2021

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM

ADMINISTRATIVE PROCEDURES GUIDE

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
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www.lghip.org

Michael Gillespie
Chairman

William L. Ashmore
CEO

MEMORANDUM

TO: All Local Government Units

FROM: William L. Ashmore
Chief Executive Officer

SUBJECT: Local Government Health Insurance Program

The Local Government Health Insurance Board is pleased to provide the Local Government Health Insurance Program (LGHIP). Legislative Act 92-303 established the LGHIP to provide affordable group health insurance coverage for employees of local government units and certain organizations and associations throughout the State of Alabama. The LGHIP is a self-insured group health insurance program funded from the premiums of the participating local government units and their subscribers. The LGHIP is administered by the Local Government Health Insurance Board (LGHIB), which was established by Alabama Legislative Act 2014-401.

The first part of this guide contains application instructions for new local government units to enroll in the LGHIP and the criteria for establishing eligibility. Also enclosed are the premiums, enrollment forms, and explanations of billing procedures. Please read and follow all instructions carefully.

We welcome this opportunity to offer you the LGHIP and trust this program will provide the health insurance coverage to meet your needs. If you have any questions or if we can be of further service, please visit the 'Contact Us' section of our website, www.lghip.org, or contact a member of the LGHIB staff at 334-263-8326 or 1-866-836-9137.

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Roger Rendleman
Chairman

William L. Ashmore
CEO

MEMORANDUM

TO: Local Government Units

FROM: James J. Bradford, COO
Local Government Health Insurance Board

SUBJECT: 2021 LGHIB Administrative Guide Summarization of Changes

The below information is a summarization of the changes contained in the 2021 LGHIB Administrative Guide. This may not contain all revisions to the Administrative Guide. The LGHIB requests you review the entire Administrative Guide each year for a full and complete understanding of all changes.

1. Section I – Local Government Unit Application and Enrollment
    a. Information for new units joining the LGHIP was moved to this section.
2. Section III – Premiums
    a. Premium categories modified to create separate premium categories for units that offer or exclude LGHIP retiree coverage. (p. 6).
    b. Preferred premium wellness participation percentage criteria increased to 80% effective January 1, 2022. (p. 7).
    c. Additional option added to the 5% retiree rule necessary to receive the preferred premium rate. (p. 7).
    d. Wellness qualifying period for the 2021 discount was extended to October 31, 2020. (p. 8).
    e. Premium schedules were modified to show single and family rates. The “total” column was removed to simplify the chart. (pp. 11-17).
3. Section IV – Employee Participation Requirement
    a. A unit must have at least one full-time employee enrolled to be an eligible participating unit in the LGHIP. (p. 19).
4. Section V – Eligibility Rules
    a. ACA Verification Form must be submitted for new ACA employees. (p. 20).
    b. Removed elected official retiree language as a result of consolidation of retiree rules. (p. 21).
    c. Incapacitated dependent determination is conducted by Blue Cross and Blue Shield of Alabama. (p. 22).
    d. Dependent Definitions and Documentation Requirements chart explaining documentation required to add specific dependents to coverage. (p. 23).
5. Section VI – Existing Unit Enrollment Rules
    a. Modified the “Enrollment Rules” section to “Existing Unit Enrollment Rules” to indicate enrollment rules for existing units. Moved the rules for new units to Section I of the book. (p. 25-27).
6. Section VII – Retirement
    a. Years of service credit will only be provided for full-time employment (requirement was already included in the Years of Service form). (p. 33).
    b. Requirements for retirement based on disability. (p. 33).
    c. Cancellation requirements for units that offer coverage to Medicare retirees. (p. 35).

7. Section IX – Eligible Participant Termination of Coverage
    a. Earliest an employee on LWOP can be canceled due to non-payment is the first day of the month after notification is provided to the LGHIB. (Page 39)
8. Section X – COBRA
    a. COBRA Medicare enrolled in Medicare Advantage. (p. 40).
    b. Additional condition added under the "What will be the Length of COBRA Coverage" (p. 43).
9. Section XI – Employee Eligibility Audit
    a. Employee Eligibility Audit section explains the procedures and treatment of audit results. (p. 45).
10. Section XIV – Wellness Program
    a. Eligibility for inclusion in the Wellness Program and the changes to the wellness program. (p. 47, 48).
11. Application Package Instructions (formerly Section IV)
    a. Moved to the General Information for Initial Enrollment form (LG11-A).
12. Forms
    a. Retiree Years of Service Verification form (LG22) added.
    b. Affordable Care Act Full-Time Employee Verification (LG23) added.

As always, the LGHIB appreciates your participation in our health insurance plan. If we can be of any assistance, please contact our office at (334) 263-8326.

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I. Local Government Unit Application and Enrollment

A. Governance and Administration

Code of Alabama Section 11-91A-2(a) through (g)
"(a) The Local Government Health Insurance Board shall govern and administer the Local Government Health Insurance Program currently governed and administered by the State Employees' Insurance Board (SEIB) pursuant to Chapter 29 of Title 36. The transfer of the governance and administration to the board shall take effect at 12:01 a.m. on January 1, 2015, and thereafter the board shall take all control and responsibility for the program under procedures and authority set out in this chapter.

(b) The program governed and administered by the board shall provide a reasonable relationship between the health care benefits to be included and the expected health care expenses to be incurred by affected employees, retirees, and their dependents. The board may establish a fully insured or self-insured health care plan for employees and retirees as defined in this chapter and may adopt and promulgate rules for the administration of the program. The program shall include appropriate controls to provide reasonable assurance of its stability in future years, which may include, but are not limited to, deductibles, copayments, coinsurance, and other cost containment measures such as medical management, utilization review, wellness initiatives, and case management for the purpose of making the benefit plan more cost effective.

(c) Except as otherwise provided herein, the program shall be funded solely from contributions of the employer participants of the program and shall not receive any funding from the state. The governing bodies of entities participating in the program (hereinafter "employer participants") are authorized to make appropriations to the board as necessary for the proper administration of the program including the payment of premiums as provided in this chapter or under rules and regulations promulgated by the board.

(d) Notwithstanding the provisions of Section 36-29-14, the following entities and organizations shall be employer participants in the program:

(1) All entities and organizations which are active participants in good standing in the Local Government Health Insurance Program governed and administered by SEIB immediately prior to 12:01 a.m. on January 1, 2015.

(2) Subject to acceptance by the board, any of the following entities or organizations not already employer participants in the program pursuant to subdivision (1) which by resolution legally conforming to rules prescribed by the board elects to have its elected officials, full-time employees, and retired employees become eligible for health care coverage under the program: Any county, any municipality, any municipal foundation, any fire or water district, authority, or cooperative, any regional planning and development commission established pursuant to Sections 11-85-50 through 11-85-73, Code of Alabama 1975; the Association of County Commissions of Alabama, the Alabama League

of Municipalities, the Alabama Retired State Employees' Association, the Alabama State Employees' Credit Union, Easter Seals Alabama, Alabama State University, the Alabama Rural Water Association, Rainbow Omega, Incorporated, The Arc of Alabama, Incorporated, and any of the affiliated local chapters of The Arc of Alabama, Incorporated, United Ways of Alabama and its member United Ways, the Alabama Network of Children's Advocacy Centers and its member Children's Advocacy Centers, the Care Assurance System for the Aging and Homebound and its affiliated local centers, any railroad authority organized pursuant to Chapter 13, Title 37, Code of Alabama 1975; or any solid waste disposal authority organized pursuant to Chapter 89A, Title 11.

(e) The agreement of an employer participant to have its full-time employees, elected officials, retirees, and dependents covered under the program may be revoked only if the employer participant, by resolution of its governing body, signifies its intention and desire to withdraw from the program. Any resolution to withdraw shall be delivered to the board by certified mail no later than six months prior to the effective date of withdrawal. Any employer participant that withdraws from participation in the program shall be responsible for paying any claims incurred prior to the date of withdrawal that are not reported and paid by the date of withdrawal and, on and after the date of withdrawal, shall be liable for interest accrued at a rate of one and one-half percent per month on any monies due the board which are over 30 days past due.

(f) Any organization that provides or administers health care benefits through or on behalf of the board shall not provide or administer health care benefits to any entity that withdraws from the program for a period of two years from the effective date of withdrawal.

(g) The board shall promulgate rules as may be necessary for the effective administration of this section."

B. Petition to Join the Local Government Health Insurance Plan

The governing body of any local government unit may petition, by resolution, the LGHIB at any time for acceptance into the LGHIP.

Upon acceptance of the local government unit by the LGHIB, the local government unit's full-time employees, elected officials, and retirees who are eligible for health care benefits for themselves or their dependents under the provisions of the LGHIP shall be entitled to coverage and benefits as designated by the LGHIB.

Each eligible participant shall be entitled to have his or her spouse and dependent children, as those persons are defined by the LGHIB, included in the coverage under rules and regulations promulgated by the LGHIB upon agreeing to pay the employee's contribution of the health care premium for the dependents.

Local government units shall provide to the LGHIB any information deemed necessary by the LGHIB for the determination of premium or other program matters.

Local government units shall submit all premium payments and any other information required pursuant to rules adopted by the LGHIB.

Any portion of the premium to be paid for full-time employees, elected officials, and retirees and their dependents may be paid by the local government unit.

C. Application Process

A $50-per-employee (minimum $100) application fee must be submitted by the local government unit along with the application package. This amount is due at the time of application and is non-refundable. The only form of payment accepted is a check drawn from the unit's bank account. In order to join the LGHIP, each prospective unit must complete a new unit application package, which includes required documents and fees.

1. Required Documents for New Unit Enrollment

The following documents must be submitted:

a. General Information form (LG11-A)
b. Participation form (LG15)
c. Resolution (LG16)
    1. *Included in the Appendix. The eligible local government unit must adopt and approve a resolution to officially apply for enrollment in the LGHIP.*
d. Application fee
    1. *A $50-per-employee (minimum $100 application fee must be submitted by the local government unit along with the application package. This amount is due at the time of application and is non-refundable. The only form of payment accepted is a check drawn from the unit's bank account.*
e. Effective Date of Coverage form (LG05)
    1. *Coverage for new employees will be effective on the first day of the second month of employment, subject to an approved probationary period, unless this form is completed and submitted to the LGHIB.*
f. Employee enrollment or declination of coverage (Required for each full-time employee)
    1. Enrollment form (LG01)
    2. Declination form (LG04)
g. A listing, separated by department, of employee names and Social Security numbers.
h. A listing of COBRA participants.
    1. *All current COBRA subscribers must be marked in red as "COBRA." List them separately on the employee departmental listing. Include their name, Social Security number, address, qualifying event, and the date COBRA coverage originally began. Do not fill out an enrollment form for COBRA subscribers. The LGHIB will send them a letter and a when the LGHIB receives your listing.*
i. For cities, towns and counties, a listing of elected officials, which includes office, term and the Social Security number of each elected official.

2. New Unit Enrollment Rules

All eligible employees must either enroll in the LGHIP or decline coverage with proof of other acceptable coverage.

Eligible Employees who Enroll in Coverage
Eligible employees who submit a completed enrollment form (LG01) to the LGHIB on or before the effective date of coverage for the new unit will be enrolled for coverage as of the effective date of coverage of the new unit. Family coverage, if elected, will also be made effective as of the effective date of coverage of the new unit.

Eligible Employees who Decline Coverage
Eligible employees may decline coverage at the time of initial enrollment of a new unit. To decline coverage, an eligible employee must submit a completed Declination of Coverage form (form LG04) and acceptable proof of other coverage to the LGHIB. Acceptable proof is current documentation from an employer/insurance carrier verifying current coverage.

Retirees who Enroll in Coverage (For Units Offering Retiree Coverage)
Eligible retirees who submit a completed enrollment form (LG01) to the LGHIB on or before the effective date of coverage for a new unit will be enrolled for coverage as of the effective date of coverage of the new unit. Family coverage, if elected, will also be made effective as of the effective date of coverage of the new unit.

Retirees who Decline Coverage (For Units Offering Retiree Coverage)
Retirees who do not elect coverage will not be allowed to enroll at a later date.

Exception: If a Medicare retiree declines coverage in the LGHIP in lieu of coverage through SelectQuote or Empower Brokerage, he or she may return to the LGHIP during the LGHIP open enrollment period, as long as there has been no break in coverage. (See the Third Party Medicare Vendor Enrollment section.)

Elected Officials (For Units Offering Coverage for Elected Officials)
An elected official is an individual elected to public office by the vote of the people at the state, county or municipal level of government. If a local government unit chooses to cover elected officials, all elected officials of a new unit have the following options:

a. Enroll in the LGHIP – Elected officials may enroll in the LGHIP at the time the unit initially joins the LGHIP. Family coverage, if elected, will be made effective as of the effective date of coverage of the new unit.

    i. Elected officials will be treated as full-time employees.

b. Decline coverage in the LGHIP – Elected officials may decline coverage in the LGHIP at the time the unit initially joins the LGHIP. If a declination form with proof of other acceptable coverage* is submitted, the elected official may enroll in the LGHIP at a later date upon loss of other acceptable coverage or at open enrollment.

c. Opt out of the LGHIP – If the elected official opts not to enroll in the LGHIP at the time the unit initially joins the LGHIP and does not submit a declination form with proof of other acceptable coverage*, the elected official may only be offered the option to enroll in the LGHIP upon election to a new term of office.

Elected officials who fail to elect one of the above options will be treated as if they chose option 3.

In order to comply with this policy, each unit will be required to submit an updated list of all elected officials by November 30 of each year.

* Other acceptable coverage includes, but is not limited to: ACA qualified group and individual plans, Marketplace, Medicare, Medicaid and Tricare.

Each prospective unit must have at least one full-time employee enrolled in the LGHIP to be eligible as a participating unit in the LGHIP.

3. **Submission of Unit Application**
All the application forms and documentation, along with the application fee must be mailed to the LGHIB at the following:

By Mail	By Overnight Delivery
Local Government Health Insurance Board **Post Office Box 304900** **Montgomery, Alabama 36130-4900**	**Local Government Health Insurance Board** **201 South Union Street, Suite 200** **Montgomery, Alabama 36104**

4. **Certificate of Participation**
If the LGHIB accepts the application for enrollment into the LGHIP, a certificate of participation will be mailed to the eligible local government unit. If the application is not accepted, the reason for not being accepted will be provided to the local government unit.

5. **Effective Date of Unit Coverage**
If the LGHIB receives, and approves, completed enrollment packages on or before the 20th of the month, the local government unit's effective date shall be the first day of the second full month following the receipt and approval of the package. For example, completed packets received and approved on or before January 20 would be eligible for an effective date of March 1. Completed packets received and approved on January 21 would be eligible for an effective date of April 1. However, local government units with more than 300 subscribers must contact the LGHIB for effective date information.

6. **Periodic Reviews**
The LGHIB will periodically conduct reviews of local government units accepted into the LGHIP to ensure conformity with the rules and regulations governing the LGHIP. See Audit section.

7. Revising Unit Information

After local government units are enrolled into the LGHIP, the General Information Changes form (LG11-B) must be used to revise the unit's enrollment information. When a change occurs in either the address, local government health insurance administrator, contact person for billing purposes, wellness coordinator contact, email address, or the telephone number, the unit must submit a new General Information Changes form with the appropriate change(s).

Throughout the remainder of this Administrative Guide, the LGHIB explains the benefit plans, premiums, wellness program and other administrative rules that units should understand and abide by while insured under the LGHIP.

II. Benefit Plans

Units may offer eligible participants coverage in one of the following benefit plans:

- LGHIP with dental coverage
- LGHIP without dental coverage

Medical benefits are administered by Blue Cross and Blue Shield of Alabama (BCBS). Prescription drug benefits are administered by OptumRx.

Dental coverage through BCBS is optional to the local government unit. The unit, as a whole, must elect whether or not it will offer dental coverage. This election can only be changed during Open Enrollment.

If elected by the unit, voluntary dental and vision coverage, administered by Southland Benefit Solutions, may also be offered to eligible participants. (See the Southland LGHIP Voluntary Insurance Plan at the end of this guide.)

If a unit elects to provide coverage to its Medicare retirees, the LGHIB offers a Medicare Advantage plan through UnitedHealthcare.

III. Premiums

The LGHIB bills in advance for the following month's coverage. To be eligible for coverage, eligible participants must comply with the LGHIP's enrollment and eligibility rules. Acceptance of premium payment does not guarantee coverage.

Each local government unit is classified into either the "standard" or "preferred" category for calculating active employee premiums. Retiree premiums are calculated based on the claims experience and do not use standard or preferred premium categories.

A. Premium Categories for Units That Do Not Offer LGHIP Retiree Coverage

The criteria used to determine a unit's premium category is as follows:

Standard

Units meeting one or more of the following criteria are classified in the standard premium category for active employees:

- Less than two (2) complete years of participation in the LGHIP.
- Less than 30%* wellness participation by their active employees during the wellness qualifying period.
- Has failed to pay its premium payment within 30 days from the due date on two or more occasions within the last two years.

Preferred

Units who meet all of the below criteria are classified in the preferred premium category for active employees:

- More than two (2) complete years of participation in the LGHIP.
- 30%* or more wellness participation by their active employees during the wellness qualifying period.
- Has not been delinquent on two premium payments within the last two years.

*Beginning January 1, 2022, the wellness participation percentage required to receive the preferred premium will increase to 80%.

B. Premium Categories for Units That Offer LGHIP Retiree Coverage

The criteria used to determine a unit's premium category is the same criteria for units that do not offer LGHIP retiree coverage with the following additional criteria:

Standard

- Less than 5% of unit's total enrollment are retirees*; or
- Unit has failed to certify that all employees eligible to retire under the LGHIP's retiree rules were offered LGHIP retiree coverage**.

Preferred

- 5% or more of unit's total enrollment are retirees*; or
- Unit has certified that all employees eligible to retire under the LGHIP's retiree rules were offered LGHIP retiree coverage**.

*If a unit sponsors a retiree health plan for its eligible retirees in addition to LGHIP retiree coverage, the unit's retirees covered under its non-LGHIP retiree health plan will count toward the 5% requirement above provided that the unit's retiree health plan is approved by the LGHIB.

** Unit must certify to the LGHIB that all employees eligible to retire under LGHIP rules were given the opportunity to enroll in LGHIP retiree coverage. The certification period is each year from November 1 through October 31. In addition, the following must be provided for each employee leaving service who is eligible to continue LGHIP coverage under the LGHIP's retiree rules:

a. For those electing LGHIP retiree coverage: submit LGHIP Status Change Form (LG02) at least 30 days prior to retirement date. Must be signed by the retiree.
b. For those declining LGHIP retiree coverage: submit LGHIP Cancellation Form (LG03) at least 10 days prior to the date of cancellation. Must be signed by the retiree.

c. Units offering a retirement plan to its eligible employees must submit a list from the retirement plan administrator of all employees participating in the unit's retirement plan who left employment during the certification period of November 1 through October 31. The LGHIB will use this information to ensure all former employees who were eligible for LGHIP retiree coverage were offered coverage by the unit.

Retiree
LGHIP Retiree premiums do not use standard or preferred premium categories.

C. Wellness Premium Discount

The LGHIB Wellness Program is a voluntary program available to active employees, non-Medicare retirees, and spouses who are covered by the LGHIP (Group 30000). See Section XIV for more information.

Local government units that have 80% or greater wellness participation by their active employees within the wellness qualifying period of August 1, 2019 through October 31, 2020 will receive a $10 premium discount per active employee each month of 2021.*** There will be no partial month or prorated discounts applied. Free wellness screenings are available at the worksite, Alabama Department of Public Health's county health departments, or through a participating pharmacy in the BCBS biometric screening pharmacy network participating pharmacy. For a listing of screening sites or participating pharmacy locations, or, please visit our website at www.lghip.org. Active employees can also have their screenings done performed by their healthcare provider; however, applicable office visit and lab copays will apply. The Provider Screening form is located on the LGHIB website and is included in this guide. The Local Government Wellness Program will accept biometrical screenings provided performed by Local Government Health Insurance Board/State Employees' Insurance Board approved providers only. Screenings received from non-approved providers will not be accepted. The screening must be completed by October 31 and submitted to the LGHIB's office by November 15.

a. The discount will be for a 12-month premium period, effective January 1.
b. The discount is applicable for all active employees, regardless of whether each individual person was screened, or whether a unit is in the standard or preferred premium category.
c. Once the premium discount has been assigned to a unit, the discount is calculated monthly based on the total number of active employees for each month of the premium period, regardless of whether an employee has been screened.

Although the wellness screening is available to non-Medicare retirees and eligible dependents, only the active employees who are employed and have participated in the wellness program, as of October 31, will be counted toward a unit's percentage of participation. Wellness screening forms will not be accepted by the LGHIB after November 15.

The LGHIB's monthly billing has a symbol by each person's name that has been screened during the current and previous screening period. You can view your billing by logging into your unit's account at www.lghip.org.

***Effective January 1, 2022, the $10 wellness premium discount will be discontinued.

D. Effective Date of Premium Category and Wellness Discount

1. Following the wellness qualifying period, November 1 through October 31, the unit premium category process will be initiated. Wellness screening forms will not be accepted after November 15. Units will be notified of their premium category no later than November 30.

2. The premium category assignment is subject to change prior to January 1 if the LGHIB discovers that a change in one of the following categories will alter the unit's initial premium category assignment.
   a. Number of employees
   b. Number of retirees
   c. Wellness participation percentage
   d. Number of late premium payments

3. Appeal of Premium Category Assignment and Wellness Discount Qualification Following Initial Notification: Units have 30 days from the date of notification to appeal their premium determination and/or wellness participation discount based on the qualifying period data. An appeal must be in writing and include all supporting documentation necessary to justify the basis of the appeal.

4. Appeal of Premium Category Assignment Following Open Enrollment: Units that experience an increase in their retiree enrollment during open enrollment that will affect their premium category, may appeal to the LGHIB to change their premium category. An appeal must be received by the LGHIB within seven days following the end of the open enrollment period (November 30). An appeal must be in writing and include all supporting documentation necessary to justify the basis of the appeal.

5. Units in the standard premium category who were previously offering coverage to retirees, and no longer have any retirees enrolled, can drop retiree coverage during Open Enrollment and may request to be moved to the preferred premium category.

6. Any changes in premium category, as well as any rate increases, will be effective as of January 1. A unit may have a rate increase and a change in rate category.

E. Collection of Premium

The LGHIB invoices each unit monthly with their balance due for the following month. Each unit determines how much they will charge their employees for both family and single coverages. The LGHIB will only accept payment from each unit, not from the unit's employees. COBRA premiums are the only exception to this rule.

Each unit must pay exactly what is reflected on the monthly invoice by the due date. Partial payments will not be accepted by the LGHIB. Any additions, deletions and changes approved by the LGHIB will be reflected on the next invoice, provided proper documentation is received by the LGHIB.

F. Premium Schedules

The following premium schedules specify the monthly premiums each local government unit will be billed for the eligible participant. COBRA subscribers will be billed directly.

Monthly premiums effective January 1, 2021
Employee Premiums

Preferred Rates with Dental	
Single	$521
Family	$1,272

Standard Rates with Dental	
Single	$571
Family	$1,441

Preferred Rates No Dental	
Single	$498
Family	$1,214

Standard Rates no Dental	
Single	$548
Family	$1,383

Monthly premiums effective January 1, 2021
Southland Voluntary Insurance Plan

Premiums reflect single or family coverage per month

Employee	
Vision Single	$12.00
Vision Family	$20.00
Dental Single	$42.00
Dental Family	$42.00

COBRA	
Vision Single	$12.00
Vision Family	$20.00
Dental Single	$43.00
Dental Family	$43.00

Monthly premiums effective January 1, 2021
Retiree Premiums

Non-Medicare Retiree – With Dental	Single	Family
Retiree	$1,078	
Retiree & dependent (not Medicare)	$1,078	$1,987
Retiree & dependent (Medicare)	$1,078	$1,276
Retiree and 2 dependents (Medicare)	$1,078	$1,474

Non-Medicare Retiree – No Dental	Single	Family
Retiree	$1,055	
Retiree & dependent (not Medicare)	$1,055	$1,929
Retiree & dependent (Medicare)	$1,055	$1,230
Retiree & 2 dependents (Medicare)	$1,055	$1,405

Medicare Retiree – With Dental	Single	Family
Retiree	$198	
Retiree & dependent (not Medicare)	$198	$947
Retiree & dependent (Medicare)	$198	$396
Retiree & 2 dependents (Medicare)	$198	$594

Medicare Retiree – Without Dental	Single	Family
Retiree	$175	
Retiree & dependent (not Medicare)	$175	$889
Retiree & dependent (Medicare)	$175	$350
Retiree & 2 dependents (Medicare)	$175	$525

Monthly premiums effective January 1, 2021
COBRA Premiums

Preferred COBRA Rates with Dental	
Single	$531
Family	$1,297

Standard COBRA Rates with Dental	
Single	$582
Family	$1,469

Preferred COBRA Rates No Dental	
Single	$508
Family	$1,238

Standard COBRA Rates No Dental	
Single	$559
Family	$1,411

COBRA Disabled Premiums

Preferred COBRA Subscriber Disabled with Dental	
Single	$782
Family	$1,548

Standard COBRA Subscriber Disabled Rates with Dental	
Single	$857
Family	$1,744

Preferred COBRA Subscriber Disabled No Dental	
Single	$747
Family	$1,477

Standard COBRA Subscriber Disabled Rates No Dental	
Single	$822
Family	$1,674

Monthly premiums effective January 1, 2021
Retiree COBRA Premiums

Non-Medicare COBRA Retiree – With Dental	Single	Family
Retired COBRA subscriber	$1,100	
Retired COBRA subscriber & dependent (not Medicare)	$1,100	$2,027
Retired COBRA subscriber & dependent (Medicare)	$1,100	$1,302
Retired COBRA subscriber & 2 dependents (Medicare)	$1,100	$1,504

Non-Medicare COBRA Retiree – Without Dental	Single	Family
Retired COBRA subscriber	$1,076	
Retired COBRA subscriber & dependent (not Medicare)	$1,076	$1,967
Retired COBRA subscriber & dependent (Medicare)	$1,076	$1,255
Retired COBRA subscriber & 2 dependents (Medicare)	$1,076	$1,433

Medicare COBRA Retiree – With Dental	Single	Family
Retired COBRA subscriber	$202	
Retired COBRA subscriber & dependent (not Medicare)	$202	$966
Retired COBRA subscriber & dependent (Medicare)	$202	$404
Retired COBRA subscriber & 2 dependents (Medicare)	$202	$606

Medicare COBRA Retiree – Without Dental	Single	Family
Retired COBRA subscriber	$179	
Retired COBRA subscriber & dependent (not Medicare)	$179	$907
Retired COBRA subscriber & dependent (Medicare)	$179	$358
Retired COBRA subscriber & 2 dependents (Medicare)	$179	$536

IV. Employee Participation Requirement

All current and future eligible employees must be enrolled in the LGHIP unless proof of other acceptable insurance is provided. All eligible employees who decline coverage must sign a Declination of Coverage form (LG04) and submit acceptable proof of other coverage. Other acceptable coverage includes, but is not limited to: Affordable Care Act (ACA) qualified group and individual plans that meet minimum essential coverage standards, Marketplace, Medicare, Medicaid and Tricare.

All eligible employees must be enrolled at all times during their employment with the unit except for any time(s) that the employee is covered by other acceptable coverage. If an eligible employee is covered by other acceptable coverage and elects to decline coverage in the LGHIP, that employee must provide a Declination of Coverage form to the LGHIB with proof of other acceptable coverage. If an eligible employee has declined coverage in the LGHIP and later loses their other acceptable coverage, that eligible employee must immediately notify the LGHIB and enroll in the LGHIP with an effective date on the date which the other acceptable coverage ended. If the eligible employee does not notify the LGHIB of the loss of other acceptable coverage and does not enroll in the LGHIP, both the eligible employee and the unit will be liable for any premiums due and will be billed retroactively to the date the eligible employee should have been enrolled (i.e. the date the other acceptable coverage ended). If the premiums are not paid, the unit will be in violation of the LGHIP's enrollment rules and may be terminated from participation in the LGHIP.

Elected officials, if covered by the unit, must elect to enroll, decline coverage with acceptable proof, or opt out of the LGHIP.

All units must have at least one full-time employee enrolled in the LGHIP to be an eligible participating unit in the LGHIP.

V. Eligibility Rules

A. Eligible Participants

1. Employee - a full-time employee, in an employer-employee relationship, working, on average, at least 30 hours per week.

   Affordable Care Act Exception: Under the ACA, an employee otherwise ineligible for coverage under the LGHIP must be offered LGHIP coverage if the unit is subject to the ACA and the employee meets the definition of a full-time employee as defined under the employer shared responsibility provisions of the ACA. Units with fewer than 50 full-time employees (including full-time equivalents) in the prior calendar year are not subject to the ACA employer shared responsibility provisions. All units subject to the ACA will be responsible for complying with all of the ACA employer shared responsibility provisions. The LGHIB cannot provide guidance with regard to a unit's compliance with the ACA.

   If your unit is subject to the ACA and you believe that you must offer coverage to one of your temporary, part-time, seasonal, intermittent, emergency, or contract employees to comply with the employer shared responsibility

provisions of the ACA, you must first provide documentation to the LGHIB verifying that:

- your unit is subject to the ACA; and
- the employee meets the definition of a full-time employee as defined under the employer shared responsibility provisions of the ACA.

Under the ACA, an employee that averages working more than 30 hours a week, or 130 hours in a month during the local government unit's measurement period, is considered full-time and must be offered health insurance coverage. In order for the unit to verify to the LGHIB that coverage should be offered to an employee eligible for coverage pursuant to the ACA, a unit must provide the following information by completing the ACA Verification Form (LG23).

- the beginning and ending date of the measurement period
- the beginning and ending date of the administrative period
- the beginning and ending date of the stability period
- the number of hours the employee averaged during the measurement period

Should the local government unit prove to the LGHIB that an employee otherwise ineligible for coverage through the LGHIP must be offered coverage because of the employer shared responsibility provisions of the ACA, the employee must enroll in the LGHIP or submit a Declination of Coverage form with acceptable proof of other coverage.

2. <u>Elected official</u> – Elected officials of a local government unit are also eligible while in office. However, the local government unit makes the determination when it joins the LGHIP as to whether its elected officials may have LGHIP coverage. This determination may only be changed during open enrollment.

   If the local government unit chooses to cover its elected officials, they will be classified for insurance purposes as active employees.

3. <u>Retiree</u> – The local government unit makes the determination whether it will allow eligible retirees to continue coverage with the LGHIP. The unit must also make the determination whether it will continue retiree coverage until Medicare entitlement or indefinitely. This determination may only be changed during open enrollment.

   If the unit elects to provide insurance coverage for its retirees, such coverage must be offered uniformly to all current and future retirees.

   The following rule applies to retiring employees:

   a. Employees may elect to continue their LGHIP coverage as a retiree if, at the time of retirement, the employee has at least 10 years of coverage in the LGHIP (coverage not required to be continuous) and:

- the employee has a combination of 25 years, or more, of service with a participating local government unit or other service as approved by the LGHIB, regardless of age, or
- the employee is 60 years old, or older, or is determined to be disabled by the Social Security Administration.

  Note: If an employee is retiring from a participating unit that has been a member unit less than 10 years, the employee must have been enrolled in the LGHIP continuously from the date the unit joined the LGHIP.

Any retired employee who does not meet the above requirements will be considered a termination. In addition, a participating unit must provide at least 30 days' notice to the LGHIB of an employee's retirement date in order for the LGHIB to send the Medicare retiree the required 21-day Medicare Advantage Opt-Out form. If 30 days' notice is not provided, the Medicare retiree may have a gap in coverage until the Medicare Advantage Opt-Out form can be sent and the 21 days has expired.

b. Disability Retiree - A former employee allowed to continue LGHIP coverage as a retiree due to disability will have 24 months from the date of the disability determination to provide the LGHIB with proof of Medicare Parts A and B coverage. Failure to provide proof of Medicare coverage after 24 months will result in termination of coverage. (See Section VII)

   Note: The unit must submit an Elected Official Retiree Enrollment form (form LG10) in order for the LGHIB to determine whether the elected official is eligible for retiree coverage.

The LGHIB may periodically require enrollment and eligibility documentation.

B. Eligible Dependents

The term "dependent" includes the following individuals, subject to appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.). NOTE: A participant may not cover any dependent who is insured or eligible to be insured as an active employee in the LGHIP.

1. The eligible participant's spouse (excludes a divorced spouse)

2. A child under age 26, only if the child is:
   a. The eligible participant's son or daughter
   b. A child legally adopted by the eligible participant or his or her spouse
   c. The eligible participant's stepchild

3. Grandchild, niece or nephew of the eligible participant or his or her spouse:
   a. under 19 years of age, and
   b. for whom the court has granted custody to the eligible participant or his or her spouse

4. An incapacitated dependent over age 25 will be considered for coverage provided dependent:
    a. is unmarried,
    b. is permanently mentally or physically disabled or incapacitated,
    c. is so incapacitated as to be incapable of self-sustaining employment,
    d. is dependent upon the eligible participant for 50% or more financial support,
    e. is otherwise eligible for coverage as a dependent except for age,
    f. had the condition prior to the dependent's 26th birthday, and
    g. is not eligible for any other group insurance benefits.

    Neither a reduction in work capacity nor inability to find employment is, of itself, evidence of eligibility. If a mentally or physically disabled dependent is employed, the extent of his or her earning capacity will be evaluated.

    To apply, contact the LGHIB to obtain an Incapacitated Dependent Certification Form. Final approval of incapacitation will be determined by Medical Review conducted by Blue Cross and Blue Shield of Alabama. Proof of disability must be provided to the LGHIB within 60 days from the date the child would otherwise cease to be covered because of age.

    Exception: There are two situations under which it may be possible to add an incapacitated dependent who meets the eligibility requirements other than exceeding the maximum age requirement:

      i. when a new eligible participant requests coverage for an incapacitated dependent within 60 days from the date of employment; or
      ii. when an eligible participant's incapacitated dependent is covered under a spouse's employer group health insurance for at least 18 consecutive months and:
          - the eligible participant's spouse loses the other coverage because:
              a. spouse's employer ceases operations, or
              b. spouse's loss of eligibility due to termination of employment or reduction of hours of employment, or
              c. spouse's employer stopped contribution to coverage; and
          - a New Dependent form is submitted to the LGHIB within 30 days of the incapacitated dependent's loss of other coverage; and
          - Medical Review approves incapacitation status.

    These requirements must be met as a minimum threshold in order to be considered for incapacitation status. The LGHIB shall make the final decision as to whether an application for incapacitated status will be accepted. NOTE: The LGHIB reserves the right to periodically recertify incapacitation.

Dependent Definitions and Documentation Requirements

TYPE OF DEPENDENT	DEFINITION	REQUIRED DOCUMENT(S) FOR VERIFICATION
Spouse	A person to whom the participant is legally married	• Government issued marriage certificate or other government issued document evidencing the marriage • Court documents recognizing marriage • Naturalization papers indicating marital status
		Common Law Marriage Only for common-law marriage that began before January 1, 2017. Alabama law requires clear and convincing evidence of the following basic requirements: • Both parties must have the present legal capacity to marry; • The parties must have entered into a mutual agreement to enter into a permanent marriage; and • There must be public recognition of the marital relationship and public assumption of marital duties and cohabitation. A member requesting to add a common law spouse will receive a letter from the LGHIB detailing necessary documentation.
Natural (biological) child	A natural (biological) child under age 26	• Birth certificate; or • Certificate of Report of Birth (DS-1350); or • Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240); or • Certificate of Birth Abroad
Adopted child	A child under age 26 the participant has adopted or is in the process of legally adopting	• Court documents filed with the court petitioning to adopt; or • Court documents signed by a judge showing that the participant has adopted the child; or • International adoption papers from country of adoptions; or • Papers from the adoption agency showing intent to adopt; or • Birth certificate
Custodial niece, nephew and/or grandchild	A niece, nephew or grandchild under age 19 for whom the participant is the legal guardian	Court Order that establishes guardianship
Stepchild	The biological or adopted child under age 26 of the participant's spouse	• Verification of marriage between employee and spouse (as outlined above) and birth certificate of the child showing the relationship to the spouse; or • Any legal document that establishes relationship between the stepchild and the participant's spouse
National Medical Support Notice child	A child who is named as an alternate recipient with respect to the participant under a National Medical Support Notice (NMSN)	NMSN issued by a state agency
Incapacitated Dependent	An unmarried dependent over the age of 25 (who falls under one of the categories previously listed) and due to a mental or physical disability, is unable to earn a living. The dependent's disability must have begun before age 26. The dependent must rely on the subscriber for 50% or more financial support and must not be eligible for other group insurance.	Completed Incapacitated Dependent Certification form to be evaluated by Medical Review.

C. Ineligible Participants

1. Ineligible Employees
   An employee of a unit who: (a) works, on average, less than 30 hours per week; or (b) is a temporary, part-time, seasonal, intermittent, emergency, or contract employee.

2. Ineligible Dependents
   An individual who does not meet the definition of an eligible dependent shall not be allowed to be covered as a dependent under the LGHIP.

An individual who meets the definition of an eligible dependent, but is also eligible to be covered as an active employee, shall not be allowed to be covered as a dependent under the LGHIP. Such individuals shall only be covered as active employees, not as dependents.

In addition, an ex-spouse is ineligible for coverage and cannot be maintained as a dependent under family coverage regardless of a judgment or divorce decree requiring the subscriber to provide health care for an ex-spouse. However, an ex-spouse may be eligible for COBRA continuation coverage.

D. National Medical Support Notices

If the LGHIB receives a National Medical Support Notice (Notice) from a child support enforcement agency directing the LGHIP to cover a child, the LGHIB will determine whether the Notice is qualified. A Notice is an order from a child support enforcement agency directing the Plan to cover the eligible employee's child regardless of whether the eligible employee has enrolled the child for coverage. If a unit is not able to withhold the necessary contribution from the eligible employee's paycheck, the LGHIB is not required to extend coverage to the child.

The LGHIB has adopted procedures for determining whether an order is a Notice. You have a right to obtain a copy of these procedures free of charge by contacting the LGHIB.

The LGHIP will cover an employee's child if required to do so by a Notice. If the LGHIB determines that an order is a Notice, the child will be enrolled for coverage effective as of a date specified by the LGHIB, but not earlier than the first day of the month following the LGHIB’s determination that the order is a Notice.

Coverage may continue for the period specified in the order up to the time the child ceases to satisfy the definition of an eligible dependent. If the employee is required to pay extra to cover the child, the LGHIB will charge the unit for that coverage. During the period the child is covered under the LGHIP as a result of a Notice, all LGHIP provisions and limits remain in effect with respect to the child's coverage except as otherwise required by federal law.

While the Notice is in effect, the LGHIP will make benefit payments – other than payments to providers – to the parent or legal guardian who has been awarded custody of the child. The LGHIB will also provide sufficient information and forms to the child's custodial parent or legal guardian to allow the child to enroll in the LGHIP. Claims reports will be sent directly to the child's custodial parent or legal guardian.

E. Notification of Eligibility Changes

1. Subscriber

   It is the responsibility of the subscriber (employee, retiree, elected official, or COBRA beneficiary) to notify the LGHIB immediately when there is a change in the eligibility of a covered dependent. The subscriber will be responsible for any adverse financial effect incurred by the LGHIP as a result of the subscriber's failure to promptly notify the LGHIB of a change in the subscriber's enrollment status or eligibility or the eligibility of a covered dependent. The subscriber is also responsible for immediately notifying the LGHIB of a change of address.

   Note: An ex-spouse is ineligible for coverage and cannot be maintained as a dependent under family coverage regardless of a judgment or divorce decree requiring the subscriber to provide health care for an ex-spouse. However, an ex-spouse may be eligible for COBRA continuation coverage.

2. Local Government Unit

   If a local government unit is notified, becomes aware of or should have been aware of a change in the eligibility of an employee or an employee's dependent and fails to promptly notify the LGHIB of the change in eligibility, the local government unit will be responsible for any adverse financial effect incurred by the LGHIP as a result of the local government unit's delinquent notification.

VI. Existing Unit Enrollment Rules

A. Enrollment of New Eligible Participants

New Eligible Employees

All new eligible employees must either enroll in the LGHIP or decline coverage with proof of acceptable other coverage.

New Eligible Employees who Decline Coverage

New eligible employees who decline coverage at the time they become eligible employees must submit a completed Declination of Coverage form (form LG04) and acceptable proof of other coverage to the LGHIB. Acceptable proof is a current letter from an employer/insurance carrier verifying current coverage.

Effective Date of Coverage of New Eligible Employees

Local government units have two options regarding the effective date of coverage for new eligible employees:

1. First Day of the Second Month: Unless a local government unit notifies the LGHIB otherwise (see below), the effective date of coverage for all new eligible employees will be the first day of the second full month following the new employee's date of hire. For example, if a new employee's hire date is in the month of January, the effective date of coverage will be March 1.

2. Date of Hire: Local government units may elect to have coverage effective for all new eligible employees on the date of employment. In order to make this election, the local government unit must complete and submit an Effective Date

of Coverage Election form (LG05) to the LGHIB at the time the unit joins the LGHIP or during any subsequent open enrollment. Once the election has been submitted and approved by the LGHIB, coverage for all future eligible employees shall be effective on the date of employment. A prorated premium will be billed for new employees on the next billing cycle. If this election is made during Open Enrollment, once form LG05 has been accepted by the LGHIB, the election will be effective January 1.

Probationary Periods

All full-time employees must enroll in the plan or decline coverage and provide proof of other acceptable coverage. However, this requirement may be temporarily delayed while a new employee serves a probationary period, provided that the probationary period is approved by the LGHIB. An acceptable probationary period must be reasonable and applied uniformly to all new full-time employees and health insurance coverage must be offered within 91 days of the date of hire or the date the employee became a full-time employee. If your unit elects to have a probationary period, the following options apply:

a. Date of hire effective date:
    - 30 day probationary period. Coverage effective on the 31st day.
    - 60 day probationary period. Coverage effective on the 61st day.
    - 90 day probationary period. Coverage effective on the 91st day.

b. First day of second month effective date:
    - 30 day probationary period.

c. Part-time to full-time employees - In the situation where a part-time employee becomes a full-time employee (by the reclassification of job duties), the unit's probationary period will be waived, provided documentation is submitted to the LGHIB for approval verifying the former part-time employee has been employed for at least the length of the approved probationary period. The employee will be enrolled the date he or she became a full-time employee or the first day of the second month following classification as a full-time employee.

Retirees who Enroll in Coverage

Eligible retirees must enroll on the date they first become eligible for retiree health benefits. Family coverage, if elected, will be made effective as of the date they first become eligible for retiree health benefits.

Retirees who Decline Coverage

If coverage is declined, enrollment will not be allowed after the retirement date. Retirees who do not elect coverage will not be allowed to enroll at a later date.
Exception: At the time of retirement, if a Medicare retiree declines coverage in the LGHIP in lieu of coverage through SelectQuote or Empower, he or she may return to the LGHIP during the LGHIP open enrollment period, as long as there has been no break in coverage. (See Third Party Medicare Vendor Enrollment section.)

Elected Officials

If a local government unit chooses to cover elected officials, all elected officials have the following options:

1. Enroll in the LGHIP – Elected officials may enroll in the LGHIP within 30-days upon assumption of the elected office and will be treated as full-time employees.

2. Decline coverage in the LGHIP – Elected officials may decline coverage in the LGHIP at the time the elected official assumes office. If a declination form with proof of other acceptable coverage* is submitted, the elected official may enroll in the LGHIP at a later date upon loss of other acceptable coverage or at open enrollment.

3. Opt out of the LGHIP – If the elected official opts not to enroll in the LGHIP at the time the elected official assumes office and does not submit a declination form with proof of other acceptable coverage*, the elected official may only be offered the option to enroll in the LGHIP upon election to a new term of office.

Elected officials who fail to elect one of the above options will be treated as if they chose option 3.

In order to comply with this policy, each unit will be required to submit an updated list of all elected officials by November 30 of each year.

Other acceptable coverage includes, but is not limited to: ACA qualified group and individual plans, Marketplace, Medicare, Medicaid and Tricare.

B. Enrollment of Eligible Dependents

A participating employee, elected official or retiree in the LGHIP may apply for family coverage at their initial enrollment (Enrollment form LG01) when they acquire a new dependent (New Dependent form LG02-B), during annual open enrollment (New Dependent form LG02-B), or if an eligible dependent experiences a special enrollment qualifying event (New Dependent form LG02-B).

Appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.) must be submitted to the LGHIB. **Note:** to ensure that enrollment deadlines are met, change forms should be submitted to the LGHIB even if all the required documentation is not available.

If the required documentation is not submitted with an Enrollment form or New Dependent form, the LGHIB will send a notice to the eligible participant that the required documentation must be submitted within 60 days of the date of the letter. If documentation is not submitted to the LGHIB within those 60 days, the request to add dependent coverage will be denied.

Acquiring New Dependent

A newly acquired dependent may be enrolled if the LGHIB is notified within 60 days of acquiring the new dependent through marriage, birth, adoption, or custody of a grandchild, niece or nephew.

The effective date of coverage will be:

- in the case of a birth - the date of birth;
- in the case of marriage – the date of marriage;
- in an adoption – the date the child was placed for adoption;
- custody of a grandchild, niece or nephew – the date of the court's order granting custody.

If the LGHIB is notified of a new dependent after 60 days, the eligible participant will not be allowed to enroll the newly acquired dependent at that time and may reapply during the annual open enrollment period.

Annual Open Enrollment
An eligible participant may apply to add a dependent or apply for family coverage during the month of November for a January 1 effective date. The effective date indicated on the form should be January 1.

Dependent Special Enrollment
If a dependent loses their other acceptable coverage, the eligible participant may apply for Dependent Special Enrollment. The effective date of coverage will be the date the other acceptable coverage ceased. The only dependents eligible are those who experienced a qualifying event.

C. Enrolled Employees and Elected Officials who Decline Coverage

Enrolled employees and elected officials may decline coverage at any time. The earliest effective date of cancellation will be the first day of the month following receipt of both the Declination of Coverage form (form LG04) and acceptable proof of other coverage. For example, if an enrolled employee or elected official completes a Declination of Coverage form (form LG04) and provides proof of other acceptable coverage on June 30, but the LGHIB does not receive the form and proof until July 2, the cancellation will be effective on August 1. Acceptable proof is a current letter from an employer/insurance carrier verifying current coverage.

D. Cancellation of Family Coverage

An eligible participant may drop family coverage at any time. The earliest effective date of cancellation will be the first day of the month following the LGHIB's receipt of written notification (form LG02-C). For example, if an eligible participant completes and submits a Dependent Cancellation form (form LG02-C) on June 30 but the LGHIB does not receive the form until July 2, the cancellation will be effective August 1. The LGHIB requires proof of divorce (divorce decree) when dropping a former spouse due to divorce.

E. Open Enrollment

There shall be an annual open enrollment held in November (for coverage to be effective January 1) of each year during which:

- Eligible employees not currently participating in the insurance may enroll by submitting the LGHIP Enrollment form (form LG01).
- Eligible participants may add dependents or family coverage. If an eligible participant wishes to add dependents or add family coverage during open

enrollment, a New Dependent form (Form LG02-B) must be completed and submitted to the LGHIB.

- Eligible participants are permitted to change insurance carriers/plans.
- Local government units may change the effective date of insurance for new hires (hire date or first day of second full month). Units must submit an Effective Date of Coverage Election form (form LG05) to have coverage for all future eligible employees effective date of employment changed.
- Local government units may add/drop retiree coverage for the unit by written request.
- Local government units may add/drop Medicare retiree coverage for the unit by written request.
- Local government units may add/drop elected official's coverage for the unit by written request.
- Eligible employees who have previously declined coverage may submit an updated Declination of Coverage form (form LG04) with acceptable proof.
- A unit may elect to add or drop the dental option during open enrollment. The effective date of that change will be January 1. A revised Participation form (LG15) must be sent to the LGHIB.
- The unit may change their probationary period during Open Enrollment

Forms must be completed and submitted to the LGHIB by November 30, with an effective date of January 1 indicated on the form. If an eligible participant does not want to change plans or add/drop family coverage during open enrollment, no paperwork is necessary.

Requests to add/drop retiree, Medicare or elected official coverage must be submitted to the LGHIB office on the requesting unit's letterhead. Submission of an enrollment or change form will not be accepted as a request to add/drop retiree, Medicare or elected official coverage.

If a unit chooses to add retiree coverage during Open Enrollment (January 1 effective date), only those employees eligible to retire after January 1 may continue coverage as a retiree. If a unit discontinues retiree coverage during Open Enrollment, all currently enrolled retirees, including supernumeraries, will lose their LGHIP coverage effective January 1. COBRA coverage will be available to those affected for a maximum of 18 months.

F. Special Enrollment Period

Eligible Employees

Under the Health Insurance Portability and Accountability Act (HIPAA), the LGHIP must offer a special enrollment period in addition to open enrollment for those eligible employees who experience a qualifying event such as loss of their other acceptable coverage or the addition of a dependent. However, since the LGHIP already requires that eligible employees enroll in the plan when they lose other acceptable coverage, special enrollment will only apply to the following qualifying events not related to loss of coverage:

- the addition of a new dependent through birth, adoption or marriage; or
- a substantial change in their other acceptable coverage; or
- a substantial change in the cost of their other acceptable coverage.

To be eligible for special enrollment, an eligible employee must have a Declination of Coverage form (form LG04) with proof of other acceptable coverage on file.

Eligible employees requesting special enrollment must notify the LGHIB in writing within 30 days of the qualifying event. Notification must include:

1. a letter requesting participation in the special enrollment;
2. a completed Enrollment form (form LG01);
3. documentation listing the name, reason and date of loss for each individual affected by loss of coverage (e.g. employment termination on company letterhead)

If proof of the qualifying event is not submitted at the time the request for special enrollment is made, proof must be submitted within 60 days of the qualifying event or the request will be denied.

All eligible employees who lose their other acceptable coverage, whether voluntarily or involuntarily, must submit an enrollment form to the LGHIB with coverage effective as of the date coverage is lost.

<u>Dependents</u>
To be eligible for dependent special enrollment, an eligible employee must submit a new dependent form with proof of loss of other acceptable coverage. Eligible employees requesting dependent special enrollment must notify the LGHIB in writing within 30 days of the qualifying event. Notification must include:

1. a letter requesting participation in the special enrollment;
2. a completed New Dependent form (form LG02-B);
3. documentation listing the name, reason and date of loss for each individual affected by the loss of coverage (e.g. employment termination on company letterhead).

If proof of the qualifying event is not submitted at the time the request for special enrollment is made, proof must be submitted within 60 days of the qualifying event or the request will be denied.

The only dependents eligible are those who experienced a qualifying event. If approved, the effective date of coverage will be the date other acceptable coverage ceased.

G. Third Party Medicare Vendor Enrollment for Medicare Retirees

SpringBoard (SelectQuote) and Empower Brokerage (Empower) are third party Medicare vendors approved by the LGHIB to offer benefits to Medicare retirees and their Medicare dependents with unbiased price comparisons on individual Medicare Supplement, Medicare Advantage and Prescription Drug (Part D) plans. This option is available to all Medicare retirees and their Medicare dependents, even if the unit does not offer retiree coverage to Medicare retirees.

Enrolling in SelectQuote and Empower Brokerage:

- The annual Medicare open enrollment period is October 15 through December 7. The effective date of coverage will be January 1 of the following year.
- Coverage through SelectQuote and Empower is offered in lieu of LGHIP coverage.
- At the time of retirement or the LGHIP's open enrollment period, if a Medicare retiree declines coverage in the LGHIP in lieu of coverage through SelectQuote or Empower, they may return to the LGHIP during the LGHIP open enrollment period, as long as there has been no break in coverage, and as long as the unit offers coverage to Medicare retirees.
- At the time of retirement, if a Medicare retiree declines coverage in both the LGHIP or through SelectQuote or Empower, he or she cannot enroll in the LGHIP at a later date. However, a Medicare retiree can enroll for coverage through SelectQuote or Empower during the Medicare Vendor enrollment period.
- Medicare retirees who are currently covered by the LGHIP can enroll for coverage through SelectQuote or Empower during the Medicare Vendor enrollment period. They may return to the LGHIP during the LGHIP open enrollment period, as long as there has been no break in coverage.

Note: If your unit offers retiree coverage to your Medicare retirees through the LGHIP and a Medicare retiree opts to enroll in coverage through SelectQuote or Empower, the retiree will still count toward your 5% retiree participation requirement.

H. Transfers

Only eligible newly hired employees meeting the following criteria will be considered as transfers under the LGHIP:

1. previously covered by the LGHIP; and
2. terminated employment with another local government unit covered by the LGHIP who became employed with a local government unit during the same calendar month of termination.

The local government unit hiring the new eligible employee who is eligible to be treated as a transfer will be invoiced for the first month following the date of hire. Units electing coverage effective on the date of hire will be invoiced from that date. The employee will be transferred with the same coverage as previously enrolled.

I. Military Leave

The Military Leave Policy of the LGHIP is in compliance with the Uniformed Services Employment and Reemployment Rights Act (USERRA), 38 USC-4317. Under the USERRA, an eligible employee on qualified military leave has the right to elect continued health insurance coverage for himself or herself, and his or her dependents, during periods of military service.

The application of the LGHIP's Military Leave Policy depends upon whether the local government unit voluntarily complies with Alabama Act number 2002-430,

effective July 1, 2002:

1. If a local government unit elects to voluntarily comply with Alabama Act number 2002-430 for its employees on military leave, then individual and dependent insurance coverage must be offered for as long as the local government unit compensates the employee on military leave. The local government unit can charge the employee only the normal employee's share of the health insurance premium, not the local government unit's share.

2. If a local government unit elects not to voluntarily comply with this law, then the LGHIP's Military Leave Policy will apply. Under LGHIP's Military Leave Policy, the individual premium for persons on military leave depends upon the length of service involved. For periods up to 30 days of training or service, the local government unit can charge the employee only the normal employee's share of the health insurance premium, not the local government unit's share. For periods of service longer than 30 days, the employee must be offered COBRA continuation coverage for 24 months. After receipt by the LGHIB of the cancellation form and appropriate military documentation, a COBRA election form will be sent to the employee.

   When an employee on military leave status with family coverage has his or her coverage terminated, the local government unit must offer the dependents one of the following two options:

   Option 1
   Offer COBRA Continuation Coverage.
   The COBRA coverage period for dependents is limited to 36 months. The COBRA coverage period for dependents will terminate prior to 36 months if:

   a. an employee's military leave period ends within 36 months and
   b. the employee returns to work within 60 days of the end of military leave.

   Or

   Option 2
   Continue dependent coverage.
   Families will be allowed to continue their health insurance coverage as if the employee on military leave was still an active employee. This dependent coverage period is limited to 24 months, or the expiration of the employee's military leave, whichever is shorter. The premium for this dependent coverage will continue to be included on the unit invoice, minus the employee's share of the premium. The local government unit will be responsible for collection and payment of the premium.

   If an eligible employee's military leave period is longer than 24 months, the coverage for dependents will be converted to COBRA coverage in month 25. The COBRA coverage will be offered for an additional 12 months and billed accordingly.

   If an eligible employee on military leave does not return to work at the end of the military leave period and the military leave period was less than 24 months,

the coverage for dependents will be converted to COBRA coverage and extended for a period not to exceed 36 months in total.

Each local government unit will decide which option will be offered to the families of employees on military leave. Once a decision has been made, the local government unit must treat all military leave dependents uniformly.

When an eligible employee returns to work, the employee must be added to coverage unless the employee submits a Declination of Coverage form with acceptable proof of other acceptable coverage. To determine the appropriate effective date of coverage, the eligible employee returning from military leave must provide his/her military release papers. If the employee had family coverage at the time of the military leave, only those dependents previously covered will be allowed to re-enroll. If the employee gained a new dependent during the time he/she was on military leave, that new dependent will be added to coverage if: 1) that new dependent is eligible to be covered; 2) the employee submits a Change form requesting the new dependent be added to coverage within the applicable time period; and 3) the appropriate documentation is submitted within the applicable time period.

VII. Retirement

A. Billing

Eligible retirees who elected LGHIP retiree coverage will remain on the local government unit's billing and it will be the responsibility of the local government unit to collect the appropriate premiums. A Status Change form (form LG02) must be sent to the LGHIB, indicating a change from active to retired status and the effective date of the retirement.

<u>The status change form must be sent 30 days prior to the retirement date</u>.

If the local government unit requires the retiree to make the premium payment and the retiree elects not to pay, the local government unit must submit a Cancellation form selecting non-payment as the reason for cancellation.

Service Retirements

For service retirements, proof of the retiree's years of full-time service with the unit must be provided. In addition to service with a participating unit, the LGHIB may also consider proof of other approved employers, such as the State of Alabama or a non-participating local government employer.

Disability Retirements

1. Employee must notify the LGHIB at least 30 days in advance that he or she intends to retiree with a disability.

2. Employee must have ten years of LGHIP coverage. Coverage is not required to be continuous. (Exception - Employee may have less than ten years of LGHIP coverage if he or she is retiring from a participating unit that has been a member unit less than 10 years. However, employee must have been enrolled in the LGHIP continuously from the date the unit joined the LGHIP.)

3. Employee must provide proof that an application for a disability determination from the Social Security Administration was made prior to retiring.

4. 18 months of COBRA coverage will be offered at retirement. If the employee receives a SSA disability determination and provides a copy of the determination letter to the LGHIB during the COBRA period, the employee's COBRA coverage will be converted to LGHIP non-Medicare retiree coverage.

5. If the retiree's unit does not offer Medicare retiree coverage, the retiree's non-Medicare retiree coverage will end either when the retiree is entitled to Medicare or 24 months from the Disability determination, whichever comes first.

6. If the retiree's unit offers Medicare retiree coverage, in order to maintain LGHIP retiree coverage, the retiree must provide the LGHIB with proof of Medicare Parts A and B coverage within 24 months from the date of the SSA disability determination. Once a copy of the SSA disability determination letter and proof of Medicare Parts A and B is provided, the employee will be enrolled in UHC Medicare Advantage coverage. Failure to provide proof of Medicare coverage within 24 months of the SSA disability determination will result in termination of coverage.

7. If the employee does not receive an SSA determination during the COBRA period , then COBRA coverage will expire at 18 months and no further coverage through the LGHIB will be offered.

Units Offering Coverage For Medicare Retirees

If a unit allows Medicare retirees to continue coverage, the local government unit must submit a status change form and a copy of the retiree's Medicare card, indicating a rate change from "Not Medicare" to "Medicare." If a retiree's only dependent is eligible for Medicare, the local government unit must submit a status change form and a copy of the dependent's Medicare card, indicating a rate change from "Not Medicare" to "Medicare." The status change form must be sent 30 days prior to the Medicare effective date.

B. Termination of Coverage

Units Not Offering Retiree Coverage

An active employee, who retires from a local government unit that does not allow retirees to continue on the coverage, will be offered COBRA upon written notification of retirement from the local government unit. See COBRA section for more information.

Units Offering Retiree Coverage
An active employee who retires from a local government unit that allows retirees to continue coverage has the option of electing retiree coverage or COBRA. If the retiree chooses to cancel health insurance, the unit must send a Cancellation form with the retiree's signature 30 days prior to the retirement date. If COBRA coverage is elected, the retiree will forfeit his or her right to elect retiree coverage at a later date. If a retiree intends to request COBRA, it should be indicated on the Cancellation form prior to the retirement date. The Cancellation form must be received by the LGHIB 30 days prior to the retirement.

Units Only Offering Retiree Coverage to Non-Medicare Retirees
A retired employee whose local government unit does not allow Medicare retirees to continue coverage in the LGHIP, must submit a Cancellation form 30 days prior to the retiree's Medicare eligibility date. A copy of the Medicare card may be required. COBRA will be offered to retirees and dependents for 18 months. If the retiree declines COBRA coverage, dependents will still be eligible for 18 months.

Units Offering Retiree Coverage to Medicare Retirees
A unit may prospectively disenroll an individual from the UnitedHealthcare Medicare Advantage plan when a participant fails to pay his/her monthly premium on a timely basis. CMS does not allow retroactive disenrollment for failure to pay monthly premiums. In order to disenroll a Medicare Advantage Participant (MAP) for failure to make a premium payment, the unit must:

1. Provide prospective notice to the MAP that his/her Medicare Advantage enrollment is ending at least 21 calendar days prior to the effective date of the disenrollment. The notice must include information about other individual plan options the beneficiary may choose and how to request enrollment; and

2. If the plan is a Medicare Advantage – Prescription Drug plan (the UnitedHealthcare plan offered by the LGHIB is a Medicare Advantage – Prescription Drug plan), the MAP must be advised that the disenrollment action means the individual will not have Medicare drug coverage and must be provided information about the potential for late-enrollment penalties that may apply in the future.

   If an MAP is in default on a premium payment, a unit must send the MAP written notice informing the MAP of the past due balance and the prospective disenrollment date. In addition, the unit must include in its notice to the MAP a "Notice of Disenrollment". These notices must be sent at least 21 calendar days before the prospective disenrollment date. If the MAP pays the total past due balance before the disenrollment date, the MAP will not be disenrolled.

   If an MAP does not pay the total past due balance by the disenrollment date, the unit must notify the LGHIB by submitting a Cancellation form (LG03). The LGHIB will then, in turn, disenroll the member from the Medicare Advantage plan. Notice to the LGHIB must be provided on or before the 25th of the month prior to the MAP's disenrollment date. The unit must affirm that it has complied with all CMS rules in regard to disenrollment by checking the box under "Retiree Non-Payment". In addition, the unit must submit a copy of the letter and Notice of Disenrollment it sent the MAP.

The LGHIB will bill the unit for an MAP's Medicare Advantage premiums during the disenrollment process. The unit is responsible for payment of those premiums. If the unit fails to pay the LGHIB for such premiums, the unit will be deemed in violation of the LGHIB's rules and procedures.

For more information, please see the LGHIB Policy for Disenrollment of Retirees from Medicare Advantage for Failure to Pay Premiums located on the LGHIB website.

Retiree One-Time Enrollment Policy
Eligible retirees must enroll on the date they first become eligible for retiree health benefits. If coverage is declined, enrollment will not be allowed after the retirement date. Retirees who do not elect coverage will not be allowed to enroll at a later date. Retirees who elect coverage and are canceled for any reason thereafter will not be allowed to enroll at a later date.

Exception: At the time of retirement or open enrollment, if a Medicare retiree declines coverage in the LGHIP in lieu of coverage through SelectQuote or Empower, he or she may return to the LGHIP during the LGHIP open enrollment period, as long as there has been no break in coverage, provided the unit allows retiree Medicare coverage.

C. Supernumeraries
Supernumeraries will be classified for insurance purposes as retired employees.

VIII. Medicare

A. Provision for Medicare for Active Employees
Active employees entitled to Medicare, and their dependents, are provided benefits through the LGHIP under the same conditions as employees and their dependents not entitled to Medicare. Medicare is secondary to benefits payable under the LGHIP for employees entitled to Medicare, and their spouses entitled to Medicare. If the service is also covered by Medicare, the claim can be submitted to Medicare which may pay all or a portion of the unpaid balance of the claim, subject to Medicare limitations.

The LGHIB will not provide an active employee or his/her spouse with benefits that supplement Medicare. The employee has the right to elect coverage under the LGHIP on the same basis as any other employee.

The LGHIP will be the primary payer for those items and services covered by Medicare. (Note that Medicare covers hospitalization, post-hospital nursing home care, home health services.) This means that the LGHIP will pay the covered claims and those of the employee's Medicare entitled dependents first, up to the limits contained in the LGHIP, and Medicare may pay all or a portion of the unpaid balance of the claims, if any, subject to Medicare limitations. If the employee's dependent(s) is not entitled to Medicare, the LGHIP will be the sole source of payment of the dependent(s)' claims.

Since the LGHIP also covers certain items and services not covered by Medicare, the LGHIP will be the sole source of payment of medical claims for these services.

For active employees entitled to Medicare as a result of End Stage Renal Disease (ESRD), the LGHIP will be primary for the 30 month coordination period, which begins on the date the active employee is first eligible to enroll in Medicare due to ESRD. After the 30 month coordination period ends, Medicare becomes primary as long as the active employee retains eligibility based on ESRD.

B. Provision for Medicare for Retirees

The LGHIP remains primary for retirees until the retiree is entitled to Medicare.

Upon receipt of a Status Change form indicating a member's entitlement to Medicare, Medicare retirees and/or their Medicare dependent(s) will be automatically enrolled in the UnitedHealthcare Group Medicare Advantage (PPO) Plan (UHC Medicare Advantage), a Medicare health and Part D plan. A copy of the retiree's or their dependent's Medicare card must also be submitted.

A Medicare retiree and/or Medicare dependent must have both Medicare Parts A and B to be enrolled in UHC Medicare Advantage. Medicare Part B premiums are the retiree's responsibility.

UHC Medicare Advantage enrollment cannot be backdated. If the LGHIB does not receive 30 days' notice of a Medicare employee's retirement, the retiree cannot be enrolled in UHC Medicare Advantage with an effective date of the Medicare employee's retirement date and may have a gap in coverage until the retiree can be enrolled in UHC Medicare Advantage at the next available effective date. In addition, any claims paid by the LGHIP while a retiree was classified as an active employee due to a unit's late notification of the employee's retirement will be recalled. The unit and the retiree will be liable for any claims that cannot be recalled.

The UHC Medicare Advantage Plan will go into effect unless the retiree completes an LGHIP (UHC Medicare Advantage) Opt-Out form and returns it to the LGHIB within 21 days from the date of the opt-out notice. If a retiree opts-out, re-enrollment is not permitted. Exception: If a Medicare retiree opts-out of coverage in the UHC Medicare Advantage Plan and elects coverage through SelectQuote or Empower, the Medicare retiree may return to the UHC Medicare Advantage Plan during the LGHIP open enrollment period, as long as there has been no break in coverage, provided the unit still allows retiree Medicare coverage.

An exception will be made for members diagnosed with end-stage renal disease (ESRD), who are serving their 30-month coordination period. These members will remain in group 30000 and the LGHIP will remain primary payer until the completion of the 30-month coordination period.

If a retiree or dependent becomes entitled to Medicare because of a disability before age 65, the retiree must notify the LGHIB to be eligible for the reduced premiums and to ensure that claims are paid properly.

Medicare retirees and/or their Medicare dependent(s) enrolled in UHC Medicare Advantage may access the Evidence of Coverage (EOC) booklet online at

www.lghip.org. The EOC outlines the plan's eligibility, rules, regulations, and benefits. The website will also contain links to the current drug formulary, the participating pharmacy directory and the provider directory.

C. Provision for Medicare for COBRA Beneficiaries

COBRA beneficiaries with Medicare Parts A and B will be enrolled in the UHC Medicare Advantage plan. Medicare-eligible COBRA beneficiaries who do not have Medicare Parts A and B will be canceled.

IX. Eligible Participant Termination of Coverage

A. Coverage Terminates

The eligible participant's coverage will terminate:

1. On the last day of the month in which employment terminates.
2. On the last day of the month in which an elected official's term of office ends.
3. When the LGHIP is discontinued.
4. When premium payments cease.
5. When the unit withdraws from the LGHIP.
6. In the case of an eligible employee who receives insurance pursuant to the provisions of the Affordable Care Act on the basis of working an average of 30 or more hours per week or 130 or more hours per month during a measurement period, coverage terminates on the first day after the applicable stability period if the employee does not average 30/130 or more hours per week/month during a subsequent measurement period.
7. In addition to the above, the coverage terminates for a dependent:
    a. on the last day of the month in which such person ceases to be an eligible dependent; or
    b. if the dependent becomes eligible to be insured as an employee in the LGHIP.

In many cases, the eligible employee and/or their dependent(s) will have the option to choose continuation of group benefits as provided by the Public Health Service Act. (See COBRA Section.)

B. Family and Medical Leave Act

The LGHIB will adhere to the provisions of the Family and Medical Leave Act.

C. Leave without Pay (LWOP)

Eligible employees on leave without pay or who are receiving proceeds or pay through a workers' compensation policy may continue their health insurance coverage for a maximum of 12 months. The eligible employee will remain on the local government unit's billing. Once an eligible employee has been on leave without pay for 12 months, or has been receiving workers' compensation proceeds or pay for 12 months, the local government unit must notify the LGHIB. The eligible employee will be offered COBRA at that time. If the unit requires the eligible employee to make the premium payment and the eligible employee elects not to pay or they are canceled for nonpayment of premiums, the unit must submit a Cancellation form to the LGHIB indicating the reason for cancellation. When the Cancellation form is received, the LGHIB will send a COBRA notice to the eligible employee.

If the eligible employee returns to work and had elected not to continue their coverage while on leave without pay, the eligible employee will be treated as a new hire. If the eligible employee returns to work and had elected to continue coverage under COBRA, the eligible employee will be treated as a transfer.

The earliest an employee on LWOP can be cancelled due to non-payment is the first day of the month of notification to the LGHIB.

X. COBRA (Continuation of Group Health Coverage)

All COBRA applications and information concerning COBRA is handled through the LGHIB. See "How is COBRA Coverage Provided?" below.

NEW UNITS ONLY: All current COBRA subscribers must be marked in red as "COBRA." List them separately on the employee departmental listing. Include their name, Social Security number, address, qualifying event, and the date COBRA coverage originally began. Do not fill out an enrollment form on the COBRA subscribers. We will send them a letter and a COBRA application when we receive your listing.

Introduction
The Public Health Service Act [42 USC Sections 300bb-1 through 300bb-8] requires that the LGHIB 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 LGHIP would otherwise end. COBRA coverage can be particularly important because it will allow employees to continue group health care coverage beyond the point at which he/she would ordinarily lose it.

This section is intended to inform local units, in a summary fashion, of employees' rights and obligations under the continuation coverage provisions of this law and should read this carefully.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of coverage under the LGHIP when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed under the section entitled "Who is a Qualified Beneficiary". After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. The employee, his/her spouse, and his/her dependent children could become qualified beneficiaries if coverage under the LGHIP is lost because of a qualifying event. Under the LGHIP, 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, in order to be a qualified beneficiary, an individual must generally be covered under the LGHIP 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 an employee is a covered employee, he/she will become a qualified beneficiary if he/she loses his/her coverage under the LGHIP because either one of the following qualifying events occurs:

- The covered employee's hours of employment are reduced, or
- The covered employee's 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 the covered employee's termination of employment or reduction in hours, assuming the covered employee pays his/her premiums on time.

If the covered employee is on a leave of absence covered by the Family and Medical Leave Act of 1993 (FMLA), and he/she does not return to work, he/she will be given the opportunity to buy COBRA coverage. The period of his/her COBRA coverage will begin when he/she fails to return to work following the expiration of his/her FMLA leave or the unit informs the LGHIB that he/she does not intend to return to work, whichever occurs first.

COBRA Rights for a Covered Spouse and Dependent Children

A covered spouse of an employee will become a qualified beneficiary if he/she loses his/her coverage under the LGHIP because one of the following qualifying events occurs:

- Spouse dies;
- Spouse's hours of employment are reduced;
- Spouse's employment ends for any reason other than gross misconduct;
- Spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
- He/she becomes divorced or legally separated from his/her spouse.

A covered employee's dependent children will become qualified beneficiaries if they lose coverage under the LGHIP 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 LGHIP as a dependent child.

COBRA Medicare Enrolled in Medicare Advantage

COBRA beneficiaries with Medicare Parts A and B will be enrolled in the Medicare Advantage plan. Medicare-eligible COBRA beneficiaries who do not have Medicare Parts A and B will be canceled.

What Coverage is Available?
If COBRA continuation coverage is chosen, the LGHIB is required to offer coverage that, as of the time coverage is being provided, is identical to the coverage provided under the LGHIP to similarly situated employees or family members.

When is COBRA Coverage Available?
COBRA continuation coverage will be offered to qualified beneficiaries only after the LGHIB has been notified that a qualifying event has occurred.

- The unit is responsible for notifying the LGHIB within 30 days of the following qualifying events:
    - End of employment,
    - Reduction of hours of employment, or
    - Death of an employee.

- The employee or a family member has the responsibility to inform the LGHIB within 60 days of the following qualifying events:
    - Divorce,
    - Legal separation, or
    - A child losing dependent status.

Written notice must be given to the LGHIB within the applicable time frame from the date of the event, or the date in which coverage would end under the LGHIP because of the event, whichever is later. All notices should be sent to the address listed under “LGHIB Contact Information” at the end of this section.

How is COBRA Coverage Provided?
When the LGHIB is notified that a qualifying event has happened, 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 a covered employee does not choose continuation coverage, his/her group health insurance will end.

After the LGHIB receives timely notice that a qualifying event has occurred, the LGHIB will (1) notify the covered employee of the option to buy COBRA, and (2) send a COBRA election notice. A qualified beneficiary has 60 days within which to elect to buy COBRA coverage. The 60-day period begins to run from the later of (1) the date the qualified beneficiary would lose coverage under the LGHIP, or (2) the date on which the LGHIB notifies the qualified beneficiary that he/she has the option to buy COBRA coverage. Each qualified beneficiary has an independent right to elect COBRA coverage. The qualified beneficiary may elect COBRA coverage on behalf of a 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 the LGHIB.

Once the LGHIB has been notified of the qualifying event, coverage under the LGHIP will be retroactively terminated and payment of all claims incurred after the date coverage ceased will be rescinded. If the qualified beneficiary elects to buy COBRA during the 60-day election period, and if premiums are paid on time, the LGHIB will retroactively reinstate

the qualified beneficiary's coverage and process claims incurred during the 60-day election period.

Because there may be a lag between the time coverage under the plan ends and the time we learn of the qualified beneficiary's loss of coverage, it is possible that the LGHIP may pay claims incurred during the 60-day election period. If this happens, the qualified beneficiary should not assume that he/she has coverage under the LGHIP. The only way the qualified beneficiary's coverage will continue is if he/she elects to buy COBRA and pays their 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 LGHIP.

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 the hours of employment.

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

- Disability – If a covered employee or a covered member of his/her family is or becomes disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act and he/she timely notifies the LGHIB, 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 day 60 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 month 18 will be 150% of the full cost of coverage under the plan, assuming that the disabled person elects to be covered under the disability extension. If the only persons who elect the disability extension are non-disabled family members, the cost of coverage will remain at 102% of the full cost of coverage.

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

For this disability extension of COBRA coverage to apply, the qualified beneficiary must give the LGHIB timely notice of Social Security's disability determination before the end of the 18-month period of COBRA coverage and within 60 days after the later of (1) the date of the initial qualifying event; (2) the date on which coverage would be lost because of the initial qualifying event; (3) the date of Social Security's determination; or (4) the date on which the subscriber, or the qualified beneficiary, is informed, through the furnishing of the SPD or COBRA general notice, of the responsibility to notify the plan and the procedures for doing so. The qualified beneficiary must also notify the LGHIB within 30 days of any revocation of Social Security disability benefits.

Extensions of COBRA for Second Qualifying Events
For a spouse and children receiving COBRA coverage, the 18-month period may be extended to 36 months if another qualifying event occurs during the 18-month period, if the qualified beneficiary gives the LGHIB timely notice of the second qualifying event. The 36-month period will run from the date of the termination of employment or reduction in hours.

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

For this 18-month extension to apply, the qualified beneficiary must give the LGHIB timely notice of the second qualifying event within 60 days after the event occurs or within 60 days after the date on which coverage would be lost because of the event, whichever is later.

Can New Dependents be added to COBRA Coverage?
The qualified beneficiary may add new dependents to his/her COBRA coverage under the circumstances permitted under the LGHIP. Except as explained below, any new dependents that the qualified beneficiary adds to his/her COBRA coverage will not have independent COBRA rights. This means, for example, that if the qualified beneficiary dies, they will not be able to continue coverage.

If the covered employee acquires a child by birth or placement for adoption while he/she is receiving COBRA coverage, then his/her new child will have independent COBRA rights.

This means that if the covered employee dies, for example, his/her child may elect to continue receiving COBRA benefits for up to 36 months from the date on which the covered employee's COBRA benefits began.

If the covered employee's 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 the covered employee timely notifies the LGHIB of Social Security's disability determination as explained above.

How Does the Family and Medical Leave Act Affect COBRA Coverage?
If the employee is on a leave of absence covered by the Family and Medical Leave Act of 1993 (FMLA), and does not return to work, he/she will be given the opportunity to elect COBRA continuation coverage. The period of COBRA continuation coverage will begin when the employee fails to return to work following the expiration of FMLA leave or he/she informs the local government unit that the employee does not intend to return to work, whichever occurs first.

How much is the COBRA Coverage Premium?
One who qualifies for continuation coverage will be required to pay the local government unit's premium plus a 2% administrative fee, directly to the LGHIB. 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 local government unit's premium for the 19th through the 29th month of coverage or the month that begins more than 30 days after the date is determined that he or she is 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.) Coverage will be canceled if he/she fails to pay the entire amount in a timely manner.

When is the COBRA Coverage Premium Due?
The initial premium payment is due 45 days after the date the employee makes their election for coverage. All subsequent premiums are due on the first day of the month of coverage. There is a 30-day grace period.

When Does COBRA Coverage End?
The law provides that COBRA continuation coverage may be terminated for any of the following reasons:

1. LGHIB no longer provides group health coverage.
2. The unit withdraws or is terminated from the LGHIP.
3. The premium for continuation coverage is not paid on time.
4. The covered beneficiary becomes covered by another group plan.
5. The covered beneficiary becomes entitled to Medicare.
6. The covered beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that he/she is no longer disabled.

In addition, COBRA coverage can be terminated if otherwise permitted under the terms of the LGHIP. For example, if a fraudulent claim is submitted, coverage will terminate.

A qualified beneficiary does not have to show that he/she is insurable to choose COBRA continuation coverage. However, under the law, he/she may have to pay all

or part of the premium for COBRA continuation coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium.

Note: If an individual is entitled to Medicare before becoming a qualified beneficiary, he/she may elect COBRA continuation coverage. An individual must have Medicare Parts A and B in order to have full coverage. If COBRA is elected, the individual will be enrolled in the LGHIP's Medicare Advantage plan.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for a qualified beneficiary 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. Individuals can learn more about many of these options at www.healthcare.gov.

Keep the LGHIB Informed of Address Changes
In order for employees to protect their COBRA rights, they must keep the LGHIB informed of any address changes for family members. Employees should maintain copies of all notices sent to the LGHIB.

If an Employee Has Any Questions
Questions concerning COBRA continuation coverage rights may be addressed by calling the LGHIB at 1-866-836-9137 or (334) 263-8326 or by mail at the contact listed below. For more information about COBRA rights, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, employees may visit the US Department of Labor Employee Benefits Security Administration's website at www.dol.gov/ebsa or call their toll-free number 1-866-444-3272. For more information about health insurance options available through a health insurance marketplace, visit www.healthcare.gov.

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

Local Government Health Insurance Board
LGHIB COBRA Section
Post Office Box 304900
Montgomery, AL 36130-4900

XI. Employee Eligibility Audit

All participating units of the LGHIP will be audited to ensure all participants are eligible for coverage in the LGHIP and that all enrollment records are accurate. LGHIB auditors will review payroll records and other necessary documentation, via electronic submission through the unit's my.lghip account or through secure email, to verify compliance with the LGHIP's eligibility and enrollment rules. Onsite visits to the units will only be necessary if any discrepancies in the records cannot be resolved by the unit submitting required documentation.

Audit Procedures

1. The LGHIB will notify each unit of its scheduled audit date. The LGHIB will coordinate with the units to ensure that the timing of the audit will be as convenient as possible.
2. Once an audit date is established, the unit will have 60 days to conduct a self-audit and present its findings to the LGHIB.
3. The unit's submission of its self-audit results must include employee payroll records for verification purposes.
4. If deemed necessary, the LGHIB will conduct an onsite audit.
5. At the conclusion of the audit, the LGHIB will present the results of the audit to the unit.

Treatment of Audit Results

1. The unit will not be penalized for any eligibility or enrollment violations identified by the unit during the self-audit and verified by the LGHIB.
2. If the LGHIB discovers any eligibility or enrollment violations not identified in the self-audit, the LGHIB may impose one or more of the following actions, depending upon the nature and severity of the violations:
   a. move the unit to the standard premium category for at least two years,
   b. require full or partial payment of back premiums,
   c. require full or partial payment of non-recallable claims.
3. Units that refuse to cooperate with the audit or fail to comply with the above listed actions will be referred to the LGHIB's Grievance Committee for possible group termination.

XII. Local Government Unit Withdrawal

A local government unit may withdraw from the LGHIP, subject to the following conditions:

1. No later than six months prior to the effective date of withdrawal, the unit must notify the LGHIB in writing via certified mail to the following address:

   Local Government Health Insurance Board
   Post Office Box 304900
   Montgomery, AL 36130-4900

2. The notice of withdrawal must include a resolution from the governing body of the local government unit signifying its intention to withdraw from the LGHIP.

3. Any local government unit that withdraws from participation shall be responsible for paying its claims incurred prior to the date of withdrawal, but not reported and paid until after the date of withdrawal.

4. Any local government unit that withdraws from participation in the LGHIP shall serve a three-year waiting period from the effective date of the unit's withdrawal before such local government unit, who is in good standing, may apply for re-enrollment into the LGHIP.

5. Any organization that provides or administers health insurance benefits through the LGHIP shall not provide or administer health insurance benefits to any entity that

withdraws from the LGHIP for a period of two years from the effective date of withdrawal.

XIII. Local Government Unit Termination

The LGHIB may terminate a local government unit's participation in the LGHIP when the LGHIB deems it to be in the best interest of the LGHIP. A local government unit's participation in the LGHIP may be terminated for any reason including, but not limited to, the following:

1. Failure to comply with the policies and procedures of the LGHIB;
2. Purposely submitting incorrect or fraudulent information; or
3. Delinquent payment of premiums.

If a local government unit's participation in the LGHIP is terminated by the LGHIB, the following conditions will apply:

1. The terminated unit shall be responsible for paying its claims incurred prior to the date of the local government unit's termination, but not reported and paid until after the date of termination;
2. Any unit terminated by the LGHIB may not apply for re-enrollment into the LGHIP until three years have elapsed. Reenrollment will be at the discretion of the LGHIB;
3. Any organization that provides or administers health insurance benefits through the LGHIP shall not provide or administer health insurance benefits to any unit that is terminated from the LGHIP by the LGHIB for a period of two years from the effective date of termination.

XIV. Wellness Program

The LGHIB Wellness Program is a voluntary program available to active employees, non-Medicare retirees, and their spouses who are covered by the LGHIP (Group 30000). If the eligible participant chooses to participate in the wellness program, the eligible participant will be asked to complete a biometric screening, which will include taking blood pressure, and measuring height, weight and waist size. It will also include taking a blood sample to check cholesterol (HDL, LDL, and total), triglycerides, and glucose. The eligible participant will also be asked whether they have or have had high cholesterol, high blood pressure, or diabetes and whether they take medicine for those conditions.

The screening is intended to identify whether the eligible participant is at risk for certain medical conditions resulting from high blood pressure, obesity, high cholesterol, or diabetes. The eligible participant is also encouraged to share the results or any concerns with his or her medical provider.

The LGHIB Wellness Program will not disclose screening results either publicly or to the employer, and will be maintained by the LGHIB. The eligible participant will not be discriminated against because of the medical information he or she provides as part of participating in the wellness program, nor will he or she be subjected to retaliation if he or she chooses not to participate. Participants who are identified with elevated screening results will be referred to the Achieve Wellness Program and may be eligible to enroll in

certain programs designed to assist the eligible participant in controlling, or decreasing, the condition identified by the wellness screening.

Local government units that have 80% or greater wellness participation by their active employees within the wellness qualifying period will be eligible for the preferred premium category.

In order to help your unit achieve 80% wellness participation, (see section III-B) screenings can be performed at any time throughout the screening period of November 1 - October 31. There are four screening options available: (1) having the screening performed onsite at the local government unit; (2) having a screening performed by a healthcare provider (copay may apply); 3) having a screening performed at a pharmacy participating in the BCBS biometric screening network; or 4) having a screening performed at a county health department. For a listing of screening sites or participating pharmacy locations, please visit our website at www.lghip.org.

Applicable office visit and lab copays will apply to active employees who have their screenings performed by their healthcare provider. The Provider Screening form is located on the LGHIB website and is included in this guide. The Local Government Wellness Program will accept biometrical screenings performed by approved providers only. Screenings received from non-approved providers will not be accepted. The screening must be completed by October 31 and submitted to the LGHIB's office by November 15.

Although the wellness screening is available to non-Medicare retirees and spouses, only active employees who are employed and have participated in the wellness program as of October 31, will be counted toward a unit's participation percentage. Wellness screening forms will not be accepted by the LGHIB after November 15.

The LGHIB's monthly billing has a symbol by each participant's name that has been screened during the current and previous screening period. You can view your billing by logging into your unit's account at www.lghip.org.

Should you have any questions or need further information regarding the LGHIB's wellness program, please contact our wellness staff at 334-263-8326 (option 4).

XV. Billing Procedures

A. Payment Notice

The LGHIB will generate an invoice (see section XVIII, LGHIP Appendix) and listing of employees insured (see section XVIII, LGHIP Appendix) for each local government unit. The invoice with employees' detailed information will be available on the unit's myLGHIP account on the LGHIB website. The insured employees' information will be compiled from the unit's enrollment information. The invoice is a summary of the total single and family subscribers insured, a tabulation of the previous balance owed, the current month's amount and the total balance due. The invoice will also show which employees have completed their wellness screening.

Local government units are not allowed to make any corrections or adjustments to this balance. All corrections and adjustments will be included in the payment notice for the upcoming month.

B. Invoice Changes

Additions, cancellations and changes in the current billing period and the upcoming months must be made from the proper forms (forms LG01, LG02, LG02-B, LG02-C, LG03, LG04, LG07, LG08, or LG09). Upon receipt of the proper paperwork, credits/debits and COBRA information will be processed.

C. Premium Credits

There is a three-month (three billing cycles) time limit for premium credits. These credits will be issued for eligible participants provided no claims have been filed.

D. Payment Options

Units will not receive mailed invoices or billing details. Invoices and billing details will be available for units to download through their unit administrator's account at my.lghip.org. Units will receive an email notification each month when their invoices are available to view and download through the my.lghip.org website.

1. **Automatic Draft Payment**

   Units may pay monthly premiums by automatic bank draft. The monthly invoice will indicate the amount withdrawn from the local government bank account on or after the first day of the following month. For example, a bill issued October 18 would include a notice that the new balance will be drafted from the unit's designated account on November 1. This service is offered at no charge to the local government unit.

   Automatic drafts may be canceled at any time. However, draft cancellations must be made at least five business days prior to the last business day of the month.

2. **Electronic-check (e-check) Service**

   Payment by e-check is available to pay monthly premiums through the LGHIB's website, www.lghip.org, or by phone. For phone payments by e-check, please call the LGHIB's Accounting Department at 1-866-836-9137.

3. **Mail Payment**

   Payment by mailed check is available to pay monthly premiums. While this option is free for the units, except for the cost of the envelope and stamp, please remember that the payment must be submitted prior to the due date to avoid coverage cancellation.

   Payments by mail may be sent to:

   Local Government Health Insurance Board
   Accounting Department
   PO Box 304900
   Montgomery, AL 36130

E. Premium Payments

The LGHIB bills in advance for the following month's coverage. To be eligible for coverage, members must comply with the LGHIP's enrollment and eligibility rules. Acceptance of premium payment does not guarantee coverage.

XVI. LGHIB Website

A. The Website

The LGHIB's website, www.lghip.org, has relevant information related to your health insurance plan, including plan books, our wellness program, rates, forms, as well as other information regarding the administration of the Plan.

B. My.LGHIP.org

1. Unit Administrators

Unit administrators may create an account for their individual unit to enroll eligible subscribers and dependents, view their unit's current and prior year's wellness participation, view invoices, pay the unit's premiums, register for the LGHIB's annual conferences and view memos from the LGHIB. The wellness participation does not disclose the individual's results, only whether they participated in the screening.

2. LGHIP Subscribers

Subscribers of the LGHIP may create an account to view and print their own individual wellness screenings and trend charts, view their dependents listed on their LGHIP coverage, update their email address and email preferences.

XVII. Forms

A. General Information for Initial Enrollment (LG11A)

To be completed by new units enrolling in the LGHIP.

B. Participation Form (LG15)

To be completed by new units or units changing coverage for dental, retirees, elected officials or probationary policy.

C. Resolution (LG16)

To be completed by new units enrolling in the LGHIP.

D. Enrollments (LG01)

To enroll in the LGHIP, a Local Government Enrollment Form (Form LG01) must be completed and signed by the eligible participant.

E. Affordable Care Act Full-Time Employee Verification (LG23)

Complete this form to validate an employee's eligibility for coverage as an ACA full-time employee.

F. New Dependent (LG02-B)

To add family coverage or to add a dependent to/from an existing contract, a Local Government New Dependent form (form LG02-B) must be completed and signed by the eligible participant.

G. Dependent Cancellation (LG02-C)

To remove family coverage or to drop a dependent from an existing contract, a Local Government Dependent Cancellation form (form LG02-C) must be completed and signed by the eligible participant.

H. Status Changes (LG02)
To make changes to the existing plan (name changes, address changes, rate changes, etc.), a Local Government Status Change form (form LG02) must be completed and signed by the eligible participant.

I. Cancellations (LG03)
To cancel all coverage, a Local Government Cancellation Form (Form LG03) must be completed and submitted to the LGHIB office.

J. Retiree Years of Service Verification (LG22)
All retirees electing retiree coverage in the LGHIP must validate their years of service with the local government entities by completing the Retiree Years of Service Verification form (Form LG22)

K. Declination of Coverage (LG04)
To decline or cancel coverage, a Local Government Declination of Coverage Form (Form LG04) must be completed, signed by the employee and submitted to the LGHIB.

L. Effective Date of Coverage Election Form (LG05)
To elect to have coverage for all future eligible full-time employees to be effective on date of employment. The form may be submitted at the initial enrollment or during the annual open enrollment.

M. General Information Changes (LG11B)
After units are enrolled into the LGHIP, the General Information Changes form will be used to revise local government unit contact information. When a change occurs in the address, local government health insurance administrator, contact person for billing purposes, or the telephone number, units must submit a new General Information Changes form with the appropriate changes.

NOTE: All applicable forms must be verified and signed by the designated unit administrator.

N. Provider Screening Form (LG12)
To be completed by a primary care provider i.e. medical doctor, doctor of osteopathic medicine, nurse practitioner, or physician assistant.

O. Pre-Authorized Payment Service Authorization Agreement (LG13)
The unit can complete the payment service authorization agreement to allow the LGHIB to electronically debit the unit’s bank account to pay the unit’s premiums.

XVIII. LGHIP Appendix

Form LG11-A
Revised 9/20

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
General Information for Initial Enrollment

Federal ID Number ______________________________

Name of Local Government Unit ______________________________

Mailing Address

PO Box or Street Address
City, State
Zip, County

Physical Address (if different)

Street Address
City, State
Zip, County

Unit Contacts

Health Insurance Administrator:	
Position/Title:	Phone Number:
Email Address:	
Primary Contact *(If different than Health Insurance Administrator)*	
Position/Title:	Phone Number:
Email Address:	
Wellness Coordinator Name and Location:	
Position/Title:	Phone Number:
Email Address:	
Additional Billing Contact:	
Position/Title:	Phone Number:
Email Address:	

For LGHIB use only. Do not write in this space.		
LGHIB Unit #	**Effective Date**	
Retirees (Non-Medicare) ☐ **Yes** ☐ **No**	**Retirees (Medicare)** ☐ **Yes** ☐ **No**	**Dental** ☐ **Yes** ☐ **No**
Elected Officials ☐ **Yes** ☐ **No**	**Probationary Period** ☐ **Yes** ☐ **No**	**New Hires**
Enroll	**Decline**	**Date**

Instructions for Form Completion

1. Enter your unit's nine-digit Federal Identification Number.
2. Enter the name of the local government unit who is eligible for enrollment in the LGHIP.
3. Enter the unit's mailing address and physical address, if different.
4. Enter the person's name, title, telephone number and email address that will be primarily responsible for managing and making decisions concerning the LGHIP.
5. Enter the person's name, title, telephone number and email address that should receive correspondence regarding enrollment, billing and wellness information.
6. Enter the person's name, title, telephone number and email address that should receiving correspondence regarding wellness information, including scheduling wellness screenings.
7. Enter the name of the additional employee who may be contacts for information when the primary unit contact is unavailable.
8. Enter the name of the person completing the form.

After local government units are enrolled into the LGHIP, the General Information Changes form will be used to revise enrollment information. When a change occurs in either the address, local government health insurance administrator, contact person for billing purposes, the wellness coordinator, email address, or the telephone number, the unit must submit a new General Information Changes form with the appropriate change(s).

Form LG15
Revised 10/20

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM

Participation Form

1. Name of Local Government Unit ____

   The above-named group certifies the following numbers and percentages of eligible and enrolled participants at the date of application:

2. Active: Enrolled ________________ Declined ________________

   Elected: Enrolled ________________ Declined ________________

   Retired: Enrolled ________________

   Total Eligible Participants: Enrolled ________________ Declined ________________

3. Eligible participants enrolled for single coverage ____________________________

4. Eligible participants enrolled for family coverage ____________________________

5. % of employee premium to be paid by employer ____________________________

   % of employee premium to be paid by employee ____________________________

6. % of dependent premium to be paid by employer ____________________________

   % of dependent premium to be paid by employee____________________________

7. Dental option is elected for all employees? YES NO

8. Provide Coverage for Non-Medicare Retirees? YES NO

9. Provide Coverage for Medicare Retirees? YES NO

10. Provide Coverage for Elected Officials? YES NO
    (For cities, towns and counties)

11. Probationary period policy for new employees that affects benefits? YES NO
    If "yes," attach a copy of the policy.

IMPORTANT: Attach to this application package an alphabetical listing, by department, of employee names and Social Security numbers included in this local government unit.

______________________________________ ______________________
Signature of Benefit Administrator Date

____
Printed Name

Local Government Health Insurance Board
PO Box 304900
Montgomery, AL 36130-4900
(334) 263-8326 • 1-866-836-9137 • Fax: (334) 263-8526

Form LG16
Revised 9/19

RESOLUTION

WHEREAS, ____, requests permission from the Local
(Name of Local Government Unit)
Government Health Insurance Board to participate in the Local Government Health Insurance Program *(Code of Alabama 1974, Section 11-91A-1, et seq.); and*

WHEREAS, ____ agrees to abide by the rules, procedures
(Name of Local Government Unit)
and audit rights established for the Local Government Health Insurance Program by the Local Government Health Insurance Board; and

WHEREAS, the information submitted for enrollment into the Local Government Health Insurance Program has been verified for completeness and accuracy; and

WHEREAS, an application fee is submitted as part of this Application Package as our equity contribution to the fund's reserves, but does not entitle ____ to any
(Name of Local Government Unit)
interest in fund reserves that have accumulated in prior years;

NOW, THEREFORE, BE IT RESOLVED, that ____ does
(Name of Local Government Unit)
hereby submit this application package to participate in the Local Government Health Insurance Program, as administered by the Local Government Health Insurance Board.

ADOPTED AND APPROVED THIS DATE: ____

____
Authorized Person's Signature

____
Type or Print Name

____
Type or Print Title

Form LG01
Revised 9/20

FOR LGHIB USE ONLY
Date ________________
Initials: ______________

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2021 ENROLLMENT FORM

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)			Gender
Social Security Number		Date of Birth	
Mailing Address	City	State	ZIP Code
Primary Phone Number	Work Phone Number	E-mail Address:	

Employment Status (Check One)

☐ Full-time Employee	☐ ACA Eligible (Must submit Form LG23)	☐ Elected Official	☐ Retired (Not Medicare Participant)	☐ Retired (Medicare Participant)

Note: If your Employment Status above is ☒ **Retired**, and you or your covered dependent(s) are covered by Medicare, you must provide a copy of your Red, White, and Blue Medicare Card and a physical address. Your name must match the name listed on your Medicare card.

NOTE: BY LISTING FAMILY MEMBERS BELOW YOU ARE APPLYING FOR AND REQUESTING FAMILY COVERAGE.

First Name	Initial	Last Name	Documentation is required. See back of form. Relationship to Employee		Date of Birth	Social Security Number
			☐ Male Spouse	☐ Female Spouse		
			☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
			☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
			☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
			☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
			☐ Grandson ☐ Nephew	☐ Granddaughter ☐ Niece		
			☐ Grandson ☐ Nephew	☐ Granddaughter ☐ Niece		

AFFIRMATION AND RELEASE

I understand and acknowledge that only eligible dependents may be added to my coverage. An ex-spouse and ex-stepchildren are ineligible for coverage and cannot be maintained as dependents under my family coverage regardless of a judgment or divorce decree requiring me to provide health care for my ex-spouse or ex-stepchildren. I understand and acknowledge that an ex-spouse and ex-stepchildren must be removed from coverage effective the first day of the month following the date of the divorce decree and it is my responsibility to notify the LGHIB immediately when the eligibility of a covered dependent changes. If it is determined that an act on my part (such as adding an ineligible person to coverage) or omission (such as failing to remove a person no longer eligible for coverage) results in or contributes to the payment of claims for persons ineligible for coverage, I will be personally responsible for all such overpayments and may be subject to disqualification from coverage under the plan.

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand that there is mandatory utilization review and I do hereby give permission to release any information necessary to evaluate, administer, and process claims for benefits to any person, entity or representative acting on the LGHIB's behalf.

______________________________ **Employee Signature**

______________________ **Date**

TO BE COMPLETED BY EMPLOYER

Probationary Period: Yes ______ No ______ **If yes:** Start Date ________________________ End Date ________________________

Full-Time Date of Hire: ____

Local Government Unit Name: ____ **Unit Number:** ____________________

Signature of Benefit Administrator: ____ **Date:** ____________________

Dependent documentation is required before dependents can be added to coverage.

GENERAL INFORMATION

Eligible Dependent
(**Appropriate documentation must be attached.)**

The term "dependent" includes the following individuals, subject to appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.):

1. The eligible participant's spouse (excludes a divorced spouse)

2. A child under age 26, only if the child is:
   a) The eligible participant's son or daughter
   b) A child legally adopted by the eligible participant or his or her spouse
   c) The eligible participant's stepchild

3. Grandchild, niece or nephew of the eligible participant or his or her spouse:
   a) under 19 years of age, and
   b) for whom the court has granted custody to the eligible participant or his or her spouse

4. An incapacitated dependent over age 25 will be considered for coverage provided dependent:
   a) is unmarried,
   b) is permanently mentally or physically disabled or incapacitated,
   c) is so incapacitated as to be incapable of self-sustaining employment,
   d) is dependent upon the eligible participant for 50% or more financial support,
   e) is otherwise eligible for coverage as a dependent except for age,
   f) had the condition prior to the dependent's 26th birthday, and
   g) is not eligible for any other group insurance benefits.

Neither a reduction in work capacity nor inability to find employment is, of itself, evidence of eligibility. If a mentally or physically disabled dependent is employed, the extent of his or her earning capacity will be evaluated.

To apply, contact the LGHIB to obtain an Incapacitated Dependent Certification Form. Final approval of incapacitation will be determined by Medical Review. Proof of disability must be provided to the LGHIB within 60 days from the date the child would otherwise cease to be covered because of age.

Exception: There are two situations under which it may be possible to add an incapacitated dependent who meets the eligibility requirements other than exceeding the maximum age requirement:

i. when a new eligible participant requests coverage for an incapacitated dependent within 60 days from the date of employment; or

ii. when an eligible participant's incapacitated dependent is covered under a spouse's employer group health insurance for at least 18 consecutive months and:
   - the eligible participant's spouse loses the other coverage because:
     a) spouse's employer ceases operations, or
     b) spouse's loss of eligibility due to termination of employment or reduction of hours of employment, or
     c) spouse's employer stopped contribution to coverage; and
   - a change form is submitted to the LGHIB within 30 days of the incapacitated dependent's loss of other coverage; and
   - Medical Review approved incapacitation status.

These requirements must be met as a minimum threshold in order to be considered for incapacitation status. The LGHIB shall make the final decision as to whether an application for incapacitated status will be accepted. NOTE: The LGHIB reserves the right to periodically recertify incapacitation.

Note: You may not cover your spouse or other dependents if they are insured or if they are eligible to be insured as an active employee in the LGHIP.

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
(334) 263-8326 | 1-866-836-9137 | FAX: (334) 263-8526

Form LG23
10/20

Local Government Health Insurance Board
Affordable Care Act Full-Time Employee
Verification Form

Please use the information below to assist in completing the form:

A. Measurement Period
The period during which an employee's hours are tracked or measured by the unit. In order to be considered as an ACA full-time employee, the employee must have averaged 30+ hours per week or 130+ hours per month during the measurement period. The period can be between 3-12 months in duration.

- An employee is due credit for an hour of service for:
  - Each hour the employee is paid, or entitled to payment, for the performance of duties for the unit, and
  - Each hour the employee is paid, or entitled to payment for a period of time during which no duties are performed due to: vacation, holiday, illness, incapacity, layoff, jury duty, military duty, or leave of absence

B. Administrative Period
The period during which the employer calculates the amount of hours the employee worked during the measurement period.

C. Stability Period
The period during which the employee is either entitled to or not entitled to coverage based on the hours the employee averaged during the measurement period. The period must be at least six month and cannot be any shorter than the measurement period.

Name (First, Middle Initial, Last)		Social Security Number
Measurement Period	_______________ (Start Date) Month/ Date/ Year	_______________ (End Date) Month/ Date/ Year
Number of hours employee worked during Measurement Period: ________________		
Administrative Period	_______________ (Start Date) Month/ Date/ Year	_______________ (End Date) Month/ Date/ Year
Stability Period	_______________ (Start Date) Month/ Date/ Year	_______________ (End Date) Month/ Date/ Year

TO BE COMPLETED BY EMPLOYER

This information is offered to assist units in complying with Affordable Care Act rules and regulations. However, all units subject to the ACA are solely responsible for complying with ACA rules and regulations. If the unit has any questions in regard to ACA compliance, the LGHIB recommends the unit confer with its attorney or other healthcare professional.

Local Government Unit Name: ____ **Unit Number:** ____________________

Signature of Benefit Administrator: ____ **Date:** ________________________

Form LG02-B
Revised 9/20

FOR LGHIB USE ONLY
Date: ____________
Initials: __________

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2021 NEW DEPENDENT FORM

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)			Date of Birth
Social Security Number	**Contract Number**	**Primary Telephone Number** ( )	**Work Telephone Number** ( ) Ext.

ADDITIONS – PROVIDE DOCUMENTATION (Must select one)
**Please read important information on the back.

☐ Change from Single to Family Coverage. Add dependent(s)**
☐ Add dependent(s) listed below to Family Coverage **

Dependent documentation is required before dependents can be added to coverage.

REASON FOR ADDITION (Must select one) — MONTH/DAY/YEAR

☐ Marriage ____________________
☐ Birth of Child ____________________
☐ Adoption of Child ____________________
☐ Open Enrollment ____________________
Effective date on form must be 1/1/21
☐ Other ____________________

Explain: ____

First Name / Initial / Last Name	Documentation is required. See back of form. Relationship to Employee		Date of Birth	Social Security Number
	☐ Male Spouse	☐ Female Spouse		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Grandson ☐ Nephew	☐ Granddaughter ☐ Niece		
	☐ Grandson ☐ Nephew	☐ Granddaughter ☐ Niece		

For additional dependents, please list the information on a separate sheet and attach to this form.

AFFIRMATION AND RELEASE

I understand and acknowledge that only eligible dependents may be added to my coverage. An ex-spouse and ex-stepchildren are ineligible for coverage and cannot be maintained as dependents under my family coverage regardless of a judgment or divorce decree requiring me to provide health care for my ex-spouse or ex-stepchildren. I understand and acknowledge that an ex-spouse and ex-stepchildren must be removed from coverage effective the first day of the month following the date of the divorce decree and it is my responsibility to notify the LGHIB immediately when the eligibility of a covered dependent changes. If it is determined that an act on my part (such as adding an ineligible person to coverage) or omission (such as failing to remove a person no longer eligible for coverage) results in or contributes to the payment of claims for persons ineligible for coverage, I will be personally responsible for all such overpayments and may be subject to disqualification from coverage under the plan.

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand that there is mandatory utilization review and I do hereby give permission to release any information necessary to evaluate, administer, and process claims for benefits to any person, entity or representative acting on the LGHIB's behalf.

________________________________ ____________________
Employee Signature Date

TO BE COMPLETED BY EMPLOYER

Requested Effective Date of Addition*: ____

**LGHIP may revise this date without notifying the unit if the requested date is incorrect*

Local Government Unit Name: ______________________________ **Unit Number:** ______________

Signature of Benefit Administrator: ______________________________ **Date:** ______________

FOR LGHIB USE ONLY:

☐ Received Documentation ____________________
(Date Received)

☐ Documentation Letter Sent ____________________
(Date Mailed)

☐ Need Marriage Documentation ☐ Need Birth Documentation
☐ Need Stepchild Birth Documentation ☐ Need Social Security Number
☐ Other (Please list) ____________________
☐ Other (Please list) ____________________

GENERAL INFORMATION

Eligible Dependent
(**Appropriate documentation must be attached.)**

The term "dependent" includes the following individuals, subject to appropriate documentation (Social Security number, marriage documentation, birth documentation, court decree, etc.):

1. The eligible participant's spouse (excludes a divorced spouse)

2. A child under age 26, only if the child is:
   a) The eligible participant's son or daughter
   b) A child legally adopted by the eligible participant or his or her spouse
   c) The eligible participant's stepchild

3. Grandchild, niece or nephew of the eligible participant or his or her spouse:
   a) under 19 years of age, and
   b) for whom the court has granted custody to the eligible participant or his or her spouse

4. An incapacitated dependent over age 25 will be considered for coverage provided dependent:
   a) is unmarried,
   b) is permanently mentally or physically disabled or incapacitated,
   c) is so incapacitated as to be incapable of self-sustaining employment,
   d) is dependent upon the eligible participant for 50% or more financial support,
   e) is otherwise eligible for coverage as a dependent except for age,
   f) had the condition prior to the dependent's 26th birthday, and
   g) is not eligible for any other group insurance benefits

Neither a reduction in work capacity nor inability to find employment is, of itself, evidence of eligibility. If a mentally or physically disabled dependent is employed, the extent of his or her earning capacity will be evaluated.

To apply, contact the LGHIB to obtain an Incapacitated Dependent Certification Form. Final approval of incapacitation will be determined by Medical Review. Proof of disability must be provided to the LGHIB within 60 days from the date the child would otherwise cease to be covered because of age.

Exception: There are two situations under which it may be possible to add an incapacitated dependent who meets the eligibility requirements other than exceeding the maximum age requirement:

i. when a new eligible participant requests coverage for an incapacitated dependent within 60 days from the date of employment; or

ii. when an eligible participant's incapacitated dependent is covered under a spouse's employer group health insurance for at least 18 consecutive months and:
   - the eligible participant's spouse loses the other coverage because:
     a) spouse's employer ceases operations, or
     b) spouse's loss of eligibility due to termination of employment or reduction of hours of employment, or
     c) spouse's employer stopped contribution to coverage; and
   - a change form is submitted to the LGHIB within 30 days of the incapacitated dependent's loss of other coverage; and
   - Medical Review approved incapacitation status.

These requirements must be met as a minimum threshold in order to be considered for incapacitation status. The LGHIB shall make the final decision as to whether an application for incapacitated status will be accepted. NOTE: The LGHIB reserves the right to periodically recertify incapacitation.

Note: You may not cover your spouse or other dependents if they are insured or if they are eligible to be insured as an active employee in the LGHIP.

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
(334) 263-8326 • 1-866-836-9137 • FAX: (334) 263-8526

Form LG02-C
Revised 10/20

FOR LGHIB USE ONLY

Date: ____________

Initials: __________

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2021 DEPENDENT CANCELLATION FORM

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)			Date of Birth
Social Security Number	Contract Number	Primary Telephone Number ( )	Work Telephone Number ( ) Ext.

DROP DEPENDENT COVERAGE (Must select one)

☐ Change from Family to Single Coverage

☐ Cancel dependent(s) listed below from Family Coverage

REASON FOR CANCEL (Must select one) MONTH/DAY/YEAR

☐ Death ____________

☐ Divorce ____________
Attach divorce decree

☐ No longer has legal custody ____________
Attach court documents

☐ No longer has legal custody ____________
Attach court documents

MONTH/DAY/YEAR

☐ Dependent eligible to be enrolled as an active employee with the LGHIP ____________

☐ Dependent no longer eligible ____________

Explain: ____________

☐ Open Enrollment (Effective 1/1/2021) ____________

☐ Other ____________

Explain: ____________

First Name Initial Last Name	Relationship to Employee		Date of Birth	Social Security Number
	☐ Male Spouse	☐ Female Spouse		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Grandson ☐ Nephew	☐ Granddaughter ☐ Niece		
	☐ Grandson ☐ Nephew	☐ Granddaughter ☐ Niece		

AFFIRMATION AND RELEASE

I understand and acknowledge that only eligible dependents may be added to my coverage. An ex-spouse and ex-stepchildren are ineligible for coverage and cannot be maintained as dependents under my family coverage regardless of a judgment or divorce decree requiring me to provide health care for my ex-spouse or ex-stepchildren. I understand and acknowledge that an ex-spouse and ex-stepchildren must be removed from coverage effective the first day of the month following the date of the divorce decree and it is my responsibility to notify the LGHIB immediately when the eligibility of a covered dependent changes. If it is determined that an act on my part (such as adding an ineligible person to coverage) or omission (such as failing to remove a person no longer eligible for coverage) results in or contributes to the payment of claims for persons ineligible for coverage, I will be personally responsible for all such overpayments and may be subject to disqualification from coverage under the plan.

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand that there is mandatory utilization review and I do hereby give permission to release any information necessary to evaluate, administer, and process claims for benefits to any person, entity or representative acting on the LGHIB's behalf.

____________________ Employee Signature

____________________ Date

TO BE COMPLETED BY EMPLOYER

Effective Date of Change*: ____________________
**LGHIP may revise this date without notifying the unit if the requested date is incorrect*

Local Government Unit Name: ____________________ **Unit Number:** ____________

Signature of Benefit Administrator: ____________________ **Date:** ____________

Local Government Health Insurance Board
PO Box 304900 | Montgomery, AL 36130-4900
(334) 263-8326 • 1-866-836-9137 • FAX: (334) 263-8526

For LGHIB Use Only
☐ Send COBRA __________
☐ Check claims __________
☐ Credit __________

Form LG02
Revised 10/20

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2021 STATUS CHANGE FORM

FOR LGHIB USE ONLY
Date: ____________
Initials: ____________

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)			Date of Birth
Social Security Number	Contract Number	Primary Telephone Number ( )	Work Telephone Number ( ) Ext.

Select the change that needs to be made from the options below:

☐ MAILING ADDRESS To: ______________________________
Street Address or Post Office Box

____
City State Zip

☐ SUBSCRIBER'S NAME From: ____________________ To: ____________________

☐ DEPENDENT'S NAME* From: ____________________ To: ____________________
Documentation Required

☐ SUBSCRIBER'S DATE OF BIRTH From: ____________________ To: ____________________

☐ DEPENDENT'S DATE OF BIRTH From: ____________________ To: ____________________

☐ TELEPHONE NUMBER: Primary (________)____________________Work: (________)____________________

☐ E-MAIL ADDRESS To: ______________________________

Retirement
Check applicable boxes

Retiree: ☐ Not Medicare ☐ Medicare
☐ Retired due to Social Security Disability (provide disability determination letter)

☐ Retired based upon years of service (must provide form LG22)

Dependent: ☐ Not Medicare ☐ Medicare

Physical address of Medicare retirees must be provided.

____
Physical Street Address

____
City State Zip

Note: If in the section above you selected: ☒ **Retiree: Medicare** or ☒ **Dependent: Medicare,** you must provide a copy of your Red, White and Blue Medicare Card and a physical address. Your name must match the name listed on your Medicare card.

AFFIRMATION AND RELEASE

I understand and acknowledge that only eligible dependents may be added to my coverage. An ex-spouse and ex-stepchildren are ineligible for coverage and cannot be maintained as dependents under my family coverage regardless of a judgment or divorce decree requiring me to provide health care for my ex-spouse or ex-stepchildren. I understand and acknowledge that an ex-spouse and ex-stepchildren must be removed from coverage effective the first day of the month following the date of the divorce decree and it is my responsibility to notify the LGHIB immediately when the eligibility of a covered dependent changes. If it is determined that an act on my part (such as adding an ineligible person to coverage) or omission (such as failing to remove a person no longer eligible for coverage) results in or contributes to the payment of claims for persons ineligible for coverage, I will be personally responsible for all such overpayments and may be subject to disqualification from coverage under the plan.

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand that there is mandatory utilization review and I do hereby give permission to release any information necessary to evaluate, administer, and process claims for benefits to any person, entity or representative acting on the LGHIB's behalf.

______________________________ ______________________________
Employee Signature **Date**

TO BE COMPLETED BY EMPLOYER

Requested Effective Date of Change: ______________________________
**LGHIP may revise this date without notifying the unit if the requested date is incorrect*

Local Government Unit Name: ______________________________ **Unit Number:** ____________________

Signature of Benefit Administrator: ______________________________ **Date:** ____________________

Form LG03
Revised 10/20

FOR LGHIB USE ONLY

Date: __________

Initials: ________

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2021 CANCELLATION FORM

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)	Date of Birth
Social Security Number	Contract Number

CANCEL ALL INSURANCE COVERAGE FOR THE FOLLOWING REASONS:
Signature not required for the following cancel reasons:

☐ Termination __________________________ ☐ Voluntary ☐ Involuntary
Last Day in Pay Status

☐ Declination of Coverage. (You MUST complete and submit a "Declination of Coverage" form.)

☐ Military Leave Date ____________________________ Attach military papers.

☐ Leave Without Pay - non-payment _________________________

☐ Death _________________________

☐ Retirement Date _____________ Unit does not allow retiree coverage

☐ Retiree Non-Payment _____________________ COBRA **will not** be offered.

☐ For Medicare retirees, the Local Government Unit affirms it has provided the retiree with CMS' 21–day notice of disenrollment

☐ Other Date _________________________ Give explanation: ________________________________

Signature is required to cancel coverage for the following reasons:

☐ Retiree Requested Cancellation __________________

☐ Other - Date _________________________________ Give explanation: ______________________

For units that provide retiree coverage, the following must be completed:

☐ Retirement Date ____________________

☐ Employee is eligible for and was offered LGHIP retiree health insurance coverage, but declined.

Note: By submitting this Cancellation Form, coverage with the LGHIP will be terminated.

AFFIRMATION AND RELEASE

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand that there is mandatory utilization review and I do hereby give permission to release any information necessary to evaluate, administer, and process claims for benefits to any person, entity or representative acting on the LGHIB's behalf.

______________________________________ ______________________________
Employee Signature Date

TO BE COMPLETED BY EMPLOYER

Requested Effective Date of Cancellation*: ____

**LGHIP may revise this date without notifying the unit if the requested date is incorrect*

Local Government Unit Name: ____________________________________ **Unit Number:** ____________________

Signature of Benefit Administrator: ____________________________________ **Date:** ____________________

LOCAL GOVERNMENT HEALTH INSURANCE BOARD | PO BOX 304900 | MONTGOMERY, ALABAMA 36130-4900
(334) 263-8326 • 1-866-836-9137 • FAX: (334) 263-8526

For LGHIB Use Only

☐ Send COBRA _____________

☐ Check Claims _____________

☐ Credit _____________

Form LG22-A
Revised 10/20

FOR LGHIB USE ONLY
Date: ____________
Initials: ____________

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2021 RETIREE YEARS OF SERVICE VERIFICATION
(Full Time Employment Only)

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)	
Social Security Number	Contract Number

Years of Service with a Local Governmental Entity Participating in the Local Government Health Insurance Plan (LGHIP)

Provide the following information listing your years of service with a local government unit participating in the LGHIP.
(If you have service with a governmental unit not participating in the LGHIP, please complete the table on the back of this form)

Date of Hire & Date of Termination	Employer	Employer Address	Employer Telephone Number	Employer Human Resources Contact
Date of Hire: ____________ **Date of Termination:** ____________ _____ Years _____ Months				
Date of Hire: ____________ **Date of Termination:** ____________ _____ Years _____ Months				
Date of Hire: ____________ **Date of Termination:** ____________ _____ Years _____ Months				
____________ **Months**	**Is employee converting accrued leave days to retirement service credit?** ☐ **Yes** ☐ **No** **If so, how much time will be converted? (Insert months in the left column)**			
______ **Total Years** ______ **Total Months**	***If additional space is needed, please include other previous employers on a separate sheet of paper.**			

AFFIRMATION AND RELEASE

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand that there is mandatory utilization review and I do hereby give permission to release any information necessary to evaluate, administer, and process claims for benefits to any person, entity or representative acting on the LGHIB's behalf.

______________________________ **Employee Signature**

______________________________ **Date**

TO BE COMPLETED BY EMPLOYER

______________________________ **Benefit Administrator Signature**

______________________________ **Date**

Form LG22-B
Revised 8/20

Years of Service with a Non-Participating Governmental Entity
(Full-Time Employment Only)

Name (First, Middle Initial, Last)

Social Security Number	Contract Number

If you are less than 60 years of age and have less than 25 years of service with a local government unit participating in the LGHIP, service with a governmental entity that does not participate in the LGHIP may be included in your years of service, if approved by the LGHIB. Provide that information in the table below.

Date of Hire & Date of Termination	Employer	Employer Address	Employer Telephone Number	Employer Human Resources Contact
Date of Hire: ______________________ **Date of Termination:** ______________________ _____ Years _____ Months				
Date of Hire: ______________________ **Date of Termination:** ______________________ _____ Years _____ Months				
Date of Hire: ______________________ **Date of Termination:** ______________________ _____ Years _____ Months				

______ **Total Years** ______ **Total Months**

***If additional space is needed, please include other previous employers on a separate sheet of paper.**

Proof of full-time employment must be attached to this form.

AFFIRMATION AND RELEASE

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand that there is mandatory utilization review and I do hereby give permission to release any information necessary to evaluate, administer, and process claims for benefits to any person, entity or representative acting on the LGHIB's behalf.

________________________________ **Employee Signature**

________________________ **Date**

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
(334) 263-8326 • 1-866-836-9137 • FAX: (334) 263-8526

Form LG04
Revised 10/20

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2021 DECLINATION OF COVERAGE FORM

FOR LGHIB USE ONLY
Date: __________
Initials: ________

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)			Gender	Date of Birth
Social Security Number	**Contract Number**	**Primary Phone Number** ( )	**Work Phone Number** ( )	
Mailing Address		**City**	**State**	**Zip Code**

I, ____, wish to decline coverage in the Local Government Health
(name of local government employee)
Insurance Program. I affirm that I currently have other acceptable health insurance coverage* through ______________________________
(name of employer/company)

My other insurance carrier is:

NAME OF INSURANCE COMPANY:		
ADDRESS:		
CITY:	STATE:	ZIP CODE:
TELEPHONE NUMBER:		

***** You must attach a current letter from employer/insurance carrier verifying coverage with the above-named carrier.**
A copy of your insurance card IS NOT acceptable as proof of coverage.

Employee Status: ☐ Full-time Employee ☐ ACA Eligible (Must submit form LG23) ☐ Elected Official

NOTICE:

Under the Health Insurance Portability and Accountability Act, the LGHIP must offer a special enrollment period in addition to open enrollment for those employees who experience a qualifying event such as loss of their other acceptable coverage or the addition of a dependent. However, since the LGHIP already requires that an employee enroll in the plan when they lose other acceptable coverage, special enrollment will only apply to the following qualifying events not related to loss of coverage:

- the addition of a new dependent through birth, adoption or marriage or
- a substantial change in their other acceptable coverage or
- a substantial change in the cost of their other acceptable coverage.

All employees who lose their other acceptable coverage, whether voluntarily or involuntarily must submit an enrollment form to the LGHIB with coverage effective as of the date coverage is lost.

To be eligible for special enrollment an employee must submit a declination of coverage form with proof of other acceptable coverage. Persons requesting special enrollment must notify the LGHIB in writing within 30 days of the qualifying event.

Notification must include:

1. a letter requesting participation in the special enrollment; and
2. a completed Enrollment form; and
3. if proof of the qualifying event is not submitted with the letter requesting special enrollment and the completed enrollment form, the documentation listing the name, reason and date of loss for each individual affected by loss of coverage (e.g. employment termination on company letterhead) must be submitted within 60 days of the qualifying event.

Full-time Date of Hire:	**Employee Signature:**
Local Government Unit Name:	
Unit Number:	**Date:**
Signature of Benefit Administrator:	

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
(334) 263-8326 • 1-866-836-9137 • FAX: (334) 263-8526

Form LG05
Revised 8/20

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2021 EFFECTIVE DATE OF COVERAGE ELECTION FORM

FOR LGHIB USE ONLY

Date: __________

Initials: ________

As a participant in good standing in the Local Government Health Insurance Program, we elect to have coverage for all future eligible full-time employees to be effective on the date of employment, subject to unit's designated probationary period, for the plan year beginning January 1, 2021.

We understand that this election must be applied uniformly to all new eligible full-time employees.

We further understand that this election is conditional upon approval by the Local Government Health Insurance Board and shall remain in effect until such time as the Local Government Health Insurance Board may determine otherwise.

LOCAL GOVERNMENT UNIT:
EFFECTIVE PLAN YEAR: BEGINNING JANUARY 1, 2021
AUTHORIZED ADMINISTRATOR'S NAME AND TITLE: (please print)
SIGNATURE:
DATE OF ELECTION AGREEMENT:

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
(334) 263-8326 • 1-866-836-9137 • FAX: (334) 263-8526

Form LG11-B
Revised 7/20

FOR LGHIB USE ONLY
Date ______________
Initials ______________

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
General Information Changes

Name of Local Government Unit________________________________ Unit # _______________

Mailing Address

PO Box or Street Address
City, State
Zip, County

Physical Address (if different)

Street Address
City, State
Zip, County

Unit Contacts

Health Insurance Administrator:	
Position/Title:	Phone Number:
Unit Email Address:	
Primary Contact: *(If different than Health Insurance Administrator)*	
Position/Title:	Phone Number:
Unit Email Address:	
Wellness Coordinator: *(If different than Health Insurance Administrator)*	
Position/Title:	Phone Number:
Unit Email Address:	
Wellness Coordinator Location:	
Additional Billing Contact:	
Position/Title:	Phone Number:
Delete Contact Person:	
Form Completed By:	Date:
Signature	

Local Government Health Insurance Board
PO Box 304900
Montgomery, AL 36130-4900
(334) 263-8326 • 1-866-836-9137 • Fax: (334) 263-8526

Form LG12
Revised 08/20

Local Government Health Insurance Board
Provider Screening Form

Prior Authorization (Must complete before the Screening)

I have read the Notice Regarding Wellness Program, understand the policies and procedures set out in the Notice to protect the privacy and confidentiality of my personally identifiable health information, and agree that my personally identifiable health information contained on this Screening Form may be disclosed and/or used in the manner described in the Notice. I further acknowledge that I am participating in this Wellness Program voluntarily in order to identify whether I am at increased risk for certain medical conditions resulting from high blood pressure, obesity, high cholesterol, or diabetes.

Participant Signature [ ]

SECTION 1 (To Be Completed by Participant)

NOTE: The screening must be completed by October 31 and submitted to LGHIB no later than November 15. Incomplete forms will not be processed.

Name (Please print)		Date of Screening	Male ☐ Female ☐	Employee ☐ Spouse ☐ Age: _____
Insurance Number LGB	Group # 30000	Last Four SSN #	Date of Birth	Day Time Phone Number ( )

Do you have (or have you been told you had) any of the following? (Mark all that apply.)

☐ High Cholesterol ☐ High Blood Pressure ☐ Diabetes ☐ N/A

Do you take Medication for any of the following? (Mark all that apply.)

☐ High Cholesterol ☐ High Blood Pressure ☐ Diabetes ☐ N/A

SECTION 2 (To Be Completed by Provider)

NOTE: The requested labs below are the only labs considered for coverage if the participant is only being seen for an LGHIB wellness screening.

☐ **Complete screening deferred due to pregnancy or other physical limitation(s)**

Blood Pressure _____ / _____	**Blood Glucose** _____ **mg/dL**
Total Cholesterol _____ **mg/dL**	**Height** _____**ft.** _____ **in**
HDL Cholesterol _____ **mg/dL**	**Weight** _____
LDL Cholesterol _____ **mg/dL**	**Waist Measurement** _____
Triglycerides _____ **mg/dL**	**Waist/Ht Ratio** _____
	BMI _____

Provider's Name: (Please print) _____

Provider Signature: _____

Provider Address: _____

Provider Phone Number: _____

Please return completed forms to:

LGHIB WELLNESS
PO BOX 304900
MONTGOMERY, AL 36130-4900

Phone: 1.866.836.9137, option 4
Fax: 334.517.9728

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
WELLNESS PROGRAM PRIVACY NOTICE

The Local Government Health Insurance Board (LGHIB) Wellness Program is a voluntary wellness program available to certain local government employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

All active employees, non-Medicare retirees, and spouses, who are covered in group 30000, are eligible to participate in one worksite wellness screening during the wellness qualifying period November 1 through October 31. You can also have your wellness screening performed by your primary care physician; however; all applicable copayments will apply. Participating pharmacies will provide screenings at no charge. For a list of those pharmacies, go to www.lghip.org.

If you choose to participate in the wellness program, you will be asked to complete a biometric screening, which will include a measurement of your blood pressure, height, weight, and waist size. Also, a blood sample will be taken to check your cholesterol, triglycerides, and glucose. You will also be asked whether you have or have had high cholesterol, high blood pressure, or diabetes and whether you take medicine for those conditions. The screening is intended to let you know whether you are at risk for certain medical conditions resulting from high blood pressure, obesity, high cholesterol, or diabetes. You are not required to participate in the wellness program and/or participate in the blood test or any other components of the biometric screening.

The results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks and may also be used by the LGHIB and our business associates to offer you services, such as wellness coaching and/or disease management coaching. You also are encouraged to share your results or concerns with your own doctor.

The LGHIB provides incentives to your employer if your employer meets certain wellness program participation percentages. Your employer may then choose to offer individual incentives for you to participate in the wellness program. However, your employer cannot deny access to health insurance or any package of health insurance benefits or retaliate against you due to your refusal to participate in the wellness program.

Protections from Disclosure of Medical Information

The LGHIB and its business associates are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the LGHIB may use aggregate information the LGHIB collects to design a program based on identified health risks in the workplace, the LGHIB Wellness Program will not disclose your screening results either publicly or to your employer, except as expressly permitted by law. Medical information that personally identifies you, that is provided in connection with the wellness program, will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are nurses, doctors, health coaches and staff from the LGHIB and our business associates in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained by the LGHIB, separate from your employer's personnel records, and no information you provide as part of the wellness program may be used by your employer in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You cannot be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor will you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the LGHIB Privacy Officer at 334-263-8326.

Please return completed forms to:

LGHIB WELLNESS
PO BOX 304900
MONTGOMERY, AL 36130-4900

Phone: 1.866.836.9137, option 4
Fax: 334.517.9728

LG13
Revision Date 8/20

Simplify Life with Payment Options!

Local Government Health Insurance Board
Accounting Department
PO Box 304900; Montgomery, AL 36130-4900

The Local Government Health Insurance Board (LGHIB) offers you three ways to make your unit's premium payments.

Option 1: Automatic Bank Drafts

When you choose to pay through automatic bank drafts, your monthly premium is automatically drafted from your bank account.

- Enrollment is simple. Complete and return the attached form to the address listed above.
- You don't have to worry about due dates, late fees, or the risk of service interruption.
- You save on postage.
- You can pay from either your checking or savings account.
- You may log in to your unit's my.lghip.org account to view your monthly bill.
- Your payment is made on the first day of the month in which your premium payment is due, as shown on your online statement.
- You can change your payment preference or cancel at anytime.
- It's FREE!

Option 2: E-Check

Using the e-check payment option will free you from the worry of late payments and save you on the rising cost of postage and check supplies. You won't have to remember to write your check and mail your payment.

- Payments can be made by e-check through your online account or by calling our office at (334) 263-8326.
- You may log in to your unit's my.lghip.org account to view your monthly bill.
- You decide when to have your bank account charged. Your payments must continue to be current to avoid cancellation.
- It's FREE!

Option 3: Traditional Mail Payment

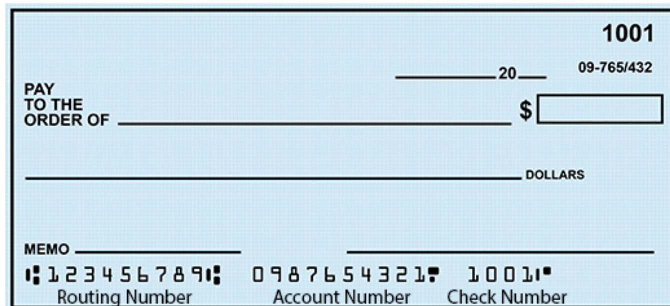
- You may log in to your unit's my.lghip.org account to view your monthly bill.
- Make your payment before the **end of the month**. Your payments must continue to be current to avoid cancellation.

LG13
Revision Date 8/20

Local Government Health Insurance Board
Pre-Authorized Payment Service Authorization Agreement

I authorize the Local Government Health Insurance Board (LGHIB) and the financial institution listed below to electronically debit or credit my account as specified:

Checking or Savings Account Number
Name of Financial Institution
Enter Routing Number



This authority is to remain in full force and effect until LGHIB and my financial institution have received written notification from me of its termination. This should be done in such time and manner as to afford the LGHIB and the financial institution a reasonable opportunity to act on it.

UNIT INFORMATION	**ACCOUNT HOLDER INFORMATION**
LGHIB Unit Number	**(If different from unit)**
LGHIB Unit Name (please print)	**Account Holder Name (please print)**
Authorized Signature ____________________ ____________________ **Date**	**Account Holder Signature** ____________________ ____________________ **Date**

Please staple a voided check to this form to verify account information for withdrawals from your checking account or a deposit slip for withdrawals from a savings account.

Return this form to: **Local Government Health Insurance Board**
Accounting Department
PO Box 304900
Montgomery, AL 36130-4900
accounting@lghip.org

XIX. Southland LGHIP Voluntary Insurance Plan

A. Summary of Benefit Plans

Each eligible participant may choose coverage through the Southland LGHIP Voluntary Insurance Plan (Southland). Southland offers voluntary dental and vision coverage. The below plan is effective January 1, 2021.

B. Eligibility and Enrollment Rules

1. Eligible Participants

All eligible participants who are eligible for coverage through the LGHIP are eligible to participate in the Southland plan.

2. Eligible Dependents

The same dependent eligibility rules apply to the Southland plan except that the eligible participant may cover their spouse or other dependents if they are insured or if they are eligible to be insured as an eligible participant in the LGHIP.

3. Eligible Participant Enrollment

Eligible participants may enroll for coverage at any time. Coverage will be effective the first day of the second month following receipt by the LGHIB of their enrollment form.

Enrollment in this plan requires a minimum participation of 12 months. Eligible participants may cancel coverage in the Plan during the next open enrollment after the 12-month minimum participation period has been met.

4. Family Coverage Enrollment

Initial Enrollment/New Eligible Participants

New eligible participants may elect to have dependent coverage begin on the date their coverage begins.

Acquiring New Dependent

A newly acquired dependent may be enrolled if the LGHIB is notified within 60 days of acquiring the new dependent through marriage, birth, adoption, or custody of a grandchild, niece or nephew. The effective date of coverage will be the first day of the next month after the Southland Change Form is submitted to the LGHIB office. If the LGHIB is notified of a new dependent after the 60 days, the request will be denied and the eligible participant will need to reapply during the annual open enrollment.

Appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.) must be submitted to the LGHIB. **Note:** to ensure that enrollment deadlines are met, change forms should be submitted to the LGHIB even if all the required documentation is not available.

If the required documentation is not submitted with the Southland Enrollment/Change Form, the LGHIB will send a notice to the eligible participant that the required documentation must be submitted within 60 days of the date of the letter. If documentation is not submitted to the LGHIB within those 60 days, the request to add dependent

coverage will be denied.

5. **Open Enrollment**
   There shall be an Annual Open Enrollment held in November (for coverage to be effective January 1) of each year to allow eligible participants to add dependents or family coverage. If an eligible participant wishes to add dependents or add family coverage during open enrollment, a change form (Form LG08) must be filled out and submitted to the LGHIB. Enrollment in this plan requires a minimum participation of 12 months. Eligible participants may cancel Southland coverage the next open enrollment after the 12-month minimum participation has been met.

   Forms must be completed in November with an effective date of January 1 indicated on the form and received in the LGHIB office by November 30. If an eligible participant does not want to make changes during open enrollment, no paperwork is necessary.

6. **Cancellation of Dependent/Family Coverage**
   Eligible participants who enrolled with a January 1, 2020 effective date of coverage may cancel dependent/ family coverage during Open Enrollment for a January 1, 2021 effective date.

   Dropping dependent coverage requires a qualifying event (death, divorce, or otherwise losing dependent status) outside Open Enrollment. Coverage will be canceled at the end of the month of the qualifying event. The LGHIB may require proof of the qualifying event.

7. **Leave without Pay/Military Leave**
   Enrollment in this plan requires a minimum participation of 12 months. If an employee returns to work and did not continue their coverage while on leave without pay or military leave, they will be re-enrolled in the Southland plan to satisfy the 12-month requirement. The employee may cancel the Southland plan coverage the next Open Enrollment after the 12-month minimum participation has been met.

8. **See COBRA Section**

C. Billing

Premiums for participation in the Southland plan will be reflected on the regular billing.

D. Forms

1. **Enrollments (LG07)**
   To enroll, a Southland Plan Enrollment form (form LG07 - See Southland Appendix) must be completed and signed by the eligible participant.

2. **Changes (LG08)**
   To add/drop family coverage to an existing contract, a Southland plan Change Form (form LG08 - See Southland Appendix) must be completed and signed by the eligible participant.

   To make changes to the existing plan (name and/or address changes), a change form must be completed and signed by the eligible participant.

3. **Cancellations (LG09)**
   To cancel all coverage, a Southland plan Cancellation form (form LG09 – See Southland Appendix) must be completed and signed by the eligible participant.
   NOTE: All forms must be verified and signed by the designated payroll/personnel officer.

XX. Southland LGHIP Voluntary Insurance Plan Appendix

Form LG07
Revised 10/20

FOR LGHIB USE ONLY

Date: ____________

Initials: __________

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2021 ENROLLMENT FORM
SOUTHLAND VOLUNTARY INSURANCE

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)			Gender
Social Security Number			Date of Birth
Mailing Address			
City	State	ZIP Code	
Primary Telephone Number ( )	Work Telephone Number ( ) Ext:		
E-mail Address:			

CHECK PLAN ELECTED

☐ Vision

☐ Dental

☐ Vision and Dental

A minimum enrollment of 12 months required for employees/ dependents without qualifying status change.

Employment Status (Check One)

☐ Full-time Employee ☐ ACA Eligible (Must submit form LG23) ☐ Elected Official ☐ Retired (Not Medicare Participant) ☐ Retired (Medicare Participant)

NOTE: BY LISTING FAMILY MEMBERS BELOW YOU ARE APPLYING FOR AND REQUESTING FAMILY COVERAGE.

First Name Initial Last Name	Documentation is required. See back of form. Relationship to Employee		Date of Birth	Social Security Number
	☐ Male Spouse	☐ Female Spouse		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Grandson ☐ Nephew	☐ Granddaughter ☐ Niece		
	☐ Grandson ☐ Nephew	☐ Granddaughter ☐ Niece		

AFFIRMATION AND RELEASE

I understand and acknowledge that only eligible dependents may be added to my coverage. An ex-spouse and ex-stepchildren are ineligible for coverage and cannot be maintained as dependents under my family coverage regardless of a judgment or divorce decree requiring me to provide health care for my ex-spouse or ex-stepchildren. I understand and acknowledge that an ex-spouse and ex-stepchildren must be removed from coverage effective the first day of the month following the date of the divorce decree and it is my responsibility to notify the LGHIB immediately when the eligibility of a covered dependent changes. If it is determined that an act on my part (such as adding an ineligible person to coverage) or omission (such as failing to remove a person no longer eligible for coverage) results in or contributes to the payment of claims for persons ineligible for coverage, I will be personally responsible for all such overpayments and may be subject to disqualification from coverage under the plan.

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand that there is mandatory utilization review and I do hereby give permission to release any information necessary to evaluate, administer, and process claims for benefits to any person, entity or representative acting on the LGHIB's behalf.

______________________________ Employee Signature

______________________________ Date

TO BE COMPLETED BY EMPLOYER

Requested Effective Date*: ______________________________

**LGHIP may revise this date without notifying the unit if the requested date is incorrect*

Local Government Unit Name: ______________________________ **Unit Number:** ______________

Signature of Benefit Administrator: ______________________________ **Date:** ______________

* A "qualifying event" is birth, marriage, adoption, death, divorce, or otherwise losing dependent status.
Dependent documentation is required before dependents can be added to coverage.

GENERAL INFORMATION

Eligible Dependent
(Appropriate documentation must be attached.)

The term “dependent” includes the following individuals, subject to appropriate documentation (Social Security number, marriage documentation, birth documentation, court decree, etc.):

1. The eligible participant’s spouse (excludes a divorced spouse)

2. A child under age 26, only if the child is:
   a) The eligible participant’s son or daughter
   b) A child legally adopted by the eligible participant or his or her spouse
   c) The eligible participant’s stepchild

3. Grandchild, niece or nephew of the eligible participant or his or her spouse:
   a) under 19 years of age, and
   b) for whom the court has granted custody to the eligible participant or his or her spouse

4. An incapacitated dependent over age 25 will be considered for coverage provided dependent:
   a) is unmarried,
   b) is permanently mentally or physically disabled or incapacitated,
   c) is so incapacitated as to be incapable of self-sustaining employment,
   d) is dependent upon the eligible participant for 50% or more financial support,
   e) is otherwise eligible for coverage as a dependent except for age,
   f) had the condition prior to the dependent’s 26th birthday, and
   g) is not eligible for any other group insurance benefits

Neither a reduction in work capacity nor inability to find employment is, of itself, evidence of eligibility. If a mentally or physically disabled dependent is employed, the extent of his or her earning capacity will be evaluated.

To apply, contact the LGHIB to obtain an Incapacitated Dependent Certification Form. Final approval of incapacitation will be determined by Medical Review. Proof of disability must be provided to the LGHIB within 60 days from the date the child would otherwise cease to be covered because of age.

These requirements must be met as a minimum threshold in order to be considered for incapacitation status. The LGHIB shall make the decision as to whether an application for incapacitated status will be accepted. **NOTE:** The LGHIB reserves the right to periodically recertify incapacitation.

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
(334) 263-8326 • 1-866-836-9137 • FAX: (334) 263-8526

Form LG08
Revised 10/20

FOR LGHIB USE ONLY
Date: _____________
Initials: ___________

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2021 CHANGE FORM
SOUTHLAND VOLUNTARY INSURANCE

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)	Social Security Number	Contract Number

Please indicate the Southland Plan that you'd like to request a change for:

☐ Vision ☐ Dental ☐ Vision & Dental

(Enrollment minimum of 12 months required without qualifying status change)

DROP DEPENDENT COVERAGE
Must have a qualifying event to add/drop dependent coverage outside Open Enrollment.* (Must select one)

☐ Change from Family to Single Coverage
☐ Cancel dependent(s) listed below from Family Coverage

ADDITIONS – PROVIDE DOCUMENTATION
Must have a qualifying event to add/drop dependent coverage outside Open Enrollment.* (Must select one)

☐ Change from Single to Family Coverage. Add dependent(s)**
☐ Add dependent(s) listed below to Family Coverage **

** Please read important information on the back.

REASON FOR CANCEL (Must select one) **MONTH/DAY/YEAR**

☐ Death ________________________
☐ Divorce ________________________
Attach divorce decree
☐ Dependent no longer eligible ________________________
Explain: ____________________________________
☐ Open Enrollment: ________________________
Effective date on form must be 1/1/21
☐ Other: ____________________________________
Explain: ____________________________________

REASON FOR ADDITION (Must select one) **MONTH/DAY/YEAR**

☐ Marriage ________________________
☐ Birth of Child ________________________
☐ Adoption of Child ________________________
☐ Open Enrollment: ________________________
Effective date on form must be 1/1/21
☐ Other: ________________________
Explain: ____________________________________

First Name Initial Last Name	Documentation is required. See back of form. Relationship to Employee		Date of Birth	Social Security Number
	☐ Male Spouse	☐ Female Spouse		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Grandson ☐ Nephew	☐ Granddaughter ☐ Niece		
	☐ Grandson ☐ Nephew	☐ Granddaughter ☐ Niece		

AFFIRMATION AND RELEASE

I understand and acknowledge that only eligible dependents may be added to my coverage. An ex-spouse and ex-stepchildren are ineligible for coverage and cannot be maintained as dependents under my family coverage regardless of a judgment or divorce decree requiring me to provide health care for my ex-spouse or ex-stepchildren. I understand and acknowledge that an ex-spouse and ex-stepchildren must be removed from coverage effective the first day of the month following the date of the divorce decree and it is my responsibility to notify the LGHIB immediately when the eligibility of a covered dependent changes. If it is determined that an act on my part (such as adding an ineligible person to coverage) or omission (such as failing to remove a person no longer eligible for coverage) results in or contributes to the payment of claims for persons ineligible for coverage, I will be personally responsible for all such overpayments and may be subject to disqualification from coverage under the plan.

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand that there is mandatory utilization review and I do hereby give permission to release any information necessary to evaluate, administer, and process claims for benefits to any person, entity or representative acting on the LGHIB's behalf.

____________________________________ ____________________________
Employee Signature Date

TO BE COMPLETED BY EMPLOYER

Requested Effective Date of Change*: ____
**LGHIP may revise this date without notifying the unit if the requested date is incorrect*

Local Government Unit Name: ____________________________________ **Unit Number:** ________________

Signature of Benefit Administrator: ____________________________________ **Date:**__________________

* A "qualifying event" is birth, marriage, adoption, death, divorce, or otherwise losing dependent status. **Dependent documentation is required before dependents can be added to coverage.**

GENERAL INFORMATION

Eligible Dependent
(Appropriate documentation must be attached.)

The term “dependent” includes the following individuals, subject to appropriate documentation (Social Security number, marriage documentation, birth documentation, court decree, etc.):

1. The eligible participant’s spouse (excludes a divorced spouse)

2. A child under age 26, only if the child is:
   a) The eligible participant’s son or daughter
   b) A child legally adopted by the eligible participant or his or her spouse
   c) The eligible participant’s stepchild

3. Grandchild, niece or nephew of the eligible participant or his or her spouse:
   a) under 19 years of age, and
   b) for whom the court has granted custody to the eligible participant or his or her spouse

4. An incapacitated dependent over age 25 will be considered for coverage provided dependent:
   a) is unmarried,
   b) is permanently mentally or physically disabled or incapacitated,
   c) is so incapacitated as to be incapable of self-sustaining employment,
   d) is dependent upon the eligible participant for 50% or more financial support,
   e) is otherwise eligible for coverage as a dependent except for age,
   f) had the condition prior to the dependent’s 26th birthday, and
   g) is not eligible for any other group insurance benefits

Neither a reduction in work capacity nor inability to find employment is, of itself, evidence of eligibility. If a mentally or physically disabled dependent is employed, the extent of his or her earning capacity will be evaluated.

To apply, contact the LGHIB to obtain an Incapacitated Dependent Certification Form. Final approval of incapacitation will be determined by Medical Review. Proof of disability must be provided to the LGHIB within 60 days from the date the child would otherwise cease to be covered because of age.

These requirements must be met as a minimum threshold in order to be considered for incapacitation status. The LGHIB shall make the decision as to whether an application for incapacitated status will be accepted. **NOTE:** The LGHIB reserves the right to periodically recertify incapacitation.

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
(334) 263-8326 • 1-866-836-9137 • FAX: (334) 263-8526

Form LG09
Revised 10/20

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2021 CANCELLATION FORM
SOUTHLAND VOLUNTARY INSURANCE
OPEN ENROLLMENT

FOR LGHIB USE ONLY
Date: __________
Initials: ________

SUBSCRIBER INFORMATION **(Please print or type.)**

Name (First, Middle Initial, Last)	
Social Security Number	Contract Number

CANCEL INSURANCE COVERAGE:
(Enrollment minimum of 12 months required without qualifying status change.)

___________ **Vision**

___________ **Dental**

___________ **Vision & Dental**

___________ **Termination of Employment. You must complete a Cancellation Form.**

AFFIRMATION AND RELEASE

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand that there is mandatory utilization review and I do hereby give permission to release any information necessary to evaluate, administer, and process claims for benefits to any person, entity or representative acting on the LGHIB's behalf.

________________________________ Employee Signature

________________________ Date

TO BE COMPLETED BY EMPLOYER

Effective Date of Cancellation: 01/01/2021

Local Government Unit Name: ____________________________________ **Unit Number:** ______________

Signature of Benefit Administrator: ____________________________________ **Date:**________________

*A "qualifying event" is birth, marriage, adoption, death, divorce, or otherwise losing dependent status.

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
(334) 263-8326 • 1-866-836-9137 • FAX: (334) 263-8526