Administrative Procedures Guide

Local Government Health Insurance Program

2014

STATE OF ALABAMA
STATE EMPLOYEES' INSURANCE BOARD

Local Government Health Insurance Plan

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Joe N. Dickson
Chairman

William L. Ashmore
Chief Executive Officer

October 11, 2013

MEMORANDUM

TO: ALL LOCAL GOVERNMENT UNITS

FROM: William L. Ashmore
Chief Executive Officer

SUBJECT: Local Government Health Insurance Program

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

The first part of this guide contains application instructions for new groups to enroll in the Local Government Program and criteria for establishing eligibility. Also enclosed are summaries of benefits, premiums, enrollment forms, and explanations of billing procedures. Please read and follow all instructions carefully.

We welcome this opportunity to offer you the Local Government Health Insurance Program 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 contact a member of the Local Government staff at 334.263.8326 or 1.866.836.9137.

WLA/ss

Local Government

Health Insurance Program Guide

Effective: January 1, 2014

Administered By:
State Employees' Insurance Board
Post Office Box 304900
Montgomery, Alabama 36130-4900
Phone: 334.263.8326
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Fax: 334.517.9778
Website: www.alseib.org

TABLE OF CONTENTS

I. GROUP APPLICATION AND ENROLLMENT

A. Code of Alabama 1975, Section 36-29-14

Any agency of the state, or any governmental entity, body, or subdivision thereto, any county, any municipality, any municipal foundation, any fire or water district, or authority, or cooperative, any regional planning and development commission established pursuant to Sections 11-85-50 through 11-85-73, that is not and was not for the twelve (12) months immediately preceding the date of application to participate in any plan created pursuant to the provisions of this article a member of an existing government sponsored health insurance program, formed under the provisions of Section 11-26-2, the Association of County Commissions of Alabama or 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, any railroad authority organized pursuant to Chapter 13, Title 37, or any solid waste disposal authority organized pursuant to Chapter 89A, Title 11 may, by resolution legally adopt to conform to rules prescribed by the State Employees' Insurance Board, may elect to have its officers, members, employees, and retired employees become eligible for health insurance coverage under the State Employees' Insurance Board without any liability to the state or the State Employees' Health Insurance Plan.

Acceptance of the employees identified above shall be optional with the State Employees' Insurance Board.

Employees, officers and retirees who are eligible for health insurance pursuant to this section shall be entitled to coverage and benefits as designated by the State Employees' Insurance Board.

Any portion of the cost of the insurance coverage as determined by the State Employees' Insurance Board for the employees, officers and retirees and their dependents pursuant to this section may be paid by the employer.

The chief fiscal officer of each employer shall remit to the State Employees' Insurance Board the amount of premiums required for employee and dependent coverage under this section. The employer shall furnish the necessary information to the State Employees' Insurance Board.

The agreement of any employer to have its employees, officer and retirees to be covered under the health insurance plan provided by the State Employees' Insurance Board may be revoked only by complying with the following provisions:

The employer, by resolution of the governing body, shall signify its intention and desire to withdraw from such plan in writing and by delivering a copy of such resolution by certified mail to the State Employees' Insurance Board no later than six months prior to the effective date of withdrawal. Any employer that withdraws from participation in such plan shall be responsible for paying its claims incurred prior to the date of withdrawal, but not reported and paid prior to the date of withdrawal. The withdrawing employer shall also be liable for interest which will accrue at a rate of 1.5 percent per month on any monies due to the State Employees' Insurance Board which are over 30 days past due. Any organization that provides or administers health

insurance benefits through the Local Government Health Insurance Program shall not provide or administer health insurance benefits to any entity which withdraws from the Local Government Health Insurance Program for a period of two years from the effective date of withdrawal. Any group that withdraws from participation shall serve a three-year waiting period from the effective date of the group's termination before such group (in good standing) may apply for re-enrollment into the Program.

The State Employees' Insurance Board shall promulgate such rules and regulations as may be necessary for the effective administration of the provisions of this section. (Title 36, Chapter 29, *Code of Alabama 1975*, as amended). The SEIB shall have absolute discretion and authority to interpret the terms of the plan and reserves the right to change the terms and/or end the plan at any time and for any reason.

B. Group Enrollment

The governing body of any local government unit may petition, by resolution, the State Employees' Insurance Board (hereafter referred to as "SEIB") at any time for acceptance into the Local Government Health Insurance Program, (hereafter referred to as "Program"). Upon acceptance of a groups' contract by SEIB, the group's effective date shall be the first day of the second full month following approval. See Section IV, H for complete details.

C. Application Fee

A $50-per-employee (minimum $100) application fee must be submitted by the local government unit along with the application package. The fee covers the equity buy-in into the Program's reserve, accumulated by existing units. This amount is due at time of application and is non-refundable. Application fee is subject to change. Contact the SEIB for current rate.

II. SUMMARY OF BENEFIT PLANS

Each employee is eligible for coverage by Blue Cross and Blue Shield of Alabama. Dental coverage is optional to the local government unit. The unit, as a whole, may elect dental coverage or not elect dental coverage.

III. PREMIUMS

Each local government unit is classified into either the “standard” or “preferred” category for calculating active employee premiums. The criteria used to determine a unit’s premium category is as follows:

A. Premium Categories

Standard

Units meeting one or more of the following criteria:

- New units with less than two (2) complete years of claims experience during the review period. For calendar year 2014, units enrolled after January 1, 2012 were classified in the standard premium category.

- Units, who enroll retirees in the Local Government Health Insurance Program, with less than 5% retiree participation in the unit's total enrollment.

- Units with less than 30% wellness participation were classified in the standard premium category during the qualifying period of June 1, 2012 to May 31, 2013. The qualifying period for the 2015 discount will be June 1, 2013 to May 31, 2014.

Preferred

Units who do not meet one of the above criteria for the standard premium category are classified in the preferred premium category for active employees.

Retiree

Retiree premiums are calculated based on the claims experience for retirees and do not use standard or preferred premium categories.

B. Premium Discount

Local Government units that have 80% or greater wellness participation within the wellness qualifying period will receive a $10 premium discount per active employee each month. Employees may participate through a worksite wellness screening or by having a provider screening form (LG12) completed by their health care provider. The form is located on the SEIB website and included in this book.

Monthly premiums effective January 1, 2014

Blue Cross Blue Shield

Active Rates

Rate		Preferred Rates			Standard Rates		
		Employee Share	Dependent Share	Total	Employee Share	Dependent Share	Total
A	Active subscriber	$ 396		$ 396	$ 432		$ 432
B	Active subscriber & dependent	$ 396	$ 567	$ 963	$ 432	$ 657	$ 1,089
J	Active subscriber (no dental)	$ 378		$ 378	$ 414		$ 414
K	Active subscriber & dependent (no dental)	$ 378	$ 541	$ 919	$ 414	$ 631	$ 1,045

Monthly premiums effective January 1, 2014

Blue Cross Blue Shield

Retiree Rates

Rate		Retiree Share	Dependent Share	Total
H	Retired subscriber (not Medicare)	$ 817		$ 817
I	Retired subscriber (not Medicare) & dependent (not Medicare)	$ 817	$ 685	$ 1,502
C	Retired subscriber (not Medicare) & dependent (Medicare)	$ 817	$ 402	$ 1,219
L	Retired subscriber (not Medicare) (no dental)	$ 799		$ 799
M	Retired subscriber (not Medicare) & dependent (not Medicare) (no dental)	$ 799	$ 659	$ 1,458
N	Retired subscriber (not Medicare) & dependent (Medicare) (no dental)	$ 799	$ 376	$ 1,175
D	Retired subscriber (Medicare)	$ 394		$ 394
E	Retired subscriber (Medicare) & dependent (not Medicare)	$ 394	$ 566	$ 960
F	Retired subscriber (Medicare) & dependent (Medicare)	$ 394	$ 402	$ 796
O	Retired subscriber (Medicare) (no dental)	$ 376		$ 376
P	Retired subscriber (Medicare) & dependent (not Medicare) (no dental)	$ 376	$ 540	$ 916
Q	Retired subscriber (Medicare) & dependent (Medicare) (no dental)	$ 376	$ 376	$ 752

Monthly premiums effective January 1, 2014

Blue Cross Blue Shield

COBRA Rates

Rate		Preferred Rates			Standard Rates		
		Employee Share	Dependent Share	Total	Employee Share	Dependent Share	Total
A	Active subscriber	$ 404		$ 404	$ 441		$ 441
B	Active subscriber & dependent	$ 404	$ 578	$ 982	$ 441	$ 670	$ 1,111
J	Active subscriber (no dental)	$ 386		$ 386	$ 422		$ 422
K	Active subscriber & dependent (no dental)	$ 386	$ 552	$ 938	$ 422	$ 644	$ 1,066
U	COBRA Disabled (Single)	$ 594		$ 594	$ 648		$ 648
W	COBRA Disabled (Family)	$ 594	$ 578	$ 1,172	$ 648	$ 670	$ 1,318
U	COBRA Disabled (Single) (no dental)	$ 567		$ 567	$ 621		$ 621
W	COBRA Disabled (Family) (no dental)	$ 567	$ 552	$ 1,119	$ 621	$ 644	$ 1,265

Monthly premiums effective January 1, 2014

Blue Cross Blue Shield

Retiree COBRA Rates

Rate		Retiree Share	Dependent Share	Total
H	Retired subscriber (not Medicare)	$ 833		$ 833
I	Retired subscriber (not Medicare) & dependent (not Medicare)	$ 833	$ 699	$ 1,532
C	Retired subscriber (not Medicare) & dependent (Medicare)	$ 833	$ 410	$ 1,243
L	Retired subscriber (not Medicare) (no dental)	$ 815		$ 815
M	Retired subscriber (not Medicare) & dependent (not Medicare) (no dental)	$ 815	$ 673	$ 1,488
N	Retired subscriber (not Medicare) & dependent (Medicare) (no dental)	$ 815	$ 383	$ 1,198
D	Retired subscriber (Medicare)	$ 402		$ 402
E	Retired subscriber (Medicare) & dependent (not Medicare)	$ 402	$ 577	$ 979
F	Retired subscriber (Medicare) & dependent (Medicare)	$ 402	$ 410	$ 812
O	Retired subscriber (Medicare) (no dental)	$ 383		$ 383
P	Retired subscriber (Medicare) & dependent (not Medicare) (no dental)	$ 383	$ 550	$ 933
Q	Retired subscriber (Medicare) & dependent (Medicare) (no dental)	$ 383	$ 383	$ 766

IV. INSTRUCTIONS FOR APPLICATION PACKAGE

A. Complete the General Information Form as follows:

1. Enter the nine-digit Federal Identification Number.
2. Enter the name of the county, municipality, fire or water district or authority, or other group who is eligible for enrollment in the Program.
3. Enter the complete address, including post office box number, where the billing statements and other correspondence related to the Program are to be mailed.
4. Enter the insurance carrier who currently administers the health insurance plan.
5. Enter the person's name, title, telephone number and e-mail address that will be primarily responsible for managing and making decisions concerning the Program.
6. Enter the person's name, title, telephone number and e-mail address that should receive the monthly invoices and be contacted for any enrollment/billing information.
7. Enter the name of an additional employee who may be contacted for information when the primary unit contact is unavailable.
8. Enter the name of the person completing the form.
9. After local governments are enrolled into the Program, the General Information Changes form will be used to revise enrollment information. When a change occurs in the address, local government health insurance administrator, contact person for billing purposes, or the telephone number, submit a new General Information Changes form with the appropriate changes

B. Distribute blank Local Government Health Insurance Enrollment Forms and Declination of Coverage Forms to all eligible participants. These forms are included in this Administrative Guide and can be reproduced as needed. After these forms are completed, collect them and submit them to the SEIB along with the rest of the enrollment package.

C. Complete the Participation Form as follows:

1. Enter the name of the county, municipality, fire or water district or authority, or other group who is eligible for enrollment in the Program.
2. Enter the total number of full-time permanent employees, elected officers and retirees who enroll in or decline participation in the Program. Eligible participants are identified in the Eligibility & Enrollment Rules section.
3. Enter the total number of employees who completed the enrollment forms and are being enrolled in the Program for **single** coverage.
4. Enter the total number of employees who are enrolled for **family** coverage.
5. Enter the percentage of the employee premium for single coverage paid by the employer and the percentage paid by the employee.
6. Enter the percentage of the dependent premium for family coverage paid by the employer and the percentage paid by the employee.
7. Circle Yes or No for the dental option. For employees to receive dental benefits, the local government unit must choose for all employees to have dental benefits.
8. Circle Yes or No whether your Local Government Unit will allow retirees without Medicare to continue on insurance.
9. Circle Yes or No whether your Local Government Unit will allow retirees with Medicare to continue on insurance.

10. Circle Yes or No whether your Local Government Unit will allow elected officials to participate.

We also require that a complete listing of all employee names and social security numbers by department be included with this application. This is for informational purposes and may be used to verify employment status.

D. After carefully studying all information and requirements relating to the Program, the county, municipality, fire or water district or authority, or other eligible group should adopt and approve a resolution to officially apply for enrollment in the Program. (A resolution is included.)

E. Submit the following documents:
1. General Information form
2. Participation form
3. Resolution
4. Application fee
5. An Enrollment Form, with documentation, or Declination of Coverage Form, with acceptable proof, for each eligible participant.
6. A listing by department of employee names and Social Security numbers.
7. A listing of COBRA participants.

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

F. If the SEIB accepts the application for enrollment into the Program, a certificate of participation will be mailed to the eligible group. If the application is not accepted, the reason for not being accepted will be forwarded to the group.

G. SEIB will periodically conduct reviews of those groups accepted into the Program to ensure conformity with the rules and regulations governing the Program.

H. If the SEIB receives, and approves, complete enrollment packages on or before the 20th of the month, the group contract's effective date shall be the first day of the second full month following the receipt and approval. For example, complete packets received on January 20 would be eligible for an effective date of March 1. Complete packets received on January 21 would be eligible for an effective date of April 1. Groups with more than 300 subscribers should contact the SEIB for effective date information.

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
General Information for Initial Enrollment

Federal ID Number _____

Name of Local Government Unit_____

Mailing Address for Billing _____

_____
City State

_____
ZIP Code County

_____
Street Address

Prior Insurance Carrier _____

Health Insurance Administrator _____
(If different from contact person for billing)

Position/Title _____Telephone _____

Unit E-Mail Address _____

Contact Person for Billing _____

Position/Title _____Telephone _____

Unit E-Mail Address _____

Additional Contact Person_____

Form Completed By: _____Date_____

FOR SEIB USE ONLY. DO NOT WRITE IN THIS SPACE.

LGHIP UNIT # _____ **DATE**_____

EFFECTIVE DATE_____ **DENTAL**_____

RETIREES (NON-MEDICARE)_____ **(MEDICARE)** _____

NEW HIRES _____

ELECTED OFFICIALS _____

ENROLL _____ **DECLINE** _____

Form LG11-B

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
General Information Changes

Name of Local Government Unit_____ Account # _____

Mailing Address for Billing _____

_____
City State

_____
ZIP Code County

_____
Street Address

Health Insurance Administrator _____
(If different from contact person for billing)

Position/Title _____Telephone _____

Unit E-Mail Address _____

Contact Person for Billing _____

Position/Title _____Telephone _____

Unit E-Mail Address _____

Additional Contact Person _____

Delete Contact Person _____

Form Completed By: _____Date _____

FOR SEIB USE ONLY. DO NOT WRITE IN THIS SPACE.

LGHIP UNIT # _____ **DATE**_____

EFFECTIVE DATE_____ **DENTAL**_____

RETIREES (NON-MEDICARE)_____ **(MEDICARE)** _____

NEW HIRES _____

ELECTED OFFICIALS _____

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 _____ Not 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. Retirees YES NO

9. Retirees with Medicare YES NO

10. Elected officials YES NO

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

_____ _____

Signature of Insurance Clerk Date

RESOLUTION

WHEREAS, _____wishes to participate in the Local Government Health Insurance Program established by *Code of Alabama 1975*, Section 36-29-14, as amended; and

WHEREAS, we agree to abide by the rules and procedures promulgated by the State Employees' Insurance Board for the Local Government Health Insurance Program; and

WHEREAS, the information submitted for enrollment into this 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 that have accumulated in prior years by existing eligible groups;

NOW, THEREFORE, BE IT RESOLVED, that _____does hereby submit this application package to participate in the Local Government Health Insurance Program, as administered by the State Employees' Insurance Board.

ADOPTED AND APPROVED THIS DATE: _____

_____

Authorized Person's Signature

_____

Type or Print Name & Title

V. ELIGIBILITY AND ENROLLMENT RULES

A. Minimum Employee Participation

All current and future eligible active employees, and elected officers if covered by the unit, must be enrolled for acceptance into the Program unless proof of other group insurance is provided. All employees who decline coverage must sign a "Declination of Coverage" form (LG04) and submit acceptable proof of other group coverage.

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 group coverage. If an eligible employee is covered by other group coverage, that employee must provide a “Declination of Coverage” form to the SEIB with proof of other group coverage. If an employee has declined coverage in the LGHIP and later loses their other group coverage, that eligible employee must immediately notify the SEIB and enroll in the LGHIP. If the eligible employee does not notify the SEIB and does not enroll in the LGHIP, both the eligible employee and the unit will be liable and will be back-billed to the date the eligible employee should have been enrolled. If the premiums for the back-billing are not paid, the unit may be cancelled from participation in the LGHIP.

If the unit elects to provide insurance coverage for its retirees, such coverage must be offered to all current and future retirees. The SEIB may periodically require and verify an employment census.

B. Eligible Participants

1. Employee - an employee must be a ***permanent active full-time employee***, who is not on layoff or leave of absence. An employee must be employed in a bona fide employer-employee relationship, working 30 hours (minimum) per week. <u>You are not eligible for coverage</u> if you are classified as an employee on a temporary, part-time, seasonal, intermittent, emergency or contract basis, or if employment is known to be for a period of one year or less.

   Elected officers of a local government unit are also eligible while in office. Elected officers will be classified for insurance purposes as active employees.

2. Retiree - a retired employee may elect to continue coverage under a plan designated by the SEIB if:
   - retiree has 25 years of creditable service, regardless of age, or
   - retiree has 10 years of service and:
     - is 60 years old or
     - is determined to be disabled by the Social Security Administration or the Retirement Systems of Alabama

   An elected official retiring from a unit that offers health insurance coverage to its retirees, but who is not eligible to receive the same pension benefits from the unit due to local, state or federal law as full-time employees may be eligible to elect to continue coverage under a plan designated by the SEIB if the retired official:
   - has at least 25 years of service with the unit he or she is retiring from, regardless of age, and

- has been enrolled in the LGHIP for at least 10 years prior to the date of retirement. (If unit has been enrolled in the LGHIP less than 10 years, the elected official must have been enrolled from the unit's inception date.)

Before the SEIB will consider coverage for a retired elected official, the unit must submit an elected official retiree enrollment form (Form LG10), which will include references to the local state or federal law that prohibits pension benefits and certify that no local, state or federal law will be violated by continuing the retired elected official's health insurance coverage.

Individuals enrolling in the LGHIP after January 1, 2005 must:

- have been enrolled in the local government health plan for 10 years prior to the date of retirement, or
- if unit has been enrolled less than 10 years, the employee must have been enrolled continuously from the unit's inception date.

Any retired employee who does not meet the above requirements will be considered a termination.

The local government unit makes the determination of allowing eligible retirees to continue on the Program. The unit also makes the determination to continue retiree coverage until Medicare eligible or indefinitely.

C. Eligible Dependents

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

1. Your spouse (excludes divorced or common law spouse)
2. A child under age 26, only if the child is:
   a. Your son or daughter (A court decree establishing paternity will be temporarily effective for 60 days, at which time an amended birth certificate listing the father's name will be due.)
   b. A child legally adopted by you (including any probationary period during which the child is required to live with you)
   c. Your stepchild
   d. Your grandchild, niece or nephew for whom the court has granted custody to you or your spouse.

3. 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 subscriber for 50% or more support,
   e. is otherwise eligible for coverage as a dependent except for age,
   f. the condition must have occurred 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 working, despite his disability, the extent of his earning capacity will be evaluated.

To apply, contact the SEIB 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 SEIB 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 except for age:

i. when a new employee requests coverage for an incapacitated dependent within 60 days of employment, or

ii. when an employee's incapacitated dependent is covered under a spouse's employer group health insurance for at least 18 consecutive months and:

- the employee'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,
- a change form is submitted to the SEIB within 30 days of the incapacitated dependent's loss of other coverage, and
- Medical Review approved incapacitation status.

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

Exclusion: You may not cover your wife, husband or other dependents if they are insured or if they are eligible to be insured as an active employee in the Local Government Health Insurance Program.

D. Initial Employee Enrollment

Eligible employees, elected officers, retirees and dependents who make application on or before the effective date of the Group Contract will be enrolled for coverage as of the effective date of the Group Contract. All eligible employees, elected officials and retirees must either elect or decline coverage.

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.

<u>This rule applies to county commissions only</u>: If a county commission chooses to cover elected officials, all county commissioners must enroll in the LGHIP or decline coverage and submit proof of other employer group coverage. All other elected officials of the county have the following options:

1. **Enroll in the LGHIP** – Elected officials may enroll in the LGHIP at the time the county commission initially joins the LGHIP or upon election to office. Elected officials 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 county commission initially joins the LGHIP or upon election to office. If a declination form with proof of other employer group coverage is submitted, the elected official may enroll in the LGHIP at a later date upon loss of other employer group 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 county commission initially joins the LGHIP or upon election to office and does not submit a declination form with proof of other employer group 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 (other than county commissioners) that fail to elect one of the above options will be treated as if they chose option 3.

E. Subsequent Enrollment of New Employees

All employees hired after the effective date of the Group Contract shall be enrolled in the Program unless evidence of other group insurance is provided. All eligible employees and elected officials must either elect or decline coverage on date of eligibility. The effective date shall 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. Retirees must enroll on the date they first become eligible for retiree health benefits.

Local Government units may elect to have coverage effective for all new full-time 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 (Form LG05) to the SEIB during Open Enrollment. Once the election has been submitted and approved by the SEIB, coverage for all future full-time employees shall be effective on the date of employment. A prorated premium will be billed for new employees on the next billing cycle.

Local Government units may elect to choose one of the two options regarding the effective date of coverage for all new employees during Open Enrollment. Once Form LG05 has been accepted by the SEIB, the election will be effective January 1.

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 group coverage. If an eligible employee is covered by other group coverage, that employee must provide a "Declination of Coverage" form to the SEIB with proof of other group coverage. If an employee has declined coverage in the LGHIP and later loses their other group coverage, that eligible employee must immediately notify the SEIB and enroll in the LGHIP. If the eligible employee does not notify the SEIB and does not enroll in the LGHIP, both the eligible employee and the unit will be liable and will be back-billed to the date the eligible employee should have been enrolled. If the premiums for the back-billing are not paid, the unit may be cancelled from participation in the LGHIP.

F. Family Coverage Enrollment

A participating employee, elected officer or retiree in the Program may apply for family coverage either upon their initial enrollment (enrollment form LG01), or acquiring a new dependent (dependent change form LG02B), or annual open enrollment (dependent change form LG02B) or dependent special enrollment (dependent change form LG02B).

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

If the required documentation is not received with an Enrollment Form or Change Form, the SEIB will send a notice to the employee that the required documentation must be submitted within 60 days of the date of the letter. If documentation is not received by the SEIB within those 60 days, the request to add dependent coverage will be denied.

Initial Enrollment/New Employees

New employees 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 SEIB 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 case of a birth - the date of birth
- in an adoption – the date of the Interlocutory Decree
- custody of a grandchild, niece or nephew – the date of the judge's order, granting custody.

If the SEIB 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 will need to reapply during the annual open enrollment.

Annual Open Enrollment

A participating employee, elected official or retiree 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 group coverage, the subscriber may apply for Dependent Special Open Enrollment. The effective date of coverage will be the date the other group coverage ceased. See "Special Enrollment Period, Dependents." The only dependents eligible are those who experienced a "qualifying event."

G. Open Enrollment

Subsequent to the effective date of the Group's Contract, there shall be an Annual Open Enrollment held in November (for coverage to be effective January 1) of each year to allow active eligible employees not currently participating in the insurance program a chance to enroll.

Eligible participants may add dependents or family coverage. If an employee wishes to add dependents or add family coverage during open enrollment, a dependent change form (Form LG02B) must be filled out and submitted to the SEIB.

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). Submit LG05 Form.

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.

Employees who have previously declined coverage must submit a completed "Declination of Coverage" 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 must be sent to the SEIB.

Forms shall be completed and signed in November with an effective date of January 1 indicated on the form and received in the SEIB office by November 30. If an employee does not want to change plans or add/drop family coverage during open enrollment, no paperwork is necessary.

H. Special Enrollment Period

Employees

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 employer group coverage or the addition of a dependent. However, since the LGHIP already requires that an employee enroll in the plan when they lose other employer group 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 employer group coverage or
- a substantial change in the cost of their other employer group coverage.

To be eligible for special enrollment an employee must have a declination of coverage form with proof of other employer group coverage on file. Employees requesting special enrollment must notify the SEIB 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. thereafter, the proof of the qualifying event, listing the reason and date of loss for all individuals affected by loss of coverage (e.g. employment termination on company letterhead); must be submitted within 60 days of the qualifying event.

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

Dependents

To be eligible for dependent special enrollment an employee must submit a dependent change form with proof of loss of other employer group coverage. Employees requesting dependent special enrollment must notify the SEIB 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 dependent change form; and

3. thereafter, the proof of the qualifying event, listing the reason and date of loss for all individuals affected by loss of coverage (e.g., employment termination on company letterhead) must be submitted within 60 days of the qualifying event.

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

I. When Coverage Commences

Coverage commences as of the effective date of the employee's insurance contract.

J. Cancellation of Family Coverage

An employee may drop family coverage at any time. The earliest effective date of cancellation will be the first day of the month following the SEIB's receipt of written notification (Form LG02B) by the SEIB office. The SEIB requires proof of divorce (divorce decree) when dropping a former spouse due to divorce.

K. Transfers

Only new employees meeting the following criteria will be considered as transfers under the LGHIP:

1. New hire, previously covered by the LGHIP or by the State Employees' Health Insurance Plan (SEHIP), and
2. New hire, terminated employment with another local government unit covered by the LGHIP, or State employee covered by the SEHIP who became employed with a local government unit during the same calendar month of termination.

The local government unit hiring the new 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.

L. Notice

Notice of any enrollment changes is the responsibility of the employee (for example: addition or deletion of dependents, address changes, etc.)

In addition, it is the responsibility of the subscriber to notify the SEIB immediately when the eligibility of a covered dependent changes. If it is determined that an act (such as adding an ineligible person to coverage) or omission (such as failing to remove a person no longer eligible from coverage) of the subscriber results in or contributes to the payment of claims by the LGHIP for persons ineligible for coverage, the subscriber will be personally responsible for all such overpayments and shall be subject to disciplinary action including termination of coverage. (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.)

M. Military Leave

The Military Leave Policy of the Local Government Health Insurance Program (LGHIP) is in compliance with the Uniformed Services Employment and Reemployment Rights Act (USERRA), 38 USC-4317. Under the USERRA, an 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 employer'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 employer'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 SEIB of 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 must offer the dependents one of the following two options:

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 63 days of the end of military leave; or
2. Offer Regular 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 share of the premium. The local government unit will be responsible for collection and payment of the premium.

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

If an 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 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 group coverage. 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.

N. Declination of Coverage

Employees 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 and acceptable proof of group coverage with another employer**. Acceptable proof is a current letter from employer/insurance carrier verifying current coverage.

O. Premium Payments

The SEIB 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.

VI. RETIREMENT

A. Continuation of Coverage

Eligible retirees who continue on the insurance 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 (LG02) must be sent to the SEIB, indicating a rate change from active to retired status and the effective date of the retirement. The status change form should be sent prior to the retirement date.

If Medicare retirees are allowed to continue coverage, 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, 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 should be sent prior to the Medicare effective date.

B. Termination of 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 "Termination of Services".)

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 will need to send a Cancellation Form with the retiree's signature prior to 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 SEIB prior to the retirement date for the retiree to receive a COBRA notice.

If the Cancellation Form is received after the retirement date the reason for cancellation should be "non-payment" and COBRA will not be offered.

A retired employee whose local government unit does not allow Medicare retirees to continue on the health insurance must submit a Cancellation Form prior to the retiree's Medicare eligibility date. A copy of the Medicare card may be required. COBRA will be offered to retiree and dependents for 18 months. If the retiree declines COBRA coverage, dependents will still be eligible for 18 months.

A retired employee whose local government unit **does** allow Medicare retirees to continue on the insurance and the retiree **chooses not** to continue coverage, the unit will need to submit a completed Cancellation Form prior to the Medicare effective date, indicating a request for COBRA and signed by the retiree. COBRA will be offered to the dependents for 18 months.

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 cancelled for any reason will not be allowed to enroll at a later date.

C. Supernumeraries

Supernumeraries will be classified for insurance purposes as retired employees.

D. Provision for Medicare

1. Active Employees

   The SEIB provides active employees over age 65, coverage under the Local Government Health Insurance Plan, under the same conditions as any employee under age 65. Medicare is secondary to benefits payable under the LGHIP for employees over age 65 and their spouses over age 65. 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.

   SEIB 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 plan will be the primary payer for both items and services covered by Medicare. (Note that Medicare covers hospitalization, post-hospital nursing home care, home health services.) This means that the plan will pay the covered claims and those of the employee's Medicare entitled spouse first, up to the limits contained in the plan, 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 spouse is not entitled to Medicare, the plan will be the sole source of payment of the spouse's claims.

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

2. Retired Employees

Health benefits will be modified when you or your dependent becomes entitled to Medicare. Coverage under the plan will be reduced by those benefits payable under Medicare Parts A and B. If a retiree or dependent becomes entitled to Medicare because of a disability before age 65, the retiree must notify the SEIB to be eligible for the reduced premiums. A copy of the retiree's or their dependent's Medicare card and a Change Form that indicates the rate change must be submitted if the unit covers Medicare retirees.

The LGHIP remains primary for retirees until the retiree is entitled/eligible to Medicare. Upon Medicare entitlement, the retiree's coverage under the LGHIP will complement his/her Medicare Parts A and B coverages. Medicare will be the primary payer and the LGHIP will be the secondary payer. A Medicare retiree and/or Medicare dependent should have both Medicare Parts A and B to have adequate coverage with the LGHIP.

Medicare Part B premiums are the retiree's responsibility. These premiums are deducted from the retiree's Social Security check.

Medicare Part D Prescription Drug Coverage

Medicare retirees and retiree Medicare dependents are enrolled in the LGHIP's prescription drug Employer Group Waiver Plan (EGWP). The LGHIP EGWP is a Medicare Part D prescription drug plan that is in addition to the coverage under Medicare Part A or Part B.

It is the retiree's responsibility to inform LGHIP if they are enrolled in another Medicare prescription drug plan. Retirees can only be enrolled in one Medicare prescription drug plan at a time. Retirees are not required to be enrolled in the LGHIP EGWP, but if they elect to opt out, they must complete an EGWP Opt-Out Form and return it to the SEIB. Opt-out forms are available on the SEIB website.

If a Medicare retiree opts out of this plan, the retiree will have no prescription drug coverage from the LGHIP. Retirees will, however, still have the LGHIP secondary Medicare Part A and B coverage if they opt out of the LGHIP EGWP.

VII. TERMINATION OF SERVICE

A. When Coverage Terminates

The member's coverage will terminate:

1. On the last day of the month in which the member's employment terminates.
2. When this plan is discontinued.
3. When premium payments cease.
4. 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 Program.

In many cases you 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 State Employees' Insurance Board will adhere to the provisions of the Family and Medical Leave Act.

C. Leave without Pay (LWOP)

Employees on leave without pay may continue their health insurance coverage for a maximum of 12 months. The employee will remain on the Local Government unit's billing. If the unit requires the employee to make the premium payment and the employee elects not to pay or they are canceled for nonpayment of premiums, the unit is to send in a Cancellation Form to the SEIB office indicating the reason for cancellation. When the Cancellation Form is received, the SEIB office will send a COBRA notice to the employee. Once an employee has been on leave without pay for 12 months, the Local Government unit is to notify the SEIB. The employee will be offered COBRA at that time.

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

D. Continuation of Group Health Coverage (COBRA)

All COBRA applications and information concerning COBRA is handled through the SEIB office. See "Election Period."

NEW UNITS ONLY: All current COBRA subscribers should 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.

The Public Health Service Act [42 USL Sections 300bb-1 through 300bb-8] requires that the SEIB offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. COBRA coverage can be particularly important as it will allow employees to continue group health care coverage beyond the point at which they would ordinarily lose it.

This information is intended to inform employers, in a summary fashion, of their employee's rights and obligations under the continuation coverage provisions of the law. **You should take the time to read this carefully to ensure that your employees are aware of their COBRA rights.**

1. Qualified Beneficiaries

   COBRA continuation coverage is a continuation of coverage under the Local Government Health Insurance Program (LGHIP) when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. Employees, their spouses and 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.

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. (An increase in the cost of retiree coverage relative to active employee coverage is also considered a loss of coverage for COBRA purposes.) 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.

An employee will become a qualified beneficiary if he or she loses coverage under the LGHIP because either one of the following qualifying events happens:

- hours of employment are reduced, or
- employment ends for any reason other than gross misconduct.

A spouse of an employee will become a qualified beneficiary if he or she loses coverage under the LGHIP because any one of the following qualifying events happens:

- 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
- spouse becomes divorced or legally separated from employee.

Dependent children will become qualified beneficiaries if they lose coverage under the LGHIP because any of the following qualifying events happens:

- 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."

2. Coverage Available

   If a qualified beneficiary chooses continuation coverage, the SEIB is required to offer coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members.

3. When the Employer Should Notify the SEIB

   COBRA continuation coverage will be offered to qualified beneficiaries only after the SEIB has been notified that a qualifying event has occurred. The employer is responsible for notifying the SEIB of the following qualifying events:

   - end of employment,
   - reduction of hours of employment or
   - death of an employee.

Employer must submit written notice to the SEIB within 30 days of the date of the qualifying event or the date in which coverage would end under the LGHIP because of the qualifying event, whichever is later. All notices should be sent to the address listed under "SEIB Contact Information" at the end of this section.

4. When Employee Should Notify the SEIB

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

- divorce,
- legal separation, or
- a child losing dependent status.

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

5. Election Period

When the SEIB 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.

A qualified beneficiary has 60 days from the date coverage is lost because of a qualifying event, or the date notice of COBRA election rights is sent to the qualified beneficiary, whichever is later, to inform the SEIB that COBRA continuation coverage has been elected.

If a qualified beneficiary does not choose continuation coverage, his or her group health insurance will end.

6. Length of 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
- a 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 former employee is determined by the Social Security Administration to be disabled and the SEIB is notified within 30 days of the determination,

- the covered employee or former employee and his or her entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage. The disability would have to have started before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. (A copy of the Social Security Administration determination must be provided to the SEIB at the address listed under "SEIB Contact Information" at the end of this section.)
- Second Qualifying Event - if an employee's or former employee's family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children may be eligible to get up to 18 additional months of COBRA continuation coverage. The SEIB must be notified within 30 days of the second qualifying event. This extension may be available to the employee's or former employee's spouse and any dependent children receiving COBRA continuation coverage when one of the following qualifying events occurs:
- employee or former employee dies,
- employee or former employee becomes entitled to Medicare benefits (under Part A, Part B or both),
- employee or former employee gets divorced or legally separated or
- dependent child loses eligibility as a "dependent child" under LGHIP.

For the extension to apply, the above listed events must have caused the spouse or dependent child to lose coverage under the LGHIP had the first qualifying event not occurred.

7. FMLA

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

8. Premium Payment

If the employee or former employee qualifies for continuation coverage, he or she will be required to pay the group's premium plus 2% administrative fee directly to the State Employees' Insurance Board (SEIB). Members who are disabled under Title II or Title XVI of the Social Security Act, will be required to pay 150% of the group'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 the employee or former employee is no longer disabled under Title II or Title XVI of the Social Security Act, whichever comes first. Coverage will be canceled if payment is not received by the SEIB in a timely manner.

The initial premium payment must be received by the SEIB within forty-five (45) days from the date of election. All subsequent premiums are due on the first day of the month of coverage. There is a thirty (30) day grace period.

9. Termination of Continuation Coverage

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

a. SEIB no longer provides group health coverage;
b. the premium is not paid on time;
c. a qualified beneficiary becomes covered, after electing continuation coverage, under another group plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary (Note: there are limitations on plans imposing a preexisting condition of exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act.);
d. qualified beneficiary become entitled to Medicare;
e. coverage has been extended for up to 29 months due to disability and there has been a final determination that the disability no longer exists.

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

Note: If a COBRA subscriber/dependent becomes entitled to Medicare before becoming a qualified beneficiary, they may elect COBRA continuation coverage; however, their Medicare coverage will be primary and the COBRA continuation coverage will be secondary. Qualified beneficiaries **must** have Medicare Parts A and B in order to have full coverage.

10. Keep the SEIB Informed of Address Changes

In order for employees to protect their COBRA rights, they should keep the SEIB informed of any changes in the address of family members. Employees should maintain copies of all notices sent to the SEIB.

11. If an Employee Has Any Questions

Questions concerning COBRA continuation coverage rights may be addressed by calling the SEIB 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.

12. SEIB Contact Information

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

State Employees' Insurance Board
LGHIP COBRA Section
201 South Union Street, Suite 200
Post Office Box 304900
Montgomery, AL 36130-4900

E. Group Termination

A group may terminate coverage with the Local Government Health Insurance Program subject to the following conditions:

1. The employer, by resolution of the governing body, shall signify its intention and desire to withdraw from such plan in writing and by delivering a copy of such resolution by certified mail to the State Employees' Insurance Board, Post Office Box 304900, Montgomery, AL 36130-4900 no later than six months prior to the effective date of withdrawal.

2. Any employer that withdraws from participation shall be responsible for paying its claims incurred prior to the date of withdrawal, but not reported and paid prior to the date of withdrawal.

3. Any group that withdraws from participation shall serve a three-year waiting period from the effective date of the group's termination before such group (in good standing) may apply for re-enrollment into the Program.

4. Any organization that provides or administers health insurance benefits through the Local Government Health Insurance Program shall not provide or administer health insurance benefits to any entity that withdraws from the Local Government Health Insurance Program for a period of two years from the effective date of withdrawal.

VIII. BILLING PROCEDURES

A. Payment Notice

The SEIB will generate an Invoice (see APPENDIX) and Listing of Employees Insured (see APPENDIX) for each local government unit. The invoice will be mailed each month and will also be available on the SEIB website. The Listing of Employees Insured information will be pulled 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.

Upon receiving the Invoice, the unit is expected to return this notice with full payment of the total balance due. You should not make any corrections or adjustments to this balance. All corrections and adjustments will be included in the payment notice for the upcoming month. The unit may keep the Listing of Employees Insured for their records.

B. Invoice Changes

Additions, cancellations and changes in the current billing period and the upcoming months will be made from the proper forms (FORMS LG01, LG02, LG02-B, LG03, LG04, LG07, LG08, or LG09). These forms are to be sent separately. 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. 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 cancelled at any time. However, draft cancellations must be made at least five business days prior to the last business day of the month.

E. Electronic-check (E-check) Service

Payment by E-check is also available to pay monthly premiums. Please call the SEIB Accounting Department at 1.866.836.9137 to make E-check payments. Payments may also be made online at the SEIB website.

IX. FORMS

A. Enrollments (LG01)

To enroll in the Program, a Local Government Enrollment Form (Form LG01 - See Appendix) *must be completed and signed by the employee/retiree.*

B. Dependent Changes (LG02-B)

To add/drop family coverage to an existing contract, a Local Government Dependent Change Form (Form LG02-B - See Appendix) *must be completed and signed by the employee/retiree.*

C. 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 - See Appendix) *must be completed and signed by the employee/retiree.*

D. Cancellations (LG03)

To cancel all coverage, a Local Government Cancellation Form (Form LG03 - See Appendix) must be completed and submitted to the SEIB office.

E. Declination of Coverage (LG04)

To decline or cancel coverage, a Local Government Declination of Coverage Form (Form LG04 - See Appendix) must be completed, signed by the employee and submitted to the SEIB office.

F. Pre-Authorized Payment Service Authorization Agreement (LG13)

To enroll in the automatic bank draft program, a Pre-Authorized Payment Service Authorization Agreement (Form LG13) must be completed and signed.

G. **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.

NOTE: All forms must be verified and signed by the designated payroll/personnel officer.

H. Provider Screening Form (LG12)

If an employee cannot or chooses not to participate in an SEIB Worksite Wellness Screening, a health screening form completed by their physician may be submitted.

I. General Information for Initial Enrollment (LG11A)

To be completed by new units enrolling in the Local Government Health Insurance Program.

J. General Information Changes (LG11B)

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

K. Participation Form (LG15)

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

L. Resolution (LG16)

To be completed by new units enrolling in the Local Government Health Insurance Program.

X. A P P E N D I X

State Employees' Insurance Board
Local Government Health Insurance Plan
P.O. Box 304900
Montgomery, AL 36130-4900

INVOICE AND STATEMENT OF ACCOUNT

Account #
Invoice #
Date:
Coverage Period:
Due Date:

Policies/Coverages	Premiums Due
Single	
Dependent	
Voluntary	
Wellness Discount	
Total Invoice	
Previous Balance:	
Total Balance Due	

Please detach the stub below and remit the total balance due by the due date. **Partial payments will not be accepted and no changes are allowed to this invoice. Additions, deletions, and changes will be reflected in your next invoice provided the proper forms (cancellation, change, or enrollment) are received in the SEIB office.** Failure to remit your payment timely may result in cancellation of coverage. Payments can be made by phone or website using e-check. Overnight payments should be sent to:

State Employees' Insurance Board
201 South Union Street, Suite 200
Montgomery, AL 36104
1.866.836.9137

SAVE A STAMP!
SIGN UP FOR AUTOMATIC DRAFTS OR CALL OR VISIT OUR WEBSITE FOR PAYMENT BY E-CHECK.
CALL 1.866.836.9137 OR VISIT WWW.ALSEIB.ORG FOR DETAILS.

----------Please Detach Here and Return ----------

Invoice
Previous Balance
Total Balance Due

Return Payment to:

Invoice #:

Amount Received: _____

State Employees' Insurance Board
P.O. Box 304900
Montgomery, AL 36130-4900

Check #: _____

Initials:_____

LGHIP Unit Billing **Unit:**

Date: **Page:**

Contract	SSN	Name	Cat	Tier	Ins	Employee Coverage From	Employee Coverage To	Employee Premium	Dependent Coverage From	Dependent Coverage To	Dependent Premium	Total Premium

Wellness Participation for 2014 Discount (Qualifying Period: 6/1/2012 - 5/31/2013)

Wellness Participation for 2015 Discount (Qualifying Period: 6/1/2013- 5/31/2014)

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2014 ENROLLMENT FORM

SUBSCRIBER INFORMATION (Please print or type.)

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

Employment Status (Check One)

☐ Full-time Employee	☐ 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.

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
	☐ Husband	☐ Wife		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Grandson ☐ Nephew	☐ Granddaughter ☐ Niece		
	☐ Grandson ☐ Nephew	☐ Granddaughter ☐ Niece		

TO BE COMPLETED BY EMPLOYER

Full-time date of hire:

Local Government Unit Name:

Account Number:

Signature of Insurance Clerk: Date:

_____ _____

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 SEIB's behalf.

_____ _____

Employee Signature **Date**

If documentation is not attached, we must receive your documentation within 60 days of receiving this enrollment form.

GENERAL INFORMATION

Eligible Dependent

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

The term "dependent" includes the following individuals subject to appropriate documentation such as a Social Security number, marriage certificate, birth certificate, court decree, etc.

1. Your spouse (excludes divorced or common-law spouse).
2. A child under age 26, only if the child is:
    a. your son or daughter. (A court decree establishing paternity will be temporarily effective for 60 days, at which time an amended birth certificate listing the father's name will be due.)
    b. a child legally adopted by you or your spouse (including any probationary period during which the child is required to live with you),
    c. your stepchild,
    d. your grandchild, niece or nephew for whom the court has granted custody to you or your spouse.

3. 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 you for 50% or more support,
    e is otherwise eligible for coverage as a dependent except for age,
    f. the condition must have occurred prior to the dependent's 26th birthday and
    g. is not eligible for any other group health 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 working, despite his disability, the extent of his earning capacity will be evaluated.

To apply, contact the SEIB 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 SEIB within 60 days from the date the child would cease to be covered because of age.

Exception: There are two situations under which it may be possible to add an incapacitated dependent who otherwise meets the eligibility requirements except for age:

1. When a new employee requests coverage for an incapacitated dependent within 60 days of employment; or
2. When an employee's incapacitated dependent is covered under a spouse's employer group health insurance for at least 18 consecutive months and:
    a. the employee's spouse loses the other coverage because:
        - spouse's employer ceases operations, or
        - spouse's loss of eligibility due to termination of employment or reduction of hours of employment, or
        - spouse's employer stopped contribution to coverage,
    b. a change form is submitted to the SEIB within 30 days of the incapacitated dependent's loss of other coverage, and
    c. Medical Review approved incapacitation status.

The above requirements must be met as a minimum threshold in order to be considered for incapacitation status. The SEIB shall make the final decision as to whether an application for incapacitated status will be accepted.

NOTE: The SEIB reserves the right to periodically re-certify incapacitation.

Exclusion: You may not cover your wife, husband, or other dependents if they are insured or if they are eligible to be insured as an active employee in the Local Government Health Insurance Program.

STATE EMPLOYEES' INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
334-263-8326 / 1-866-836-9137 / FAX: 334.517-9778

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2014 STATUS CHANGE FORM

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)			Sex
Social Security Number	Contract Number	Home Telephone Number ( )	Work Telephone Number ( ) Ext.

CHANGE: ☐ MAILING ADDRESS To: _____
Street Address or Post Office Box

_____
City State Zip

☐ SUBSCRIBER'S NAME From: _____ To: _____

☐ DEPENDENT'S NAME From: _____ To: _____

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

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

☐ E-MAIL ADDRESS To: _____

CHANGE RATE: ☐ Retired Subscriber (Not Medicare Participant)
☐ Dependent not Medicare ☐ Dependent Medicare

CHANGE RATE: ☐ Retired Subscriber (Medicare Participant)
☐ Dependent not Medicare ☐ Dependent Medicare

Note: If in your rate above you selected: ☒ **Retired Subscriber (Medicare Participant)** or ☒ **Dependent Medicare,** you must provide a copy of your Red, White, and Blue Medicare Card.

TO BE COMPLETED BY EMPLOYER

Effective Date of Change: _____

_____
Local Government Unit Name

_____
Account Number

_____
Signature of Insurance Clerk Date

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 SEIB's behalf.

_____
Employee Signature Date

STATE EMPLOYEES' INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
334-263-8326 / 1-866-836-9137 / FAX: 334.517-9778

Form LG02-B

Revised 9/13

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2014 DEPENDENT CHANGE FORM

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)			Sex
Social Security Number	Contract Number	Home Telephone Number ( )	Work Telephone Number ( ) Ext.

DROP DEPENDENT COVERAGE

☐ Change from Family to Single Coverage

☐ Cancel dependent(s) listed below from Family Coverage

ADDITIONS – PROVIDE DOCUMENTATION

**Please read important information on the back.

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

☐ Add dependent(s) listed below to Family Coverage **

REASON FOR CANCEL MONTH/DAY/YEAR

☐ Death _____

☐ Divorce
Attach divorce decree _____

☐ Dependent no longer eligible _____

Explain: _____

☐ Other: _____

Explain: _____

REASON FOR ADDITION MONTH/DAY/YEAR

☐ Marriage _____

☐ Birth of Child _____

☐ Adoption of Child _____

☐ Other _____

Explain: _____

First Name Initial Last Name	Documentation is required. See back of form. Relationship to Employee		Date of Birth	Social Security Number
	☐ Husband	☐ Wife		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ 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.

TO BE COMPLETED BY EMPLOYER

Effective Date of Change: _____

_____
Local Government Unit Name

_____
Account Number

_____
Signature of Insurance Clerk Date

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 SEIB's behalf.

_____
Employee Signature Date

If documentation is not attached, we must receive your documentation within 60 days of receiving this change form.

GENERAL INFORMATION

Eligible Dependent

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

The term "dependent" includes the following individuals subject to appropriate documentation such as a Social Security number, marriage certificate, birth certificate, court decree, etc.

1. Your spouse (excludes divorced or common-law spouse).
2. A child under age 26, only if the child is:
    a. your son or daughter. (A court decree establishing paternity will be temporarily effective for 60 days, at which time an amended birth certificate listing the father's name will be due.)
    b. a child legally adopted by you or your spouse (including any probationary period during which the child is required to live with you),
    c. your stepchild,
    d. your grandchild, niece or nephew for whom the court has granted custody to you or your spouse.

3. 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 you for 50% or more support,
    e is otherwise eligible for coverage as a dependent except for age,
    f. the condition must have occurred prior to the dependent's 26th birthday and
    g. is not eligible for any other group health 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 working, despite his disability, the extent of his earning capacity will be evaluated.

To apply, contact the SEIB 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 SEIB within 60 days from the date the child would cease to be covered because of age.

Exception: There are two situations under which it may be possible to add an incapacitated dependent who otherwise meets the eligibility requirements except for age:

1. When a new employee requests coverage for an incapacitated dependent within 60 days of employment; or
2. When an employee's incapacitated dependent is covered under a spouse's employer group health insurance for at least 18 consecutive months and:
    a. the employee's spouse loses the other coverage because:
        - spouse's employer ceases operations, or
        - spouse's loss of eligibility due to termination of employment or reduction of hours of employment, or
        - spouse's employer stopped contribution to coverage,
    b. a change form is submitted to the SEIB within 30 days of the incapacitated dependent's loss of other coverage, and
    c. Medical Review approved incapacitation status.

The above requirements must be met as a minimum threshold in order to be considered for incapacitation status. The SEIB shall make the final decision as to whether an application for incapacitated status will be accepted.

NOTE: The SEIB reserves the right to periodically re-certify incapacitation.

Exclusion: You may not cover your wife, husband, or other dependents if they are insured or if they are eligible to be insured as an active employee in the Local Government Health Insurance Program.

STATE EMPLOYEES' INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
334-263-8326 / 1-866-836-9137 / FAX: 334.517-9778

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2014 CANCELLATION FORM

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)	Sex	Date of Birth

Social Security Number	Contract Number

CANCEL ALL INSURANCE COVERAGE FOR THE FOLLOWING REASONS:

_____ Voluntary Termination _____
Last Day in Pay Status

_____ Involuntary Termination _____
Last Day in Pay Status

_____ Retirement Date _____

_____ Military Leave Date _____ Attach military papers.

_____ Death _____

_____ Leave Without Pay - non-payment _____

_____ Other Date _____ Give explanation: _____

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

Note: By submitting this Cancellation Form, health insurance coverage will be terminated.

TO BE COMPLETED BY EMPLOYER

Effective Date of Cancellation:

_____

_____
Local Government Unit Name

_____
Account Number

_____
Signature of Insurance Clerk Date

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 SEIB's behalf.

_____
Employee Signature Date

STATE EMPLOYEES' INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
334.263.8326 / 1.866.836.9137 / FAX: 334.517.9778

Form LG04

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2014 DECLINATION OF COVERAGE FORM

Revised 9/13

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)			Sex	Date of Birth
Social Security Number	Contract Number	Home Telephone Number ( )	Work Telephone 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 group 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 ☐ 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 employer group coverage or the addition of a dependent. However, since the LGHIP already requires that an employee enroll in the plan when they lose other employer group 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 employer group coverage or
- a substantial change in the cost of their other employer group coverage.

All employees who lose their other employer group coverage, whether voluntarily or involuntarily must submit an enrollment form to the SEIB 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 employer group coverage. Persons requesting special enrollment must notify the SEIB 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. thereafter, the proof of the qualifying event listing the reason and date of loss for all individuals 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:	
Account Number:	**Date:**
Signature of Insurance Clerk:	

STATE EMPLOYEES' INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
334.263.8326 / 1.866.836.9137 / FAX: 334.517.9778

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2014 EFFECTIVE DATE OF COVERAGE ELECTION FORM

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 for the plan year beginning January 1**,** 2014.

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 State Employees' Insurance Board and shall remain in effect until such time as the State Employees' Insurance Board may determine otherwise.

LOCAL GOVERNMENT UNIT:
EFFECTIVE PLAN YEAR: BEGINNING JANUARY 1, 2014
AUTHORIZED AGENT'S NAME AND TITLE (please print)
SIGNATURE:
DATE OF ELECTION AGREEMENT:

STATE EMPLOYEES' INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
334.263.8326 / 1.866.836.9137 / FAX: 334.517.9778

Now there are more ways to pay your premiums!

That's right. The SEIB now offers you three different ways to make your premium payments.

- Automatic bank drafts
- E-check
- Traditional mail

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

Recurring monthly payment option

- A charge is made to your designated bank account on the first day of the month for your premium payment as shown on your statement.
- Enrollment is simple. Return the attached form to SEIB accounting.
- You will receive a monthly bill advising of your balance due.

"You make the call" option

- **You** decide when to have your bank account charged. (Your payments must continue to be current to avoid cancellation.)
- Payments can be made calling our office.
- You will receive a monthly bill advising you of your balance due.

Cost to You: None.
Benefits to You: No more checks and no more stamps!

If you have any questions regarding these payment options contact our accounting department at 1.866.836.9737, option 5, and then option 5 again.

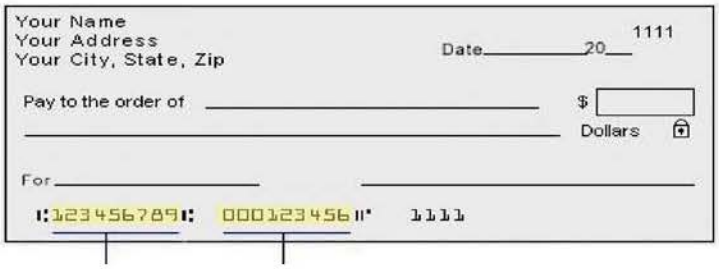
If you choose to enroll in the recurring payment option, please complete the form on the back and return to:

State Employees' Insurance Board
Accounting Department
Post Office Box 304900
Montgomery, Alabama 36130-4900

State Employees' Insurance Board
Local Government Health Insurance Program
Pre-Authorized Payment Service Authorization Agreement

I authorize the State Employees' Insurance Board (SEIB) and the financial institution, listed below, to electronically debit or credit my account as specified:

Account Number*
Name of Financial Institution
Routing Number**



Routing Number** Account Number*

Please staple your voided check to this form.

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

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

Please staple your voided check to this form to verify account information for withdrawals from your Checking Account.

Please return this form to:

State Employees' Insurance Board
Accounting Department
Post Office Box 304900
Montgomery, Alabama 36130-4900

Form may be returned with your payment.

State Employees' Insurance Board
Local Government Health Insurance Plan
Provider Screening Form

Instructions: If you cannot or choose not to participate in SEIB's Worksite Wellness screenings, you may submit your health screening results through your physician. You are to complete Section 1 of the form and your provider is to complete Section 2. The completed form must be returned to SEIB no later than May 31st. NOTE: Incomplete forms will be returned.

SECTION 1 (To Be Completed by Employee)

Member Name (Please print)	**Screening Date**	**Male** ☐ **Female** ☐	**Age:**

Contract Number	**Social Security #**	**Date of Birth**	**Day Time Phone Number**

What best describes your race/ethnicity?

☐ White ☐ Black/African American ☐ Asian ☐ Indian or Alaska Native

☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ Other

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

☐ High Cholesterol ☐ High Blood Pressure ☐ Diabetes

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

☐ High Cholesterol ☐ High Blood Pressure ☐ Diabetes

SECTION 2 (To Be Completed by Provider)

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

Provider's Name: (Please print)_____

Provider Signature: _____

Provider Address: _____

Please return completed form to:
STATE EMPLOYEES' INSURANCE BOARD
P O BOX 304900
MONTGOMERY AL 36130-4900
1.866.838.3059
FAX: 334.517.9980

SOUTHLAND NATIONAL VOLUNTARY PLAN
Effective January 1, 2014

SUMMARY OF BENEFIT PLANS

Each employee is eligible for coverage through the Southland National Voluntary Plan. Southland offers supplemental dental and vision coverage.

MONTHLY PREMIUMS

Vision	Dental	COBRA Vision	COBRA Dental
$20.00	**$40.00**	**$20.00**	**$41.00**

ELIGIBILITY AND ENROLLMENT RULES

A. Eligible Participants

All participants who are eligible for coverage through the Local Government Health Insurance Program are eligible to participate in the Southland National Voluntary Plan.

B. Eligible Dependents – see page 32.

The same dependent eligibility rules apply to Southland National except that **you may** cover your wife, husband or other dependents if they are insured or if they are eligible to be insured as an active employee in the Local Government Health Insurance Program.

C. Subsequent Enrollment of New Employees

All new hires that elect to participate in the Southland National Voluntary Plan will have coverage effective the first day of the second month following receipt by SEIB of their enrollment form. For example, if a new employee's enrollment form is received by the SEIB in the month of August, the effective date of coverage will be October 1. The enrollment form must be received within 60 days of the hire date.

NOTE: A minimum enrollment of 12 months is required for employees/dependents. Unless there is a qualifying event (death, divorce or otherwise losing dependent status), participants will be allowed to cancel Southland National Voluntary Plan coverage during the November open enrollment for coverage effective January 1, 2014.

D. Family Coverage Enrollment

Initial Enrollment/New Employees

New employees 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 SEIB 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 received in the SEIB office. If the SEIB is notified of a new dependent after the 60 days, 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 SEIB. **Note**: to ensure that enrollment deadlines are met, change forms should be submitted to the SEIB even if all the required documentation is not available.

If the required documentation is not received with the Southland Enrollment/Change Form, the SEIB will send a notice to the employee that the required documentation must be submitted within 60 days of the date of the letter. If documentation is not received by the SEIB within those 60 days, the request to add dependent coverage will be denied.

E. Open Enrollment

There shall be an Annual Open Enrollment held in November (for coverage to be effective January 1) of each year to allow active eligible employees not currently participating in the insurance program a chance to enroll.

Eligible participants may add dependents or family coverage. If an employee wishes to add dependents or add family coverage during open enrollment, a change form (Form LG08) must be filled out and submitted to the SEIB.

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

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

F. Cancellation of Dependent/Family Coverage

Employees who enrolled with a January 1, 2013 effective date of coverage: may cancel dependent/ family coverage during Open Enrollment for a January 1, 2014 effective date.

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

G. 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 National Voluntary Plan to satisfy the 12-month requirement. The employee may cancel Southland National Voluntary coverage the next Open Enrollment after the 12-month minimum participation has been met.

H. Continuation of Group Health Coverage (See COBRA Section.)

BILLING PROCEDURES

Payment Notice

Premiums for participation in the Southland National Voluntary Plan will be reflected on the regular billing.

FORMS

A. Enrollments (LG07)

To enroll, a Southland National Voluntary Plan Enrollment Form (Form LG07 - See Appendix) must be completed and signed by the employee/retiree.

B. Changes (LG08)

To add/drop family coverage to an existing contract, a Southland National Voluntary Plan Change Form (Form LG08 - See Appendix) must be completed and signed by the employee/retiree.

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

C. Cancellations (LG09)

To cancel all coverage, a Southland National Voluntary Plan Cancellation Form (Form LG09 – See Appendix) must be completed and signed by the employee/retiree.

NOTE: All forms must be verified and signed by the designated payroll/personnel officer.

XI. SOUTHLAND NATIONAL VOLUNTARY PLAN APPENDIX

Form LG07 Revised 9/13

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2014 ENROLLMENT FORM
SOUTHLAND NATIONAL VOLUNTARY INSURANCE

SUBSCRIBER INFORMATION (Please print or type.)

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

CHECK PLAN ELECTED

- ☐ Vision (Monthly premium $20)
- ☐ Dental (Monthly premium $40)
- ☐ Vision and Dental (Monthly premium $60)

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

Employment Status (Check One)

☐ Full-time Employee ☐ 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
	☐ Husband	☐ Wife		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Grandson ☐ Nephew	☐ Granddaughter ☐ Niece		
	☐ Grandson ☐ Nephew	☐ Granddaughter ☐ Niece		

TO BE COMPLETED BY EMPLOYER

Effective Date: _____

_____
Local Government Unit Name

_____
Account Number

_____
Signature of Insurance Clerk Date

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 SEIB's behalf.

_____
Employee Signature Date

* A "qualifying event" is birth, marriage, adoption, death, divorce, or otherwise losing dependent status.
If documentation is not attached, we must receive your documentation within 60 days of receiving this enrollment form.

GENERAL INFORMATION

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

The term "dependent" includes the following individuals subject to appropriate documentation such as a Social Security number, marriage certificate, birth certificate, court decree, etc.

1. Your spouse (excludes divorced or common-law spouse).
2. A child under age 26, only if the child is:
   a. your son or daughter. (A court decree establishing paternity will be temporarily effective for 60 days, at which time an amended birth certificate listing the father's name will be due.)
   b. a child legally adopted by you or your spouse (including any probationary period during which the child is required to live with you),
   c. your stepchild,
   d. your grandchild, niece or nephew for whom the court has granted custody to you or your spouse.
3. 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 you for 50% or more support,
   e is otherwise eligible for coverage as a dependent except for age,
   f. the condition must have occurred prior to the dependent's 26th birthday and
   g. is not eligible for any other group health 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 working, despite his disability, the extent of his earning capacity will be evaluated.

To apply, contact the SEIB 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 SEIB within 60 days from the date the child would cease to be covered because of age.

NOTE: The SEIB reserves the right to periodically re-certify incapacitation.

STATE EMPLOYEES' INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
334-263-8326 / 1-866-836-9137 / FAX: 334.517-9778

Form LG08 Revised 9/13

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2014 CHANGE FORM
SOUTHLAND NATIONAL VOLUNTARY INSURANCE

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)	Sex	Date of Birth

Social Security Number	Contract Number	Home Telephone Number	Work Telephone 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)

CHANGE: ____ MAILING ADDRESS To: _____

____ NAME From: _____ To: _____

____ E-MAIL ADDRESS To: _____

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

☐ 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.*

☐ 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 — MONTH/DAY/YEAR

☐ Death _____
☐ Divorce _____
Attach divorce decree
☐ Dependent no longer eligible _____
Explain: _____
☐ Other: _____
Explain: _____

REASON FOR ADDITION — MONTH/DAY/YEAR

☐ Marriage _____
☐ Birth of Child _____
☐ Adoption of Child _____
☐ Other: _____
Explain: _____

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

TO BE COMPLETED BY EMPLOYER

Effective Date of Change: _____

_____
Local Government Unit Name

_____
Account Number

_____
Signature of Insurance Clerk Date

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 SEIB's behalf.

_____
Employee Signature Date

* A "qualifying event" is birth, marriage, adoption, death, divorce, or otherwise losing dependent status.
If documentation is not attached, we must receive your documentation within 60 days of receiving this change form.

GENERAL INFORMATION

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

The term "dependent" includes the following individuals subject to appropriate documentation such as a Social Security number, marriage certificate, birth certificate, court decree, etc.

1. Your spouse (excludes divorced or common-law spouse).
2. A child under age 26, only if the child is:
   a. your son or daughter. (A court decree establishing paternity will be temporarily effective for 60 days, at which time an amended birth certificate listing the father's name will be due.)
   b. a child legally adopted by you or your spouse (including any probationary period during which the child is required to live with you),
   c. your stepchild,
   d. your grandchild, niece or nephew for whom the court has granted custody to you or your spouse.
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   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 you for 50% or more support,
   e is otherwise eligible for coverage as a dependent except for age,
   f. the condition must have occurred prior to the dependent's 26th birthday and
   g. is not eligible for any other group health insurance benefits.

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To apply, contact the SEIB 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 SEIB within 60 days from the date the child would cease to be covered because of age.

NOTE: The SEIB reserves the right to periodically re-certify incapacitation.

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LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2014 CANCELLATION FORM
SOUTHLAND NATIONAL VOLUNTARY INSURANCE
OPEN ENROLLMENT

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)	Sex	Date of Birth

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.**

TO BE COMPLETED BY EMPLOYER

Effective Date of Cancellation: 01/01/2014

_____
Local Government Unit Name

_____
Account Number

_____
Signature of Insurance Clerk Date

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 SEIB's behalf.

_____
Employee Signature Date

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

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