Dependent child loses eligibility as a dependent child under the Plan.

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

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

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

- Disability – if you or a covered member of your family is or becomes disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act and you timely notify Local Gov, 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, if the disabled person elects to be covered under the

disability extension. If the only persons who elect the disability extension are non-disabled family members, the cost of coverage will remain at 102% of the full cost of coverage.

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

For this disability extension of COBRA coverage to apply, you must give Local Gov timely notice of Social Security's disability determination before the end of the 18-month period of COBRA coverage and within 60 days after the later of (1) the date COBRA continuation coverage begins, or (2) the date the Social Security Administration issued the Disability Determination letter. You must also notify Local Gov within 30 days of any revocation of Social Security disability benefits.

- Extensions of COBRA for Second Qualifying Events – If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if Local Gov is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage had the first qualifying event not occurred. You must notify Local Gov within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

Can New Dependents Be Added to Your COBRA Coverage?

You may add new dependents to your COBRA coverage under the circumstances permitted under the Plan. Except as explained below, any new dependents added to your COBRA coverage will not have independent COBRA rights. For example, 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 Local Gov of Social Security's disability determination as explained above.

How Does the Family and Medical Leave Act Affect my COBRA Coverage?

If you are on a leave of absence covered by FMLA, and you do not return to work, you will be given the opportunity to elect COBRA continuation coverage. The period of your COBRA continuation coverage will begin when you fail to return to work following the expiration of your FMLA leave or you inform your employer that you do not intend to return to work, whichever occurs first.

How much is COBRA Coverage?

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

Your coverage will be canceled if you fail to pay the entire amount timely.

When is my COBRA Coverage Premium Due?

Your initial premium payment must be submitted to Local Gov within forty-five (45) days from your date of election. All subsequent premiums are due on the first day of the month of coverage. There is a 30-day grace period.

Termination of Continuation Coverage

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

- Local Gov no longer provides group health coverage;
- The unit withdraws from the LGHIP;
- The premium for your continuation coverage is not paid on time;
- You become covered, after electing continuation coverage, under another group plan;
- You become entitled to Medicare;
- You extend coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled.

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

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

Note: If you are entitled to Medicare before you become a qualified beneficiary, you may elect COBRA continuation coverage; however, your Medicare coverage will be primary and your COBRA continuation coverage will be secondary. You must have Medicare Parts A and B to have full coverage.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a special enrollment period. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.Healthcare.gov.

Keep Local Gov Informed of Address Changes

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

If You Have Any Questions

Questions concerning your COBRA continuation coverage rights may be addressed by calling Local Gov at 1-866-836-9137 or 334-851-6802 or by mail at the contact listed below. For more information about your COBRA rights, visit the Centers for Medicare & Medicaid Services (CMS) website at www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/COBRA.html. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Local Gov Contact Information

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

Local Gov Health and Wellness
COBRA Section
P.O. Box 304901
Montgomery, AL 36130

Chapter 5
Subrogation

Right of Subrogation

If Southland pays or provides any benefits for you under the dental policy, the Plan is subrogated to all rights of recovery that you have in contract, tort, or otherwise against any person or organization for the amount of benefits Southland has paid or provided. Southland may use your right to recover money from that other person or organization. Your right to be made whole is superseded by our right of subrogation.

Right of Reimbursement

Separate from and in addition to the right of subrogation, if you or a member of your family recovers money from the other person or organization for any injury or condition for which benefits were provided, you agree to reimburse the Plan from the recovered money the amount of benefits we have paid or provided. That means that you will pay to Southland the amount of money recovered by you through judgment or settlement from the third person or his insurer, as well as from any person, organization, or insurer, up to the amount of benefits paid or provided by us. Our right to reimbursement comes first even if others have paid for part of your loss or if the payment you receive is for, or is described as for, your damages (such as for personal injuries) other than health or dental care expenses, or if the member recovering the money is a minor.

Right to Recovery

You agree to promptly furnish Southland all information that you have concerning your rights of recovery or recoveries from other persons or organizations and to fully assist and cooperate with Southland in protecting and obtaining our reimbursement and subrogation rights in accordance with this Section. You may receive questionnaires requesting more information. Any member who has not responded within 30 days of receiving three questionnaires will have their claims suspended until they have complied with the questionnaire. You or your attorney will notify us before filing any suit or settling any claim 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 can 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 Southland such 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 section 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, Southland may suspend or terminate payment or provision of any further benefits for you under the Plan.

Chapter 6
Southland Appeal Process

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

- To appeal, the participant must submit a request for review, in writing, to Southland within 60 days from the date of the notice from Southland denying payment of a claim. This request must contain the specific reasons the participant contends claim denial was improper. Within the same time period, participant may submit any other evidence which participant contends supports his or her position.

- Southland will review the claim, any written requests or other evidence received from the participant and advise the participant of its final determination. The Southland decision will be final and will exhaust administrative remedies.

Chapter 7
LGHIB Appeal Process

Issues involving eligibility and enrollment should be addressed directly with the LGHIB through the appeal process outlined below. However, all issues regarding benefit determinations should be addressed through the Southland appeal process. The following issues will not be reviewed under the LGHIB appeal process:

- Medical Necessity
- Investigational Related Services
- Cosmetic Surgery
- Custodial Care
- Allowed Amounts

Note: Medical decisions will not be questioned.

All requests must be sent to the following address:

Local Gov Health and Wellness
Attention: Legal Department
P.O. Box 304901
Montgomery, Alabama 36130

Informal Review

If you feel an enrollment or eligibility decision was not in conformity with LGHIB rules, policies, or procedures, you may request an informal review. In many cases, the issue can be resolved over the phone without the need for an administrative review or formal appeal. A request for an informal review must be received by the LGHIB within 60 days from the date of an adverse decision by the LGHIB. Untimely requests will be denied.

Administrative Review

If you are unsatisfied with the informal review decision, you may then request an administrative review. All requests for administrative review must be received by the LGHIB within 60 days from the date of the informal review decision. Untimely requests will be denied. If the LGHIB determines that an administrative review is appropriate, you will be sent a LGHIB administrative review form to complete and return. A copy of the initial adverse determination and informal review decision must be submitted with the administrative review form. The administrative review committee will review the request, usually within 60 days. Oral arguments will not be considered unless approved by the LGHIB. The administrative review committee will issue a decision in writing to all parties involved in the review.

Formal Appeal

If you do not agree with the administrative review decision, you may file a request for a formal appeal before the Board. Requests for a formal appeal must be received by the LGHIB within 60 days following the date of the administrative review committee's decision. Untimely requests will be denied. Oral arguments will not be considered unless approved by LGHIB. If your request for a formal appeal is granted a decision will be issued within 90 days following approval of the request for formal appeal. The number of days may be extended by notice from the LGHIB. If you have not received a decision or notice of extension within 90 days, you may consider your appeal denied. The Board's decision will be final, and all member administrative appeal options will be exhausted.

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

Plan Summary

Dental Benefit Schedule

	Plan I (Employee Only)	Plan II (Employee & Full Family)
Maximum benefits applicable per person per plan year:	$1,250.00	$1,000.00
Diagnostic & Preventative Services: Based on Reasonable & Customary Charges		
Deductible	None	None
Oral Examinations	100%	100%
Cleaning of Teeth	100%	100%
Fluoride Applications for Children	None	100%
Space Maintainers for Children	None	Limited
X-Rays	100%	100%
Emergency Office Visits	100%	100%
Sealants	None	100%
Basic & Major Services: Based on Reasonable & Customary Charges		
Deductible	None	$25.00
Fillings	80%	60%
General Anesthetics	80%	60%
Oral Surgery	80%	60%
Periodontics	80%	60%
Endodontics	80%	60%
Dentures	80%	60%
Crowns	80%	60%

Covered Dental Expenses

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

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

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

Reasonable and Customary Charges

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

- The **usual fee** which the individual dentist in Alabama most frequently charges most of his patients for service rendered;

- The **prevailing range of fees** charged in the same areas by dentists in Alabama of similar training and experience for service rendered; and

- **Circumstances or complications** requiring additional time, skill, and experience.

Diagnostic and Preventive Expenses

This plan will pay all reasonable and customary charges for:

NO ORTHODONTIC BENEFITS

- Space maintainers limited to $125.00 per unit.
- Deductibles are applied per person, per plan year with a maximum of three (3) per family.
- Oral surgery excludes any procedures covered under a group medical program.
- No benefits are provided for replacement of teeth removed before coverage is effective.
- Expenses are incurred at the preparation date and not the installation, service, or "seating" date
- Benefits are not provided for temporary partials

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

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

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

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

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

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

Other Covered Dental Expenses

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

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

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

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

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

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

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

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

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

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

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

Pre-Determination of Benefits

Before beginning a course of treatment for which dentists' charges are expected to be $150.00 or more, a description of the proposed course of treatment and charges to be made should be filed on a claim form with Southland. Southland will then determine the estimated benefits payable for covered dental expenses expected to be incurred and advise the employee and the dentist before treatment begins. Services must be completed within a reasonable length of time from the date predetermination was processed.

Emergency treatments, oral examinations including prophylaxis and dental x-rays are considered part of a course of treatment, but these services may be rendered before the pre-determination of benefits procedure has begun.

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

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

In the event there is no claim for a predetermination of benefits, the benefit will be paid based upon the information submitted to Southland at the time of the claim.

Alternate Procedures

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

DentaNet Benefits

The dental coverage administered by Southland will offer a dental network to members and dependents enrolled in the dental plan. Under the Southland dental network, known as "DentaNet", members can use the network dentists but still have the freedom to use any dentist. DentaNet dentists cannot balance bill you for the difference between the negotiated fee schedule and what they normally charge. On services requiring you to pay a coinsurance fee, the coinsurance payment will be based on a negotiated fee. Local Gov and its members save money when DentaNet dentists are used.

Visit www.southlandbenefit.com for a list of DentaNet providers.

Dental Exclusions

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

1. Expenses incurred by or on account of an individual prior to such person's effective date of coverage under the plan.
2. Replacement of teeth removed before coverage is effective.
3. Work done for appearance (cosmetic) purposes. Facing on crowns and pontics posterior to the second bicuspid are always considered to be cosmetic.
4. Work done while not covered under this plan.
5. Services or supplies in connection with orthodontia except for extractions.
6. Extra sets of dentures or other appliances.

7. Missed appointment.
8. Replacing lost or stolen prosthetic appliances.
9. Completion of claim forms or filing of claims.
10. Educational or training programs, dietary instructions, plaque control programs, and oral hygiene information.
11. Implantology (implants).
12. Periodontal splinting.
13. Work covered under the group health plan.
14. Experimental procedures.
15. Drugs or their administration.
16. Anesthetic services billed by anyone other than the attending dentist or his or her assistant.
17. Services and supplies not ordered by a dentist or physician and not necessary for treatment of injury or dental disease.
18. Appliances, restorations, and procedures to alter vertical dimension including, but not limited to, harmful habit appliances.
19. Services or supplies that exceed the reasonable and customary charges in Alabama.
20. Treatment of an accident related to employment or sickness if either or both are covered under Workers' Compensation or similar laws.
21. Work that is otherwise free of charge to patients or charges that would not have been made if there were no insurance.
22. Work that is furnished or payable by the Armed Forces of any government.
23. Services or supplies furnished by the United States, state, or local government.
24. Services received for injuries or sickness due to war or any act of war, whether declared or undeclared, which war or act of war shall have occurred after the effective date of this plan.
25. Expenses to the extent of benefit provided under any employer group plan other than this plan in which the state of Alabama participates in the cost thereof.
26. Such other expenses as may be excluded by regulations of the board.
27. Gold foil restorations.
28. Pulp capping or acid etching as a separate procedure.
29. Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes.
30. Periodontal cleaning aids or devices.
31. Specific charges for infection control and/or protection supplies, including but not limited to, gloves, masks, gowns, shoes, or other items.

32. Microscopic bacteriological examinations.
33. Antimicrobial irrigation.
34. Temporomandibular joint (TMJ) disorders.
35. Benefits are not provided for temporary partials.
36. Expenses for which the individual is not required to make payment, including but not limited to, reductions or readjustments to the charges made by the health care provider.
37. All claims not submitted in writing, not completed, without the requisite certification of the health care provider, or received by Southland more than 365 days following the claim incurrence.
38. Services of a dentist who is related to the member by blood or marriage or who regularly resides in the same household.
39. Hospital expenses for dental work performed in the hospital.

Coordination of Dental Benefits

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

Order of Benefit Determination

Which plan is primary is decided by the first rule below that applies:

Noncompliant Plan

If the other plan is a noncompliant plan, then the other plan shall be primary and this plan shall be secondary unless the coordination of benefits terms of both plans provide that this plan is primary.

Employee/Dependent

The plan covering a patient as an employee, member, subscriber, or contract holder (that is, other than as a dependent) is primary over the plan covering the patient as a dependent. In some cases, depending upon the size of the 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.

Dependent Child – Parents Not Separated or Divorced

If both plans cover the patient as a dependent child of parents who are married or living together (regardless of whether they have ever been married), the plan of the parent whose birthday falls earlier in the year will be primary. If the parents have the same birthday, the plan covering the patient longer is primary.

Dependent Child – Separated or Divorced Parents

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

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

  If the court-ordered parent has no dental care coverage for the dependent child, benefits will be determined in the following order:
    - first, the plan of the spouse of the court-ordered parent;
    - second, the plan of the non-court-ordered parent; and
    - last, the plan of the spouse of the non-court-ordered parent. If a court decree states that both parents are responsible for the dependent child's dental care expenses or dental care coverage, the provisions of "Dependent Child – Parents Not Separated or Divorced" (the "birthday rule") above shall determine the order of benefits.

      If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental care expenses or dental care coverage of the dependent child, the provisions of the "birthday rule" shall determine the order of benefits.
- For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under the "birthday rule" as if those individuals were parents of the child.

<u>Active Employee or Retired or Laid-Off Employee</u>

- The plan that covers a person as an active employee (that is, an employee who is neither laid off nor retired) or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

- If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.

This rule does not apply if the rule in the paragraph “Employee/Dependent” above can determine the order of benefits. For example, if a retired employee is covered under his or her own plan as a retiree and is also covered as a dependent under an active spouse's plan, the retiree plan will be primary and the spouse's active plan will be secondary.

COBRA

- If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

- If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

- This rule does not apply if the rule in the paragraph “Employee/Dependent” above can determine the order of benefits. For example, if a former employee is receiving COBRA benefits under his former employer's plan (the “COBRA plan”) and is also covered as a dependent under an active spouse's plan, the COBRA plan will be primary and the spouse's active plan will be secondary. Similarly, if a divorced spouse is receiving COBRA benefits under his or her former spouse's plan (the “COBRA plan”) and is also covered as a dependent under a new spouse's plan, the COBRA plan will be primary and the new spouse's plan will be secondary.

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

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

Determination of Amount of Payment

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

If this plan is a secondary plan on a claim, should it wish to coordinate benefits (that is, pay benefits as a secondary plan rather than as a primary plan with respect to that claim), this plan shall calculate the benefits it would have paid on the claim in the absence of other healthcare coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. When paying secondary, this plan may reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other healthcare coverage. In some instances, when this plan is a secondary plan, it may be more cost effective for the plan to pay on a claim as if it were the primary plan. If the plan elects to pay a claim as if it were primary, it shall calculate and pay benefits as if no other coverage were involved.

Coordination of Benefits Terms

Allowable Expense: Except as set forth below or where a statute requires a different definition, the term “allowable expense” means any dental care expense, including coinsurance, copayments, and any applicable deductible that is covered in full or in part by any of the plans covering the person.

The term “allowable expense” does not include the following:

- An expense or a portion of an expense that is not covered by any of the plans.
- Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person.
- Any type of coverage or benefit not provided under this plan. In addition, the term “allowable expense” does not include: (a) the amount of any reduction in benefits under a primary plan because the covered person failed to comply with the primary plan's provisions concerning second surgical opinions or precertification of admissions or services, or (b) the covered person had a lower benefit because he or she did not use an in-network dentist.

Birthday: 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.

Custodial Parent: The term “custodial parent” means:

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

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

Noncompliant Plan: The term “noncompliant plan” means a plan with coordination of benefits rules that are inconsistent in substance with the order of benefit determination rules of this plan. Examples of noncompliant plans are those that state their benefits are “excess” or “always secondary.”

Plan: The term “plan” includes group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); dental care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

The term “plan” does not include non-group or individual health or medical reimbursement insurance contracts. The term “plan” also does not include hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Primary Plan: The term “primary plan” means a plan whose benefits for a person's dental care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if:

- The plan either has no order of benefit determination rules, or its rules differ from those permitted by this provision; or
- All plans that cover the person use the order of benefit determination rules required by this provision, and under those rules the plan determines its benefits first.

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

Coverage and Maximum Annual Benefits

Examination (actual charges not to exceed):	$95.00
AND	
Frames	$95.00
Lenses not to exceed:	
Single Vision	$100.00
Bifocals	$130.00
Trifocals	$180.00
Lenticular	$180.00
OR	
Contacts	$180.00
OR	
Refractive Surgery	$180.00

Plan provides benefits for only one of the following in the same plan year: (a) contacts, (b) frames and lenses, or (c) refractive surgery.

It is the responsibility of the member to submit a claim for (a) contacts, (b) frames and lenses, or (c) refractive surgery, and the payment will be made based on the date the claim is received.

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

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

- Case history
- External examination of the eye and adnexa
- Determination of refractive status
- Ophthalmoscopy

- Application of pharmaceutical agents for diagnostic purposes when indicated and allowed by state law
- Tonometry test for glaucoma when indicated
- Binocular measure
- Summary finding and recommendations
- Prescribing corrective lenses, if needed

Definitions

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

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

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

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

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

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

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

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

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

Refractive Surgery: Refractive eye surgery is a surgical method of vision correction by changing the refractive properties of the eye, with the goal to reduce or remove the need for corrective lenses. Types of surgery to correct refractive errors include: laser assisted in-situ keratomileusis (LASIK); photorefractive keratectomy (PRK); radial keratotomy (RK); astigmatic keratotomy (AK); automated lamellar keratoplasty (ALK); laser thermal keratoplasty (LTK); conductive keratoplasty (CK); intracorneal ring (Intacs). Refractive

surgery does not include any procedures covered under another health insurance plan.

Vision Exclusions

Vision care plan benefits will not be provided for certain charges, including but not limited to charges for:

1. Expenses incurred by or on account of an individual prior to such persons effective date of coverage under the plan;
2. Services or supplies for which coverage is provided or available under the Local Government Health Insurance Program, or by Workers' Compensation Laws, or by any safety lens program;
3. Drugs or any other medication;
4. Any medical or surgical treatments (with the exception of refractive surgery);
5. Special or unusual treatment such as orthoptics, vision training, sub-normal vision aids, aniseikonia lenses or tonography;
6. Services or supplies not prescribed by a licensed physician, optometrist, or ophthalmologist, and lenses which do not require a prescription;
7. Service or supplies which are experimental in nature or are not approved by the American Ophthalmology Association;
8. The extra charge for oversized, photo sensitive, or anti-reflective lenses, whether or not medically necessary;
9. Sunglasses, including lenses and frames;
10. Follow-up visits, fitting fees, dispensing fees, coating or care kits;
11. Expenses for which the individual is not required to make payment, including but not limited to, reductions or readjustments to the charges made by the health care provider;
12. All claims not submitted in writing, not completed, with the requisite certification of the health care provider or received by Southland more than 365 days following the claim occurrence.
13. Services of a physician who is related to the member by blood or marriage or who regularly resides in the same household.

Coordination of Vision Benefits

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

A. **Hospital Confinement**: $350.00 per day for the first 90 consecutive days of hospital confinement for inpatient charges; $500.00 per day thereafter. Readmission 30 days after discharge starts $350.00 daily payment again. No limit on confinement days or dollar amount.

In-hospital benefit (per day) under this Policy does not cover charges for outpatient or same-day surgery UNLESS you are admitted on an inpatient basis where you are charged for a private or semi-private room or for an observation room for more than 24 continuous hours. Emergency room, outpatient room, observation room less than 24 continuous hours, or a similar type room is not to be considered as a private or semi-private room and benefits are not provided for such charges under this Policy.

B. **Hospice Care**: Actual charges to a maximum of $250.00 per day for care provided by a licensed Hospice agency, organization, or unit that provides to persons terminally ill and to their families, a centrally administered and autonomous continuum of palliative and supportive care. The care must be directed and coordinated by the Hospice organization in the patient or family home. This benefit does not apply to non-terminally ill patients, nor does it apply to home health care or custodial care benefits. Lifetime maximum of $5,000 per insured.

C. **Cancer Surgery**: Actual charges for operation depending on the type of surgery (see schedule of policy), to a maximum of $2,400.00. Hospitalization is not required. No limit on the number of operations.

D. **Anesthesia**: Actual charges to a maximum of $500.00 per operation. No limit on the number of operations.

E. **Radiation & Chemotherapy**: Actual charges to a lifetime maximum of $10,000.00. Hospitalization is not required. Diagnostic tests are not included.

F. **Blood & Plasma**: Actual charges to a lifetime maximum of $2,000.00. Includes transfusions, administration, processing and procurement, and cross-matching (excludes other laboratory expenses). Hospitalization not required.

G. **Nursing Service**: Actual charges for full-time private care and attendance to $125.00 per day for RN or LPN for each day the insured is eligible for Hospital Confinement Benefit.

Such services to be rendered by a person who does not ordinarily reside in the same household with the covered person, and who is not related by blood, marriage, or legal adoption to the covered person. No lifetime maximum.

H. **Attending Physician**: Actual charges to a maximum of $20.00 per day for physician other than the surgeon for each day the insured is eligible for Hospital

Confinement Benefit. No lifetime maximum.

I. **Ambulance**: Actual charges to a maximum of $100.00 per trip to and from the hospital where the insured is confined as an in-patient. Limit two trips per confinement. No lifetime maximum.

J. **Prosthetic Devices**: Actual surgery charges to a maximum of $500.00 for each surgically implanted prosthetic device that is prescribed as a direct result of cancer surgery. Lifetime maximum of $1,000.00 per insured.

Schedule of Operations

(Maximum Amounts Payable)

If two or more surgical procedures are performed by the same surgical approach or in the same operative field, the amount paid by the Policy will be that of the more expensive of the two procedures performed.

Procedure	Amount
ABDOMEN	
Paracentesis	$100.00
Exploratory laparotomy	$600.00
Cholecystectomy	$800.00
BLADDER:	
Cystoscopy	$150.00
Cystectomy	
(Partial)	$1,000.00
(Complete)	$1,800.00
TUR bladder tumors	$600.00
BRAIN:	
Exploratory Craniotomy	$1,200.00
Burr holes not followed by surgery	$300.00
Excision brain tumor	$2,400.00
BREAST:	
Needle Biopsy	$150.00
Cutting Operation Biopsy	$300.00
Mastectomy	
(Simple)	$800.00
(Radical)	$1,200.00
Lumpectomy	$400.00
CERVIX:	
Dilation and Curettage (D&C)	$200.00
Colposcopy	$200.00
Hysterectomy - Abdominal and Vaginal	
Uterus only	$800.00
Uterus, tubes, & ovaries	$1,200.00
CHEST:	
Thoracentesis	$100.00
Bronchoscopy	$300.00
Mediastinoscopy	$300.00
Thoracostomy	$800.00
Pneumonectomy	$1,600.00

Wedge Resection	$1,200.00

Lobectomy	$1,400.00
ESOPHAGUS:	
Esophagoscopy	$300.00
Resection of Esophagus	$1,600.00
Esophagogastrectomy	$1,400.00
EYE:	
Enucleation	$400.00
P32 uptake	$200.00
INTESTINES:	
Sigmoidoscopy	$150.00
Proctosigmoidoscopy	$150.00
Colonoscopy	$300.00
Cutting Operation of rectum for biopsy	$300.00
Colostomy or revision of	$400.00
Heostomy	$400.00
Colectomy	$1,000.00
Abdominal-Perineal approach for removal of cancer of sigmoid colon or rectum	$2,000.00
Resection small intestine	$2,000.00
KIDNEY:	
Nephrectomy	$2,000.00
LIVER:	
Needle Biopsy	$150.00
Wedge Biopsy	$300.00
Resection of liver	$1,000.00
LYMPHATIC:	
Excision of lymph node	$200.00
Splenectomy	$800.00
Axillary node dissection	$800.00
Lymphadenectomy	
(Unilateral)	$800.00
(Bilateral)	$1,000.00
MANDIBLE:	
Mandibulectomy	$1,600.00
MISCELLANEOUS:	
Bone Marrow Biopsy or Aspiration	$150.00

Pathological Fracture Hip	$1,000.00

MOUTH:	
Hemiglossectomy	$400.00
Glossectomy	$800.00
Resection of Palate	$800.00
Tonsil/Mucous membrane	$600.00
PANCREAS	
Jejunostomy	$1,000.00
Pancreatectomy	$2,400.00
Whipple Procedure	$2,400.00
PENIS:	
Amputation	
(Partial)	$300.00
(Complete)	$600.00
(Radical)	$800.00
PROSTATE:	
Cystoscopy	$150.00
TUR Prostate	$600.00
Radical Prostatectomy	$1,400.00
SALIVARY GLANDS:	
Biopsy	$400.00
Parotidectomy	$800.00
Radial Neck Dissection	$1,600.00
SKIN:	
Excision of lesion of skin	$150.00
With flap or graft	$400.00
SPINE:	
Laminectomy	$1000.00
Cordotomy	$600.00
STOMACH:	
Gastroscopy	$300.00
Partial Gastrectomy	$1,000.00
Gastrectomy	$1,400.00
Gastrojejunostomy	$1,000.00
TESTIS:	
Orchiectomy	$400.00

THROAT:	
Laryngoscopy	$300.00

Laryngectomy	
(Without neck dissection)	$800.00
(With neck dissection)	$1,600.00
Tracheostomy	$300.00
THYROID:	
Thyroidectomy	
Partial (one lobe)	$600.00
Total (both lobes)	$800.00
VULVA:	
Partial	$600.00
Radical	$1,200.00

Limitations and Exclusions

A. This policy pays only for loss resulting from hospitalization for definitive cancer treatment including direct extension, metastatic spread, or recurrence. Pathologic proof must be submitted to support each claim. This policy does not cover any other disease, sickness, or incapacity, and benefits are not provided for premalignant conditions with malignant potential or human immunodeficiency virus.

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

- Expenses incurred by or on account of an individual prior to such person's effective date of coverage under the Policy;
- Hearing aids and examinations for the prescription or fitting of hearing aids;
- Cosmetic surgery or treatment, specifically but not limited to, coverage for reconstruction that is prescribed as a direct result of cancer surgery except as provided in Paragraph J. "Prosthetic Devices" under the Cancer Program.
- Benefits for treatment in a United States government hospital unless the covered individual is actually charged for the treatment and is legally required to pay such charge;
- Services received for injury or sickness due to war or any act of war, whether declared or undeclared, which war or act of war shall have occurred after the effective date of this Policy;
- 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;
- Expenses to the extent of benefits provided under any employer group plan other than this Policy in which the state of Alabama participates in the cost thereof;
- Such other expenses as may be excluded by regulations of the Board;
- Expenses due to Convalescent Long-Term Care, Nursing Home confinement or rehabilitation (the recovery of health and strength after disease, sickness, or injury);
- All claims not submitted in writing, not completed, without the requisite certification of the health care provider or received by Southland more than 365 days following the claim incurrence.
- Services of a physician who is related to the member by blood or marriage or who regularly resides in the same household.

Definitions

A. Cancer Defined - Positive Pathology Required

Cancer is defined as a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells, the invasion of tissue, or leukemia.

Such cancer must be positively diagnosed by a legally licensed doctor of medicine certified by the American Board of Pathology to practice Pathologic Anatomy, or an Osteopathic Pathologist. Diagnosis must be based on a microscopic examination of fixed tissue or preparations from the hemic system (either during life or post-mortem). The pathologist establishing the diagnosis shall base his judgment solely on the criteria of malignancy as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen. Clinical diagnosis does not meet this standard.

B. Hospital Defined

Hospital means a lawfully operating institution engaged mainly in providing treatment for sick or injured persons on an inpatient basis at the patient's expense. The treatment must be under the supervision of a licensed physician. The hospital must maintain diagnostic and therapeutic facilities on-premises for surgical and medical treatment of such persons. These facilities must be supervised by a staff of legally qualified physicians and must include a laboratory, x-ray equipment, and operating room. Permanent, full-time facilities for the care of overnight resident bed patients must be maintained.

The hospital must have surgical facilities on-premises where major surgery is performed on a routine basis. The hospital must be approved by the Joint Commission on the Accreditation of Hospitals, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities.

Hospital does not include the institution, or part thereof, used as: a Hospice unit including any beds designated as a Hospice; a swing bed; a convalescent home; a rest home; a rest or nursing facility; pain clinic; psychiatric unit; rehabilitation unit; an extended care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care or treatment for persons suffering from mental disease or disorders, care for the aged, drug and/or substance-addicted or alcoholics.

Chapter 11
TruHearing Choice Discount

Southland plan participants have access to TruHearing, a discount network for digital hearing aids. TruHearing is available at no additional premium. Benefits included with the TruHearing program are listed below:

- Free hearing test available on the TruHearing website
- Risk-free 60-day trial period
- 1 year of follow-up visits
- 80 free batteries per non-rechargeable hearing aid
- Full 3-year manufacturer warranty
- One-time loss and damage replacement (deductible applies)
- No-interest finance available
- Dedicated hearing consultant through life of the hearing aid
- Selection of the newest technology hearing aids from the top manufacturers
- Over 7,000 providers nationwide
- RIC, IIC, ITE, ITC, CIC and BTE hearing aids available through discount program.

Website: TruHearing.com/Southland
Phone: 1-833-414-6907 | TTY: 711
Hours: 8am-8pm, Monday - Friday

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