2027



ADMINISTRATIVE PROCEDURES GUIDE

LOCAL GOV
health + wellness
SERVICE EXCELLENCE INNOVATION



Local Gov Health and Wellness is pleased to offer your employees health insurance coverage under the Local Government Health Insurance Plan (LGHIP). Our mission is to provide a best-in-class, affordable health care program that is effectively communicated and offers excellent benefits, financial soundness, and innovative approaches to improve the health and well-being of our members. We take this mission seriously and it is embedded in everything we do.

For years, Local Gov has provided a robust suite of benefits at a cost significantly lower than the average premiums found in Alabama, the Southeast, and nationwide. A key contributor to this success is our proactive wellness program which identifies members at-risk for serious health conditions and connects them with targeted support. Programs like Virta, Hinge Health, Dr+ on Demand, and other virtual wellness programs have made a measurable difference in our members' health outcomes and have helped keep premiums affordable.

We are committed to staying at the forefront of healthcare innovation. Our team continually evaluates new programs that can positively impact members' well-being and reinforce our leadership in providing health insurance for local government entities.

Exceptional service is a cornerstone of our approach. Each month, we recognize team members who go above and beyond to deliver 'white glove' service to our benefit administrators and members. It is our goal for each of our employees to embody this standard, ensuring that every interaction feels like a white glove experience- thoughtful, attentive, and exceptional from start to finish.

This guide provides a comprehensive overview of eligibility and enrollments, the wellness program, premium details, and the billing procedures. If you have any questions or if we can be of further service, please visit the 'Contact Us' section of our website, www.lghip.org, or contact a member of our staff at (334) 851-6802 or 1-866-836-9137.

We thank you for trusting Local Gov to provide the health insurance benefits for your employees.

Sincerely,

David C. Hilyer,
Chief Executive Officer

LOCAL GOV
health + wellness

Local Government Health Insurance Board
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Phone: 334-851-6802 or 1-866-836-9137 | www.lghip.org

2027 LGHIB ADMINISTRATIVE GUIDE

Summary of Changes

The information below is a summary of changes to the 2027 Administrative Guide. This may not contain all revisions to the Administrative Guide. We recommend you review the entire Administrative Guide each year for a full and complete understanding of all updates.

- **Update to the Retired Participants Returning to Work Rules** - Retired participants that return to work and enroll in active employee coverage through the State Employees' Health Insurance Plan (SEHIP), Public Education Employees Health Insurance Plan (PEEHIP) or the (LGHIP), will be allowed a one-time special enrollment period to re-enroll in LGHIP retiree coverage through their former employer. (See page 14 for additional information).
- **Update to the Premium Invoice Payment Procedures** - If a unit is delinquent on two consecutive payments, the unit's coverage will be cancelled retroactively back to the end of the month for which the last premium was received. (See page 27 and the Unit Termination Provisions in Chapter 11 for more information).



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CHAPTER 1

Coverage Details

Coverage for Active Employees and Non-Medicare Retirees

Local Gov offers medical benefits through Blue Cross and Blue Shield of Alabama (BCBSAL) and prescription drug benefits through Prime Therapeutics for active employees and non-Medicare retirees. A unit may also choose to offer dental coverage administered by BCBSAL in addition to medical coverage.

Coverage for Medicare Retirees

Local Gov offers a Medicare Advantage plan through UnitedHealthcare for units that elect to provide coverage for their Medicare retirees.

Voluntary Plans

Local Gov also offers voluntary dental, vision, and cancer plans administered by Southland Benefit Solutions. These plans may be elected individually by eligible employees. (See the Southland Voluntary Insurance Plan section later in this Guide for more information).

More Information

You can find more information about these plans by visiting Local Gov's website, www.lghip.org. The website has relevant information on our health insurance program, including plan books, the wellness program, rates, forms, and other information related to the administration of the program.

CHAPTER 2

Employee Participation Requirement

Within 30 days of employment, all newly eligible employees must either enroll in the LGHIP or decline coverage by submitting a Declination of Coverage form (LG04) with proof of acceptable other coverage. This other acceptable coverage must comply with the Affordable Care Act (ACA) and provide minimum value coverage or otherwise provide minimum essential coverage as defined in the ACA. Acceptable plans include, but are not limited to, qualified group and individual plans, Marketplace, Medicare, Medicaid, and Tricare.

If an eligible employee has declined coverage and later loses their other coverage, the unit must immediately enroll the employee in the LGHIP. Coverage will be effective the date the other coverage ended.

Upon initial hire or loss of other coverage, if a unit fails to timely enroll an eligible employee or provide a Declination form with proof of other acceptable coverage, the unit will be subject to monetary penalties. Local Gov will also enroll the employee in coverage for the following month or allow the employee to decline coverage going forward by providing proof of other acceptable coverage. If the monetary penalties are not paid, the unit will be in violation of the LGHIP's rules and may be terminated from participation in the LGHIP.

Elected officials, if covered by the unit, must either enroll or decline coverage by providing proof of acceptable other coverage, or opt out of the LGHIP.

A unit cannot offer any other health insurance coverage for eligible employees or retirees (if the unit offers LGHIP retiree coverage) in competition to the LGHIP.



CHAPTER 3
Who is Eligible?

The definitions in this section apply to all units regardless of whether the unit is subject to the ACA employer shared responsibility provisions.

PARTICIPANTS

Eligible Employee*

An employee who receives a W-2, is in an employee/employer relationship and regularly works 30 hours or more per week.

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

Elected Official*

An elected official is an individual elected to public office by the vote of the people at the state, county, or municipal level of government. The unit decides when it joins the LGHIP whether it will cover its elected officials. This decision may only be changed during open enrollment.

Retiree*

The unit also decides when it joins the LGHIP whether it will allow eligible retirees to continue coverage with the LGHIP and whether it will provide coverage for Medicare retirees. These decisions may only be changed during open enrollment. If the unit decides to provide coverage for its retirees, the coverage must be offered uniformly to all retirees. For more information on retiree coverage rules, please see the Retiree Coverage section later in this Guide.

ELIGIBLE DEPENDENTS

The term "dependent" includes the following individuals:

- The participant's spouse (excludes a divorced spouse)
- A child under age 26, only if the child is:
  - The participant's biological son or daughter
  - Legally adopted by the participant, or
  - The participant's stepchild
- A dependent, under age 19, for whom the participant, or his or her spouse, has legal and physical custody granted by a court of competent jurisdiction. Proof of custodial relationship must be verified every two years by Local Gov.
- An incapacitated child** over age 25 provided the child is:
  - unmarried,
  - permanently mentally or physically disabled or incapacitated,
  - incapable of self-sustaining employment,
  - dependent upon the participant for 50% or more financial support,
  - otherwise eligible for coverage as a dependent child except for age,
  - had the condition prior to the child's 26th birthday, and
  - not eligible for any other group insurance benefits.

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

*The term "employee" and "participant" as used throughout the remainder of this Guide may refer to eligible employees, elected officials and retirees. Any differences will be specifically mentioned in this Guide.

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

See the "Enrolling an Incapacitated Child" section for critical enrollment deadlines. If deadlines are not met, coverage may be denied.

DEPENDENT DEFINITIONS AND DOCUMENTATION REQUIREMENTS

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

INELIGIBLE PARTICIPANTS

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

Affordable Care Act (ACA) Exception

Under the ACA, a temporary, seasonal, intermittent or emergency employee otherwise ineligible for coverage under the LGHIP's enrollment rules must be offered coverage if the unit is subject to the ACA with 50 or more full-time employees (or full-time equivalents) in the prior calendar year and the employee averages working more than 30 hours a week, or 130 hours in a month, during the unit's measurement period. Units with fewer than 50 full-time employees (including full-time equivalents) are not subject to the ACA employer shared responsibility provisions. All units subject to the ACA will be responsible for complying with all ACA employer shared responsibility provisions. Local Gov cannot provide guidance regarding a unit's compliance with the ACA.

If your unit is subject to the ACA and you believe that you must offer coverage to one of your temporary, seasonal, intermittent, or emergency employees, you must submit an ACA Verification Form (LG23) verifying that your unit is subject to the ACA, and the employee averages working more than 30 hours a week, or 130 hours a month, during the unit's measurement period. The form must include the following information:

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

An employee eligible pursuant to the ACA provisions must enroll in the LGHIP or submit a Declination of Coverage form with proof of acceptable other coverage.

Ineligible Elected Officials

An individual that does not meet the elected official definition in this Guide. For example, a board member elected by a governmental entity or an association.

Ineligible Retirees

An individual that does not meet the retiree eligibility criteria outlined in this Guide, such as an individual who is involuntarily terminated.

INELIGIBLE DEPENDENTS

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

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

NATIONAL MEDICAL SUPPORT NOTICES

A National Medical Support Notice (Notice) is an order from a child support enforcement agency directing the LGHIP to cover the eligible employee's child regardless of whether the employee has enrolled the child for coverage. If Local Gov receives a Notice from a child support enforcement agency directing the child be enrolled in the LGHIP, Local Gov will determine whether the Notice is qualified. Local Gov has adopted procedures for determining whether a Notice is qualified, and a copy of the procedures may be obtained free of charge by contacting us.

The LGHIP will cover an employee's child if required to do so by a Qualified Notice and the child will be enrolled for coverage effective as of a date specified by Local Gov, but not earlier than the first day of the month following Local Gov's determination the Notice is qualified. If a unit is not able to withhold the necessary contribution from the employee's paycheck, Local Gov is not required to extend coverage to the child.

Coverage may continue for the period specified in the Notice until the child ceases to qualify as an eligible dependent. If the employee is required to pay extra to cover the child, Local Gov will charge the unit for that coverage. During the period the child is covered due to a Qualified Notice, all LGHIP provisions and limits remain in effect except as otherwise required by federal law.

While the Qualified Notice is in effect, the LGHIP will make benefit payments – other than payments to providers – to the parent or legal guardian who has been awarded custody of the child. Claims reports will be sent directly to the child's custodial parent or legal guardian.

RETIRED PARTICIPANTS RETURNING TO WORK

Retired participants that return to work averaging 30 or more hours per week or become an eligible elected official will be considered an eligible employee for insurance purposes and will have to either enroll as an active employee or decline coverage and provide proof of other acceptable coverage. For purposes of this section, acceptable coverage may include LGHIP non-Medicare retiree coverage through another unit. For example, John Smith is enrolled in LGHIP non-Medicare retiree coverage under Unit A, and is now employed 35 hours per week at Unit B. John must either enroll as an active employee under Unit B and cancel his retiree coverage under Unit A, or decline coverage through Unit B and remain enrolled in LGHIP non-Medicare retiree coverage through Unit A.

Retired participants that return to work and enroll in active employee coverage through the State Employees' Health Insurance Plan (SEHIP), Public Education Employees Health Insurance Plan (PEEHIP) or the LGHIP, will be allowed a one-time special enrollment period to re-enroll in LGHIP retiree coverage through their former employer. The retiree must re-enroll in retiree coverage within 60 days of loss of active employee coverage in the SEHIP, PEEHIP, or LGHIP. Retirees who do no not enroll during this one-time special enrollment period will not be allowed to re-enroll later.

One-Time Enrollment Policy:
Eligible retirees must enroll at the time of retirement. If coverage is declined, enrollment will not be allowed after the retirement date. Retirees who elect coverage and are canceled for any reason thereafter will not be allowed to enroll later, unless permitted under the Retired Participants Returning to Work section.

MEDICARE AND PARTICIPANTS

Enrolled employees entitled to Medicare, and their dependents, are provided benefits through the LGHIP under the same conditions as other eligible employees and their dependents not entitled to Medicare. Local Gov will not provide benefits that supplement Medicare. The employee has the right to elect coverage under the LGHIP on the same basis as any other eligible employee.

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

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

For participants entitled to Medicare because of End Stage Renal Disease (ESRD), the LGHIP will be primary for the 30-month coordination period, which begins on the date the participant is first eligible to enroll in Medicare due to ESRD. After the 30-month coordination period ends, Medicare becomes primary if the participant retains eligibility based on ESRD.



NOTIFICATION OF ELIGIBILITY CHANGES

Participant

It is the participant's responsibility to notify Local Gov immediately of any eligibility changes, including change of address. The participant will be responsible for any claims paid by the LGHIP because of the failure to promptly notify Local Gov of a change in the enrollment status, or the eligibility, of a covered dependent.

Unit

It is the unit's responsibility to notify Local Gov of any change in eligibility of a participant.



CHAPTER 4

Enrollment Rules

NEW ELIGIBLE EMPLOYEES

Within 30 days of employment, all new eligible employees must either enroll in the LGHIP or decline coverage by submitting a Declination of Coverage form (LG04) with proof of acceptable other coverage. Acceptable proof is current documentation from an employer/insurance carrier verifying current coverage.

ACCEPTABLE PROOF

- Proof of Coverage letter/certificate from the insurance carrier with a current date (may be printed from the carrier's website or on letterhead)
- Medicare Card
- Letter from employer stating employee is currently covered under the employer's plan

NOT ACCEPTABLE PROOF

- Insurance card
- Explanation of Benefits Documentation (EOB)
- Paystub
- Form 1095

EFFECTIVE DATE OF COVERAGE

Units have two options regarding the effective date of coverage for new employees:

- Date of Hire: The effective date of coverage will be the date of employment. A prorated premium will be billed for new employees on the next billing cycle.

- First Day of the Second Month After Date of Hire: The effective date of coverage will be the first day of the second full month following the employee's date of hire. For example, if an employee is hired in January, the effective date of coverage will be March 1.

Units may change their selection for the effective date of coverage by submitting a Unit Change form (LG11) during the annual open enrollment period in November. Upon approval by Local Gov, the new effective date of coverage will begin January 1.

Probationary Periods

As of January 1, 2022, the LGHIB will no longer allow probationary periods impacting the effective date of LGHIP coverage; however, existing units with an LGHIB approved probationary period as of January 1, 2022, will be grandfathered and allowed to continue utilizing the approved probationary period.

ELECTED OFFICIALS

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

- Enroll in the LGHIP within 30 days of assuming office. Elected officials will be treated as eligible employees for coverage purposes.
- Decline coverage in the LGHIP by submitting a Declination form with proof of acceptable other coverage.
- An elected official who declines coverage may enroll in the LGHIP upon loss of other coverage or at open enrollment.
- Opt-out of the LGHIP – If the elected official opts not to enroll at the time the elected official assumes office and does not submit a declination form with proof of acceptable other coverage, the elected official may only be allowed to enroll in the LGHIP upon election to a new term of office.
- An elected official who is covered as a dependent in the LGHIP may continue coverage as a dependent.

Elected officials who fail to elect one of the above options will be treated as if they chose to opt out of the LGHIP.

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

ENROLLMENT OF ELIGIBLE DEPENDENTS

A participant may apply for family coverage at their initial enrollment by submitting an Enrollment form (LG01). A participant may also apply for family coverage during open enrollment or due to a special enrollment event by submitting a New Dependent form (LG05) within 60 days of the qualifying event. See open enrollment and special enrollment sections for more information.

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

Note: To ensure that enrollment deadlines are met, forms should be submitted to Local Gov even if all the required documentation is not available.



ENROLLING AN INCAPACITATED CHILD

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

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

In these two situations, the child must meet all the Incapacitated Child eligibility requirements, including medical review approved by BCBSAL.

OPEN ENROLLMENT

An annual open enrollment period is held in November for eligible employees, participants, and units to make certain changes. Any changes submitted due to open enrollment will be effective January 1. Forms must be completed and submitted to Local Gov by November 30, with an effective date of January 1 indicated on the form.

During open enrollment, eligible employees may enroll by submitting an Enrollment form (LG01) and participants may add dependents or family coverage by submitting a New Dependent form (LG05).

If a participant does not want to change plans or add/drop family coverage during open enrollment, no paperwork is necessary.

During open enrollment, units may make the following changes by submitting a revised Unit Change form (LG11):

- change the effective date of coverage for new hires (date of hire or first day of second month after date of hire)
- add/drop non-Medicare/Medicare retiree coverage for the unit
- add/drop elected official's coverage for the unit
- add/drop BCBSAL dental coverage

Submission of a participant's enrollment or change form will not be accepted as a request to add/drop retiree, Medicare, elected official or dental coverage.

If a unit chooses to add retiree coverage during open enrollment, only those eligible employees who retire after January 1 may continue coverage as a retiree. If a unit discontinues retiree coverage during open enrollment, all currently enrolled retirees, including supernumeraries, will lose their LGHIP coverage effective January 1. COBRA coverage will be available to participants enrolled in non-Medicare retiree coverage for a period of 18 months. COBRA is not available for participants enrolled in the Medicare Advantage plan.

SPECIAL ENROLLMENT DUE TO THE LOSS OF OTHER COVERAGE

Eligible employees and dependents who decline coverage due to other acceptable coverage have special enrollment rights to enroll in the LGHIP when they lose their other coverage. Examples of qualifying events include:

- COBRA coverage (if elected) is exhausted;
- Loss of eligibility (including termination, divorce, death, reduction of hours of employment);
- Employer stopped contributing to coverage;
- A substantial change in their other acceptable coverage; or
- A substantial change in cost of the acceptable other coverage; or
- Loss of coverage under Medicaid or the state Children's Health Insurance Program (CHIP).

To request special enrollment, a participant must submit an Enrollment form (LG01) or a New Dependent Form (LG05) if adding a dependent within 60 days of losing other coverage. The request must also include documentation listing the name, reason, and date of loss for everyone affected by the loss of coverage (e.g., employment termination on company letterhead).

SPECIAL ENROLLMENT TO ADD FAMILY COVERAGE OR ADD A NEW DEPENDENT

Participants are also permitted to enroll a new dependent due to marriage, birth, adoption, placement for adoption, or legal custody. In addition, these qualifying events also allow the eligible employee to enroll in the LGHIP.

To add family coverage or add a new dependent, a participant must submit a New Dependent form (LG05) within 60 days of the qualifying event, along with proof of gaining a new dependent (e.g., marriage certificate, birth certificate, adoption papers).

Tag-Along Rule

When a new dependent becomes eligible for special enrollment, all eligible dependents can be added to LGHIP coverage at that time.

In the event the eligible employee declined coverage and now wants to enroll due to gaining a new dependent, the employee should submit an Enrollment form (LG01) along with the proper documentation.

The effective date of coverage will be:

- the date of birth;
- the date of marriage;
- the date the child was placed for adoption;
- the date of the court's order granting custody.

CANCELLATION OF DEPENDENT/FAMILY COVERAGE

A participant may only drop dependent/family coverage upon the occurrence of a qualifying event or during annual open enrollment. Proof of the qualifying event must be provided. The effective date of cancellation will be the last day of the month after the qualifying event, or January 1 if submitted during open enrollment. Qualifying events to cancel a dependent's coverage include, but are not limited to:

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

TRANSFERS

Participants who terminate employment from one unit and begin employment with another unit during the same calendar month will have coverage through their former employer to the end of the month. Coverage with the new unit will be based on that unit's effective date of coverage, with the exception of units that begin coverage on the date of hire. In that situation, coverage with the new unit will be effective the first day of the month following the date of hire.

Example for units with a date of hire effective date:
John is covered under Unit A and terminates his employment on August 14 to begin a new job with Unit B on August 15. Unit B offers coverage on the date of hire. In this scenario, John will have coverage through the end of August under Unit A and his new coverage through Unit B will begin on September 1.

Example for units with an effective date of the first day of the second month:
John is covered under Unit A and terminates his employment on August 14 to begin a new job with Unit B on August 15. Unit B offers coverage on the first day of the second month. In this scenario, John will have coverage through the end of August under Unit A and his new coverage through Unit B will begin on October 1. John may elect COBRA coverage under Unit A to have coverage during the month of September.

REHIRES

If an eligible employee is rehired by the same unit within 13 weeks and was enrolled in the LGHIP before their employment ended, the employee may re-enroll with coverage effective on the date of their rehire. If the unit is subject to the ACA provisions with 50 or more full-time employees (or full-time equivalents) in the prior calendar year, the employee must be offered coverage on the date of their rehire.

If an eligible employee is rehired by the same unit after 13 weeks from the termination of employment or the employee was not enrolled in the LGHIP before their employment ended, the employee will be treated as a new employee and coverage will be effective based on the unit's effective date for new employees.

MILITARY LEAVE

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA) and Alabama law, an employee on qualified military leave longer than 30 days has the right to elect continued health insurance coverage during periods of military service. Alabama Code § 36-12-6 provides the following regarding compensation for employees of local government entities:

> *"The governing body of any local governmental entity in this state may provide for any public employee of the entity who is called into active service in the Armed Forces of the United States during the war on terrorism which commenced in September 2001, to receive from his or her employer compensation in an amount which is equal to the difference between the lower active duty military pay and the higher public employment salary which he or she would have received if not called to active service. The amount of compensation which may be paid under this section to a local public employee called into active service may be paid for a period as determined by the local governing body under rules and regulations for processing claims for and payments of the compensation promulgated and implemented by the local governing body."*

Regarding health insurance coverage for public employees on military leave longer than 30 days, Alabama Code § 36-12-7(a) states:

> *"Any public employee who receives compensation from a public employer as provided by this act, while he or she is serving on active duty in the armed forces of the United States, may elect to continue with his or her individual or dependent coverage under the health insurance plan of the public employer for the duration of the time he or she receives the compensation. Premiums for dependent coverage shall be deducted from the compensation in the amount in effect at the time for an active employee with dependent coverage."*

When a participant receives compensation while on military leave, the participant may elect to continue individual or dependent coverage. The premiums will remain the same and will remain on the unit's billing.

If a participant does not receive compensation while on military leave longer than 30 days, the participant will be offered USERRA continuation coverage for up to 24 months. The premiums will be based on the applicable COBRA rate and billed to the participant.

In addition, COBRA continuation coverage will be offered to a participant and their dependents individually for up to 18 months. COBRA coverage may be extended to 36 months for a second qualifying event. The COBRA coverage period runs concurrently with the USERRA 24 months. The premium will be based on the applicable COBRA rate and will be billed to the participant.

If a participant on military leave does not return to work at the end of the military leave period, COBRA continuation coverage may be offered for up to 18 months for the employee and dependents.

PARTICIPANT TERMINATION OF COVERAGE

A participant's coverage will terminate on the last day of the month after the following events:

- Death;
- Termination;
- Leave without pay;
- Retirement;
- Elected official's term of office ends;
- When the participants cancel coverage (i.e., to enroll in other acceptable coverage);
- When premium payments cease;

- In the case of an ACA eligible participant, after the end of the applicable stability period if the participant does not average 30/130 or more hours per week/month during a subsequent measurement period; or
- When the unit withdraws from the LGHIP.

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

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

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

In many cases, the participant and/or their dependent(s) will have the option to choose COBRA continuation coverage. (See COBRA Section for more information)

LEAVE WITHOUT PAY (LWOP)

Participants on leave without pay (LWOP) or who receive proceeds or pay through a workers' compensation policy may continue coverage for a maximum of 12 months. The participant will remain on the unit's billing. Once a participant has been on LWOP for 12 months or has received workers' compensation proceeds or pay for 12 months, the unit must notify Local Gov. The participant may be eligible for COBRA at that time.

If the unit requires the participant to make the premium payment and the participant is canceled for nonpayment of premiums, the unit must submit a Cancellation form to Local Gov indicating the reason for cancellation. The cancellation will be effective on the last day of the month following notification to Local Gov.

If the participant returns to work and elected not to continue their coverage while on LWOP, the participant will be treated as a new hire. If the participant returns to work and elected to continue coverage under COBRA, the participant will not have a gap in coverage, as long as the COBRA period has not expired.

FAMILY AND MEDICAL LEAVE ACT

Local Gov will adhere to the provisions of the Family and Medical Leave Act.

ELECTRONIC SIGNATURE POLICY

In accordance with the Alabama Uniform Electronic Transaction Act (Ala. Code § 8-1A-1et seq.), Local Gov will accept electronic signatures for coverage requests provided the unit certifies that its electronic signature process complies with the Alabama Uniform Electronic Transaction Act and the following security requirements:

- Provides an identical copy of the original signed and executed document to the signer;
- Ensures non-repudiation; that the signer cannot deny the fact that he or she electronically signed the document.
- Captures information about the process used to capture signatures (i.e., create an audit trail), including but not limited to:
  - IP address;
  - Date and time stamp of all events;
  - All web pages, documents, disclosures, and other information presented;
  - What each party acknowledged, agreed to, and signed.
- Encrypts, end-to-end, all communication within the signature process. Encryption technologies shall comply with state encryption standards, including the requirements that cryptographic modules be validated to the current Federal Information Processing Standards (FIPS).

By signing and submitting a form with an electronic signature, the unit acknowledges and certifies its electronic signature process complies with the Alabama Electronic Transactions Act and the security requirements outlined in this section. These requirements constitute the minimum required for an acceptable electronic signature.



CHAPTER 5

Unit Online Portal/ Online Enrollment

MY.LGHIP.ORG

Local Gov's website, www.lghip.org, includes a secure portal for units and participants to access important information about their LGHIP coverage located at my.lghip.org.

Unit Administrators

Unit administrators must create an online unit administrator account to enroll eligible employees and dependents, terminate an employee's coverage, view their unit's wellness participation, and pay invoices.

Each unit must have an account on my.lghip.org.

LGHIP Participants

Participants may create an account to view their individual wellness screenings, view dependents listed on their coverage and update their email address and email preferences.

ONLINE ENROLLMENT

Unit administrators should utilize Local Gov's online enrollment program through my.lghip.org to enroll an eligible employee and dependents in LGHIP coverage or submit a Declination of Coverage form for the eligible employee.

When a unit enrolls an employee through the online enrollment system, Local Gov will send the unit emails on the status of the enrollment including whether it was submitted, not submitted, rejected, or completed. Training opportunities for online enrollment are available on the Local Gov's YouTube channel. The direct link to this channel can be found by visiting www.lghip.org and clicking on the YouTube icon.

ONLINE CANCELLATION

Unit administrators can efficiently cancel a participant's coverage through the unit's my.lghip account. Cancellations can be effective for a past, current, or future date.

CHAPTER 6

COBRA (Continuation of Group Health Coverage)

Federal law requires Local Gov to offer participants and their covered dependents who lose their LGHIP coverage the opportunity for a temporary extension of coverage. All participants enrolled in BCBSAL group 30000 coverage will have the right to choose continuation of coverage upon the loss of group health coverage due to a reduction in hours of employment or termination of employment (for reasons other than gross misconduct on the part of the participant).

UNIT NOTIFICATION RESPONSIBILITY

The unit is responsible for notifying Local Gov within 30 days of the following qualifying events:

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

COBRA ELECTION NOTIFICATION

It is the participant or dependent's responsibility to elect COBRA within 60 days from the date the notice was mailed or loss of coverage date, whichever is later.

TERMINATION FOR GROSS MISCONDUCT

If a unit terminates a participant for gross misconduct, the participant is not eligible for COBRA continuation coverage. However, the unit must indicate the termination was due to gross misconduct on the Cancellation form. If the unit only selects "involuntary termination" on the Cancellation form, a COBRA notice will be sent to the participant.

FMLA

If the participant is on a leave of absence covered by the Family and Medical Leave Act of 1993 (FMLA), and does not return to work, the participant, and all covered dependents, will be given the opportunity to elect COBRA coverage. The period of COBRA coverage will begin when the participant fails to return to work following the expiration of FMLA leave or when the unit informs Local Gov the participant does not intend to return to work, whichever occurs first.

PARTICIPANTS ON COBRA WHO RETURN TO WORK

When a former employee enrolled in COBRA continuation coverage returns to work for a unit, the individual must provide a letter requesting cancellation of COBRA coverage and an Enrollment form.

PROVISION FOR MEDICARE FOR COBRA BENEFICIARIES

COBRA beneficiaries with Medicare Parts A and B will be enrolled in the Medicare Advantage plan.

ADDITIONAL INFORMATION

For additional information on COBRA continuation coverage, including specific deadlines and lengths of coverage, please see the LGHIP Planbook.

IF AN EMPLOYEE HAS ANY QUESTIONS

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

LOCAL GOV CONTACT INFORMATION

All notices and requests for information should be sent to the following address:
Local Gov Health and Wellness
Attn: COBRA
Post Office Box 304901
Montgomery, AL 36130



CHAPTER 7

Employee Eligibility Audit

Local Gov will periodically audit all units to ensure all participants enrolled in the LGHIP are eligible and that all eligible employees have either enrolled or declined in the LGHIP. The Local Gov Audit department will review payroll records and other necessary documentation, via secure email, to verify compliance with the LGHIP's eligibility and enrollment rules. Onsite visits to a unit will only be necessary if any discrepancies in the records cannot be resolved.

AUDIT PROCEDURES

- Local Gov will notify each unit of its scheduled audit date.
- Once a unit receives an audit notice, the unit will have 10 business days to provide the requested documentation.
- If deemed necessary, Local Gov will conduct an onsite visit.
- At the conclusion of the audit, Local Gov will provide the unit with the findings from the audit.

TREATMENT OF AUDIT RESULTS

Local Gov may impose one or more of the following actions for enrollment violations:

- move the unit to the standard premium category for at least two years;
- require full or partial payment of back premiums;
- require full or partial payment of non-recallable claims;
- impose monetary penalties.

Units that refuse to cooperate with the audit may be subject to group termination.

CHAPTER 8

Wellness Program

The Local Gov wellness program supports members in managing their health. This free, voluntary program is available to active employees, non-Medicare retirees, and their spouses covered by LGHIP (Group 30000).

The main feature is a voluntary wellness screening, which includes:

- Blood pressure check
- Height and weight measurement
- Testing for cholesterol (HDL, LDL, total), triglycerides, and glucose levels via a finger-stick blood sample

Participants will also be asked about their history of high cholesterol, high blood pressure, or diabetes, and any medications they take for these conditions. The screening is designed to help identify risk factors at an early stage where treatment can lead to better outcomes. If the results deem the member at risk, they are encouraged to discuss the results with their medical provider and they will receive a referral to their primary care physician with the office visit copay waived. Early detection can reduce the risk of hypertension, pre-diabetes, diabetes, heart disease, and obesity. Information on programs like Virta, which helps manage type 2 diabetes and pre-diabetes, may also be provided during the screening. Eligible members can enroll in Virta at no cost.

Screenings can be performed at the worksite, by a provider (copays may apply), at a BCBSAL participating pharmacy, or a county health department. If performed by a provider, the Provider Screening form from the Local Gov website must be used.

The Wellness Program will only accept screenings completed by an approved method. For a list of screening sites and pharmacies, visit www.lghip.org.

Screening results are confidential and will not be disclosed publicly or to the unit. Participants cannot be discriminated against based on their medical information or for choosing not to participate.

Units with 80% or higher participation by active employees from August 1 to July 31 may qualify for the preferred premium category if other conditions are met. Only active employees who participated by July 31 are counted towards the unit's participation percentage. Screenings must be completed by July 31 and submitted by August 15.

Units can view their wellness participation and a listing of active employees who have been screened by logging into your unit's my.lghip.org account and selecting 'Wellness Participation' from the menu.

Should you have any questions or need further information regarding Local Gov's Wellness Program, please contact our wellness department at (334) 851-6802 (option 4).

CHAPTER 9

Premiums

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

PREMIUM CATEGORY CRITERIA FOR UNITS THAT DO NOT OFFER LGHIP RETIREE COVERAGE

Standard

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

- Less than three months of participation in the LGHIP.
- Less than 80% wellness participation* by their active employees during the wellness qualifying period.
- Delinquent on two or more occasions within the last two years. Local Gov may allow units to pay their premium payments via automatic bank draft and remain in the preferred premium category.

Preferred

Units who meet all the criteria below are classified in the preferred premium category:

- More than three months of participation in the LGHIP.
- 80% or more wellness participation* by their active employees during the wellness qualifying period.
- Has not been delinquent on two premium payments within the last two years.

***Units can view their wellness participation and a listing of active employees who have been screened by logging into your unit's my.lghip.org account.*

ADDITIONAL PREFERRED PREMIUM CRITERIA FOR UNITS OFFERING RETIREE COVERAGE

Units that offer retiree coverage must also meet these additional requirements to be classified in the preferred premium category:

- 5% or more of unit's total enrollment are retirees, or
- Unit has certified that all retired employees eligible for coverage under the LGHIP's retiree rules were offered LGHIP retiree coverage. The LGHIB will send a certification form to all units that offer retiree coverage and are below the 5% threshold to certify they have offered coverage to all eligible retirees. If the unit does not submit the form to the LGHIB, the unit will be classified in the standard premium category.

EFFECTIVE DATE OF PREMIUM CATEGORY

Changes in premium category, as well as any Board approved rate changes, are typically effective the beginning of the next plan year (January 1). However, units moving to the standard premium category due to late payments could have a premium category change take effect during the plan year. A unit may also have a rate increase and a change in rate category in the same year. Following the wellness qualifying period, Local Gov will begin the premium category assignment process. Wellness screening forms will not be accepted after August 15. After the wellness deadline, units will be notified of their premium category that will be effective January 1.

The premium category assignment is subject to change if Local Gov determines that the unit no longer meets the criteria for the preferred premium category.

Appeal of Premium Category Assignment
Units may appeal to Local Gov to change their premium category. An appeal must be received by Local Gov within fifteen calendar days following the date of the unit's category notice. An appeal must be in writing and include all supporting documentation necessary to justify the basis of the appeal.

PAYMENT OF PREMIUM

Each unit determines the portion of the premium it will charge its employees, and retirees, for both single and family coverage. Local Gov will only accept payment from the unit, not from the unit's employees or retirees. COBRA premiums are the only exception to this rule and may be paid by the unit's former employee.

Each unit must pay the invoice as written. Partial payments will not be accepted and changes to the invoice are not allowed. Additions, deletions and changes will be reflected on the next invoice provided the proper forms (cancellation, change or enrollment) are received and approved by Local Gov.

If a unit is delinquent on two consecutive payments, the unit's coverage will be cancelled retroactively back to the end of the month for which the last premium was received. (See the Unit Termination Provisions in Chapter 11 for more information.)

(See the Billing Procedures Chapter for more information).

PREMIUMS

The following premium schedules specify the monthly premiums each unit will be billed. COBRA subscribers will be billed directly.



MONTHLY PREMIUMS

EFFECTIVE JANUARY 1, 2027

Premiums reflect single or family coverage per month.

EMPLOYEE PREMIUMS

STANDARD RATES WITH DENTAL	
Single	$753
Family	$1,901

STANDARD RATES NO DENTAL	
Single	$723
Family	$1,826

PREFERRED RATES WITH DENTAL	
Single	$688
Family	$1,676

PREFERRED RATES NO DENTAL	
Single	$658
Family	$1,601

COBRA PREMIUMS

STANDARD COBRA RATES WITH DENTAL	
Single	$768
Family	$1,939

STANDARD COBRA RATES WITHOUT DENTAL	
Single	$737
Family	$1,862

PREFERRED COBRA RATES WITH DENTAL	
Single	$702
Family	$1,710

PREFERRED COBRA RATES WITHOUT DENTAL	
Single	$671
Family	$1,633

COBRA DISABLED PREMIUMS

STANDARD COBRA SUBSCRIBER DISABLED RATES WITH DENTAL	
Single	$1,130
Family	$2,301

STANDARD COBRA SUBSCRIBER DISABLED RATES WITHOUT DENTAL	
Single	$1,085
Family	$2,210

PREFERRED COBRA SUBSCRIBER DISABLED RATES WITH DENTAL	
Single	$1,032
Family	$2,040

PREFERRED COBRA SUBSCRIBER DISABLED RATES WITHOUT DENTAL	
Single	$987
Family	$1,949

CHAPTER 10

Billing Procedures

INVOICE

Local Gov will generate an invoice for each unit in advance of the following month's coverage with a listing of participants and their coverage election. The invoice is a summary of the total single and family participants covered, the previous balance owed, if any, the current month's amount, and the total balance due. Units will receive an email notification each month when their invoices are available to view and download from the unit's myLGHIP account. Units will not be mailed invoices or billing details.

The invoices also show which participants have completed a wellness screening. The unit's myLGHIP account will also show the unit's wellness percentage for the current screening period.

The unit must pay the balance shown on the invoice. Units are not allowed to make any corrections or adjustments to this balance.

If a unit is delinquent on two consecutive payments, the unit's coverage will be cancelled retroactively back to the end of the month for which the last premium was received.

INVOICE CHANGES

All corrections and adjustments approved by Local Gov will be reflected on the next month's invoice after additions, cancellations and changes in the current billing period are processed. Premium credits will be issued subject to timely notifications of cancellations.

PAYMENT OPTIONS

Automatic Draft Payment

This service is offered at no charge to the unit. The monthly invoice will indicate the amount withdrawn from the unit's bank account on the due date or the next business day. For example, a bill issued October 18 will provide the amount that will be drafted from the unit's account on November 1 or the following business day. Units shall provide the LGHIB with at least 60 calendar days' notice before making any change to its bank account or other information that may impact ACH transactions. Units can makes these changes using the ACH form. Instructions and contact information are available on the LGHIB website.

Electronic Check (e-check) Service

Payment by e-check is available by logging in to the unit's my.lghip.org or by calling Local Gov's Accounting Department at 1-866-836-9137.

Mail

Please remember payment must be received prior to the due date to avoid coverage cancellation. Payments by mail may be sent to:

Local Gov Health and Wellness
Accounting Department
PO Box 304901
Montgomery, AL 36130

CHAPTER 11

Local Government Unit Withdrawal and Termination

UNIT WITHDRAWAL

A unit may withdraw from the LGHIP by providing written notice to Local Gov at least six months prior to the effective date of withdrawal via certified mail to the following address:

Local Gov Health and Wellness
Post Office Box 304901
Montgomery, AL 36130

The notice of withdrawal must include a resolution from the unit's governing body signifying its intent to withdraw from the LGHIP. Any unit that withdraws shall be responsible for paying its claims incurred prior to the date of withdrawal, but not reported and paid until after the date of withdrawal. Any unit that withdraws shall serve a three-year waiting period from the effective date of the unit's withdrawal before the unit may apply for re-enrollment into the LGHIP. The unit must have been in good standing with Local Gov prior to withdrawal to be reinstated.

Pursuant to Alabama Code § 11-91A-2(f), any organization that provides or administers health insurance benefits through the LGHIP shall not provide or administer health insurance benefits to any entity that withdraws from the LGHIP for a period of two years from the effective date of withdrawal.

UNIT TERMINATION

Local Gov may terminate a unit's participation in the LGHIP when Local Gov deems it to be in the best interest of the LGHIP or for any reason including, but not limited to:

- Failure to comply with Local Gov's policies and procedures; or
- Delinquent payment of two consecutive premiums.

If Local Gov terminates a unit's participation, the unit shall be responsible for paying its claims incurred prior to the date of the local unit's termination but not reported and paid until after the date of termination. Any unit terminated shall serve a three-year waiting period from the effective date of the unit's termination before the unit may apply for re-enrollment into the LGHIP.

Pursuant to Alabama Code § 11-91A-2(f), any organization that provides or administers health insurance benefits through the LGHIP shall not provide or administer health insurance benefits to any unit that is terminated from the LGHIP by Local Gov for a period of two years from the effective date of termination.

CHAPTER 12

Unit Forms

FORM #	FORM NAME	FORM USES
LG11	Unit Change Form	Unit completes to change information regarding type of participation, coverage election and effective date of coverage.
LG13	Preauthorized Payment Service Agreement	Unit completes to enroll in automated payment for monthly billing.
LG23	Affordable Care Act Full-Time Employee Verification Form	Unit completes to enroll an employee who may be eligible for coverage based on the Affordable Care Act.
LG28	Listing of Elected Officials for a City or Town	Municipalities complete form regardless of whether unit offers coverage for elected officials.
LG29	Listing of Elected Officials for a County Commission	County Commissions complete form regardless of whether unit offers coverage for elected officials.
	Blue Cross and Blue Shield Supply Request Form	Unit completes form to order BCBSAL plan books, Local Gov's benefit guides, summary of benefits and more.

To view all unit forms, visit www.lghip.org/employer/unit-lghib-forms-premiums.

CHAPTER 13

Member Forms

FORM #	FORM NAME	FORM USES
LG01	Employee Enrollment	Enroll eligible employee into the LGHIP
LG04	Declination of Coverage	New eligible employee completes if they are currently enrolled in other acceptable health insurance coverage and desires to decline LGHIP coverage. Must submit proof of other coverage when submitting this form.
LG02	Member Information Changes Form	Change participant's or dependent's name, address, date of birth, telephone number and email address.
LG05	New Dependent Form Must submit form within 60 days of dependent eligibility.	• Change participant's coverage from single to family, adding dependents. • Add new dependents to current family coverage.
LG06	Dependent Cancellation Form **Must submit form within 60 days of qualifying event for cancellation.**	• Change participant's coverage from family to single coverage. • Cancel health insurance coverage for dependents from participant's coverage.
LG03	Cancellation Form Must submit form within 30 days of termination or as soon as possible. Subscriber cancellations can be processed online through my.lghip.org	Must be completed if the participant is no longer employed; loses eligibility for LGHIP coverage; participant wishes to decline and enroll in acceptable coverage; retires and is not enrolling in retiree coverage; goes on military leave or leave without pay; or dies.
LG12	Provider Screening Form	Participant or spouse uses this form if annual wellness screening is performed by their health care provider.
LG17	HIPAA Authorization Form	Member completes this form to request LGHIP release protected health information to authorized individual.
LG14	COBRA Automatic Payment Authorization	COBRA subscribers may complete to enroll in automatic payments.

Note: All forms must be verified and signed by the designated payroll/personnel officer with the exception of the Provider Screening Form (LG12) HIPAA Authorization Form (LG17), and COBRA Automatic Payment Authorization Form (LG14).

To view all member forms, visit www.lghip.org/member/member-lghib-forms.

CHAPTER 14
Retiree Coverage

This chapter only applies to units offering retiree coverage.

Units that provide retiree coverage must offer it uniformly to all future eligible retirees. To enroll in LGHIP retiree coverage, a completed Retiree Coverage Enrollment form (LG22) must be submitted to Local Gov 30 days prior to the retirement date.

RETIREE ELIGIBILITY RULES

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

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

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

Only retirees who retire from active status are eligible to continue LGHIP coverage as a retiree. Employees who are involuntarily terminated are not eligible for retiree coverage.

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

ELECTED OFFICIALS

Elected officials are subject to the retiree eligibility rules above. The unit must submit a Retiree Coverage Enrollment form to continue coverage.

SERVICE RETIREMENTS

For service retirements, a participant must have 10 years of coverage in the LGHIP and provide proof of the retiree's years of full-time service with a unit covered under the LGHIP. In addition to service with a participating unit, below is a listing of governmental service that Local Gov will accept toward the 25 years of service requirement for retirees under 60:

- Military Service (must be active military service. No credit given for National Guard Service, unless deployed)
- Municipal and county service
- Service with the State of Alabama
- Service with an employer that meets the definition of an entity eligible to participate in a retirement plan administered by the Retirement Systems of Alabama*.
- Up to one year of annual and sick leave time (combined) which employee would have been compensated for upon retirement**

*Service credit is not dependent upon whether the employer actually participated in the retirement plan, only that the employer met the definition of an employer eligible to participate in a retirement plan administered by the Retirement Systems of Alabama. Also, service credit is not dependent upon whether past service is purchased from a retirement plan.

**Leave compensation must be verified by the employer. Leave time used to purchase retirement credit in lieu of cash compensation will also be accepted.

DISABILITY RETIREMENTS

In addition to having 10 years of creditable coverage in the LGHIP, retirees must provide proof that an application for a disability determination from the Social Security Administration (SSA) was made prior to retiring. Eighteen months of COBRA coverage will be offered at retirement. If the retiree does not receive an SSA determination during the COBRA period, the retiree's COBRA coverage will expire after 18 months and no further coverage through Local Gov will be offered.

If the retiree receives an SSA approved disability determination and provides a copy of the determination letter to Local Gov during the 18-month COBRA period, the retiree's COBRA coverage will be converted to non-Medicare retiree coverage.

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

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

ONE-TIME ENROLLMENT POLICY

Eligible retirees must enroll at the time of retirement. If coverage is declined, enrollment will not be allowed after the retirement date. Retirees who elect coverage and are canceled for any reason thereafter will not be allowed to enroll later unless permitted under the Retirees Returning to Work section in Chapter 3.

TERMINATION OF COVERAGE

A participant who retires from a unit that allows retirees to continue coverage has the option of electing retiree coverage or COBRA. If the participant chooses to cancel health insurance, the unit must send a signed Cancellation form 30 days prior to the retirement date. If a participant intends to request COBRA, it should be indicated on the Cancellation form; however, if COBRA coverage is elected, the participant will forfeit their right to elect retiree coverage later.



A retired participant whose unit does not allow Medicare retirees to continue coverage in the LGHIP must submit a Cancellation form 30 days prior to the participant's Medicare eligibility date. A copy of the Medicare card may be required. COBRA will be offered to participants and dependents for 18 months.

Retired members do not pay LGHIP premiums with pre-tax dollars, so a retiree can cancel their LGHIP coverage anytime during the plan year on a prospective basis. A signed Cancellation or Dependent Cancellation form must be sent to Local Gov to cancel coverage. The coverage will be canceled on the last day of the month following receipt of the Cancellation or Dependent Cancellation form.

MONTHLY PREMIUMS

EFFECTIVE JANUARY 1, 2027

RETIREE PREMIUMS

RETIRED PARTICIPANTS RETURNING TO WORK

For information on retirees who return to work averaging 30 or more hours per week at a participating unit, please see the section, "Retired Participants Returning to Work" in Chapter 3.

SUPERNUMERARIES

Supernumeraries will be classified for insurance purposes as retired employees.

BILLING

Participants who elected LGHIP retiree coverage will remain on the unit's billing, and it will be the unit's responsibility to collect the appropriate premiums.

If the unit requires the retiree to make the premium payment and the retiree elects not to pay, the unit must submit a Cancellation form selecting non-payment as the reason for cancellation. A retiree's coverage cannot be cancelled retroactively.

NON-MEDICARE RETIREE WITH DENTAL	SINGLE	FAMILY
Retiree	$1,421	
Retiree & dependent (not Medicare)	$1,421	$2,621
Retiree & dependent (Medicare)	$1,421	$1,649
Retiree & 2 dependents (Medicare)	$1,421	$1,877

NON-MEDICARE RETIREE WITHOUT DENTAL	SINGLE	FAMILY
Retiree	$1,391	
Retiree & dependent (not Medicare)	$1,391	$2,546
Retiree & dependent (Medicare)	$1,391	$1,589
Retiree & 2 dependents (Medicare)	$1,391	$1,787

MEDICARE RETIREE WITH DENTAL	SINGLE	FAMILY
Retiree	$228	
Retiree & dependent (not Medicare)	$228	$1,214
Retiree & dependent (Medicare)	$228	$456
Retiree & 2 dependents (Medicare)	$228	$684

MEDICARE RETIREE WITHOUT DENTAL	SINGLE	FAMILY
Retiree	$198	
Retiree & dependent (not Medicare)	$198	$1,139
Retiree & dependent (Medicare)	$198	$396
Retiree & 2 dependents (Medicare)	$198	$594



MONTHLY PREMIUMS

EFFECTIVE
JANUARY 1, 2027

RETIREE COBRA PREMIUMS

COBRA NON-MEDICARE RETIREE WITH DENTAL	SINGLE	FAMILY
Retired COBRA subscriber	$1,449	
Retired COBRA subscriber & dependent (not Medicare)	$1,449	$2,672
Retired COBRA subscriber & dependent (Medicare)	$1,449	$1,682
Retired COBRA subscriber & 2 dependents (Medicare)	$1,449	$1,915

COBRA NON-MEDICARE RETIREE WITHOUT DENTAL	SINGLE	FAMILY
Retired COBRA subscriber	$1,419	
Retired COBRA subscriber & dependent (not Medicare)	$1,419	$2,597
Retired COBRA subscriber & dependent (Medicare)	$1,419	$1,621
Retired COBRA subscriber & 2 dependents (Medicare)	$1,419	$1,823

COBRA MEDICARE RETIREE WITH DENTAL	SINGLE	FAMILY
Retired COBRA subscriber	$233	
Retired COBRA subscriber & dependent (not Medicare)	$233	$1,239
Retired COBRA subscriber & dependent (Medicare)	$233	$466
Retired COBRA subscriber & 2 dependents (Medicare)	$233	$699

COBRA MEDICARE RETIREE WITHOUT DENTAL	SINGLE	FAMILY
Retired COBRA subscriber	$202	
Retired COBRA subscriber & dependent (not Medicare)	$202	$1,162
Retired COBRA subscriber & dependent (Medicare)	$202	$404
Retired COBRA subscriber & 2 dependents (Medicare)	$202	$606

CHAPTER 15

Medicare

The LGHIP remains primary for retirees until the retiree is entitled to Medicare. Once enrolled in Medicare, Medicare coverage becomes primary, and the LGHIP will pay as secondary coverage.

A Medicare retiree and/or Medicare dependent must have both Medicare Parts A and B to enroll the UnitedHealthcare Group Medicare Advantage (PPO) Plan (Medicare Advantage), a Medicare health and Part D plan. Medicare Part B premiums are the retiree's responsibility.

To enroll in the Medicare Advantage plan, a Retiree Coverage Enrollment form must be sent 30 days prior to the Medicare effective date, or for an active employee, prior to the employee's retirement date. The form should indicate "Medicare" under the Retirement section of the form. Upon receipt by Local Gov, Medicare retirees and/or their Medicare dependent(s) will be automatically enrolled in the Medicare Advantage Plan.

Medicare Advantage enrollment cannot be backdated. If Local Gov does not receive 30 days' notice of a Medicare employee's retirement, the retiree cannot be enrolled in Medicare Advantage with an effective date of the Medicare employee's retirement date and may have a gap in coverage until the retiree can be enrolled at the next available effective date.

The Medicare Advantage Plan will go into effect unless the retiree completes an LGHIP (Medicare Advantage) Opt-Out form and returns it to Local Gov within 21 days from the date of the opt-out notice. If a retiree opts-out, re-enrollment is not permitted.

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

If a retiree or dependent becomes entitled to Medicare because of a disability before age 65, the retiree must notify Local Gov to enroll in Medicare Advantage.

Participants enrolled in Medicare Advantage can review the Evidence of Coverage (EOC) booklet online at www.lghip.org. The EOC outlines the plan's eligibility, rules, regulations, and benefits. The website will also contain links to the current drug formulary, the participating pharmacy directory, and the provider directory.

MEDICARE PART B

If a Medicare-eligible participant is transitioning from active to retiree status and misses the Medicare enrollment period, then:

- The participant may have coverage in the LGHIP group 30000 until the next Medicare General Enrollment period, which runs from January 1st - March 31st, for benefits that would have been covered by Medicare Part B and for prescription drug coverage. The participant will be required to pay the non-Medicare rate for this coverage.
    - If the participant does not pay this amount or does not enroll in Medicare Part B coverage during the next Medicare General Enrollment period, the participant's coverage will be cancelled, and the participant will not be allowed to re-enroll in coverage through Local Gov.

At any time, if a retired participant's Medicare-eligible dependent fails to maintain Part B coverage, the Medicare-eligible dependent's coverage will be cancelled.

TERMINATION OF COVERAGE

A unit may prospectively disenroll a participant from the Medicare Advantage plan due to failure to pay monthly premiums on a timely basis. CMS does not allow retroactive disenrollment for failure to pay monthly premiums. To disenroll a participant for failure to make a premium payment, the unit must:

- Send the participant written notice informing the participant of the past due balance and the prospective disenrollment date; **AND**

- Provide prospective notice to the participant that their Medicare Advantage enrollment is ending at least 21 calendar days prior to the effective date of the disenrollment. The notice must include information about other individual plan options the participant may choose and how to request enrollment. The notice must also advise the participant that the disenrollment action means the individual will not have Medicare drug coverage and provide information about the potential for late-enrollment penalties that may apply in the future.

- If the participant pays the total past due balance before the disenrollment date, the participant will not be disenrolled.

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

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

For more information, please see Local Gov's Policy for Disenrollment of Retirees from Medicare Advantage for Failure to Pay Premiums located on Local Gov's website.

PROVISION FOR MEDICARE FOR COBRA BENEFICIARIES

COBRA beneficiaries with Medicare Parts A and B will be enrolled in the Medicare Advantage plan.

CHAPTER 16

Retirement Forms

FORM #	FORM NAME	FORM USES
LG22	Retiree Coverage Enrollment and Years of Service Verification Form	Enrollment into either the LGHIP's non-Medicare or Medicare coverage. Form also verifies years of service with an LGHIP unit or approved non-LGHIP employer to go toward eligibility for retiree coverage.
LG03	Cancellation Form	Must be completed if the participant retires and is not enrolling in retiree coverage
LG18	UHC Opt-Out Form	Eligible retiree or Medicare dependent will complete if they do not elect to be enrolled in LGHIP's Medicare Advantage coverage through UnitedHealthcare.

Note: All forms must be verified and signed by the designated payroll/personnel officer with the exception of the UHC Opt-Out Form (LG18). Forms must be submitted 30 days prior to retirement date.

To view all retirement forms, visit www.lghip.org/member/member-lghib-forms

CHAPTER 17

Southland Voluntary Insurance Plan

SUMMARY OF BENEFIT PLANS

Eligible employees and eligible retirees may choose dental, vision, or cancer coverage through the Southland LGHIP Voluntary Insurance Plan (Southland).

ELIGIBLE EMPLOYEES AND RETIREES

All eligible employees who are eligible for coverage through the LGHIP are eligible to participate in the Southland plan. Non-Medicare and Medicare retirees enrolled in the LGHIP health coverage may also enroll in the Southland Plan. Retirees not enrolled in LGHIP health coverage are not eligible to enroll in the Southland Plan.

ELIGIBLE DEPENDENTS

The same dependent eligibility rules apply to the Southland plan except the participant may cover their spouse if they are covered, or if they are eligible for coverage, as an eligible employee.

ENROLLMENT

Eligible employees may enroll for coverage upon initial hire or during open enrollment. New employees' coverage will be effective according to the unit's effective date of coverage for health insurance. Existing employees can elect coverage during open enrollment which will be effective January 1.



FAMILY COVERAGE ENROLLMENT

Enrollment of Eligible Dependents

An employee may apply for family coverage at their initial enrollment by submitting a Southland Enrollment form (LG07) or if an eligible dependent qualifies for special enrollment by submitting a Southland Change and Cancellation form (LG08) within 60 days of the qualifying event, or during annual open enrollment. See Open Enrollment and Special Enrollment sections for more information.

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

Note: to ensure that enrollment deadlines are met, change forms should be submitted to Local Gov even if all the required documentation is not available.

OPEN ENROLLMENT

An annual open enrollment period is held in November during which participants may drop dependents or family coverage by submitting a change form (Form LG08). Any changes made during open enrollment will be effective January 1.

CANCELLATION OF PARTICIPANT'S COVERAGE

A participant can cancel coverage in the Southland Plan during open enrollment for an effective date of January 1 of the following year. Outside of open enrollment, canceling Southland coverage requires proof of a qualifying event. To cancel coverage, a participant must submit a Southland Change and Cancellation form (LG08). Coverage will be canceled at the end of the month following the qualifying event.

CANCELLATION OF DEPENDENT/ FAMILY COVERAGE

Outside of open enrollment, dropping dependent coverage requires a qualifying event (death, divorce, or otherwise losing dependent status). A participant must submit a Southland Change and Cancellation form (LG08) along with proof of the qualifying event. Coverage will be canceled at the end of the month following the qualifying event.

COBRA

See COBRA section earlier in the book for additional details.

BILLING

Premiums for participation in the Southland plan will be reflected on the unit's monthly billing.

MONTHLY PREMIUMS

EFFECTIVE JANUARY 1, 2027

SOUTHLAND VOLUNTARY INSURANCE PREMIUMS

EMPLOYEE	
Vision Single	$12
Vision Family	$20
Dental Single	$44
Dental Family	$44
Cancer Single	$12
Cancer Family	$24

COBRA	
Vision Single	$12
Vision Family	$20
Dental Single	$46
Dental Family	$46
Cancer Single	$12
Cancer Family	$24

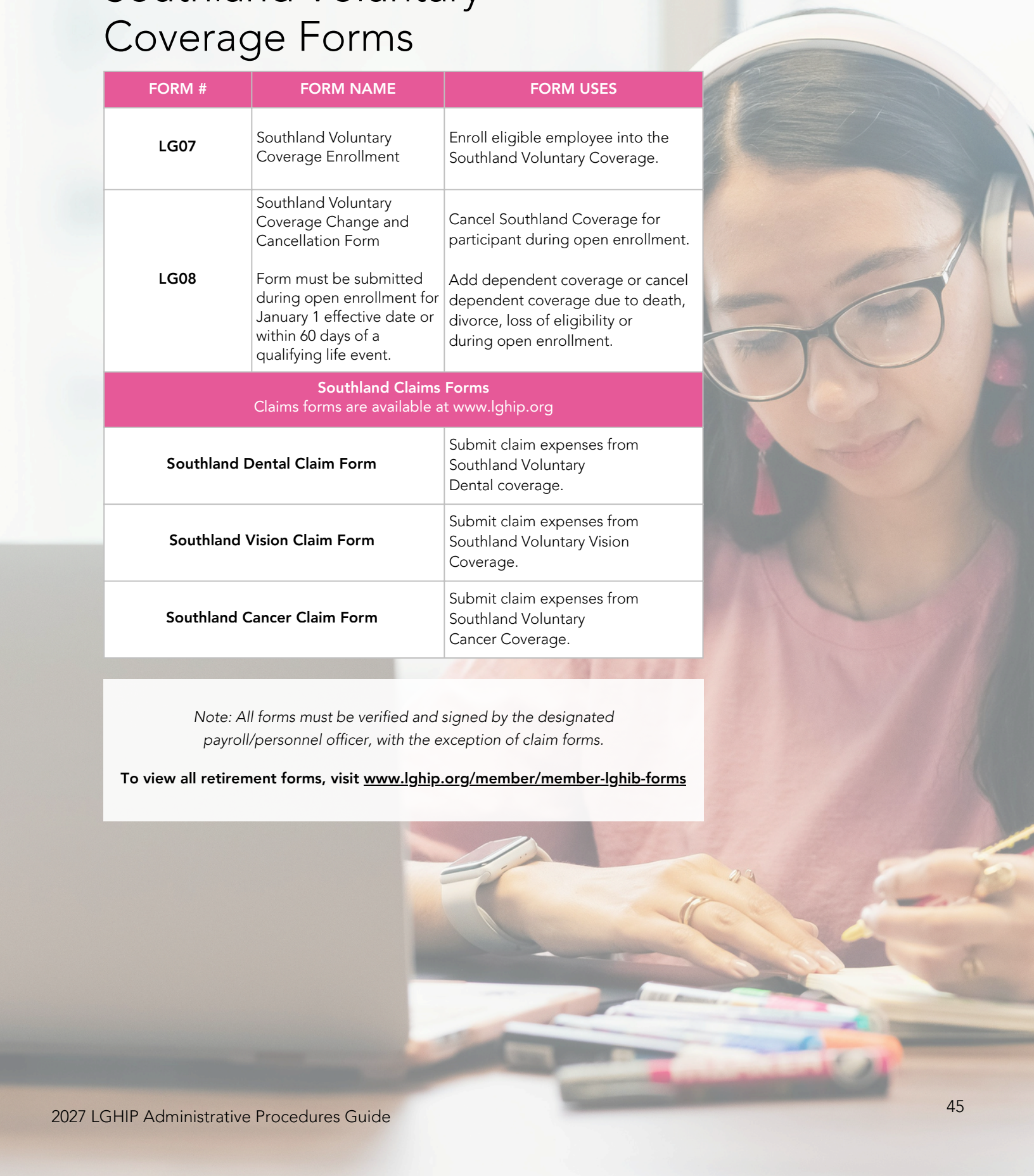
CHAPTER 18

Southland Voluntary Coverage Forms

FORM #	FORM NAME	FORM USES
LG07	Southland Voluntary Coverage Enrollment	Enroll eligible employee into the Southland Voluntary Coverage.
LG08	Southland Voluntary Coverage Change and Cancellation Form Form must be submitted during open enrollment for January 1 effective date or within 60 days of a qualifying life event.	Cancel Southland Coverage for participant during open enrollment. Add dependent coverage or cancel dependent coverage due to death, divorce, loss of eligibility or during open enrollment.
Southland Claims Forms Claims forms are available at www.lghip.org		
Southland Dental Claim Form		Submit claim expenses from Southland Voluntary Dental coverage.
Southland Vision Claim Form		Submit claim expenses from Southland Voluntary Vision Coverage.
Southland Cancer Claim Form		Submit claim expenses from Southland Voluntary Cancer Coverage.

Note: All forms must be verified and signed by the designated payroll/personnel officer, with the exception of claim forms.

To view all retirement forms, visit www.lghip.org/member/member-lghib-forms



CHAPTER 19

New Unit Application & Enrollment

If you are interested in joining our Plan, please contact Local Gov and we will determine if your entity is eligible. In determining eligibility, we may request a copy of your entity's incorporating documents, bylaws, and information regarding how your entity is funded. If we determine your unit qualifies for coverage in the Plan, the unit must submit a New Unit Application as outlined below.

NEW UNIT APPLICATION

A New Unit Application includes the following required documents:

- Resolution/Memorandum of Understanding (MOU): The unit, or its governing body, must adopt and approve the Resolution to enroll in the Plan. The Unit must also sign the MOU to participate in the Plan.
- Participation form: This form includes a unit's coverage election, effective date of coverage, contact information and enrollment census information. Also on the form, units may elect to provide coverage for elected officials and retirees pursuant to our rules. The following documents must also be submitted with the participation form:
    - A list of all employee names and the last four digits of their Social Security numbers. Local Gov can provide the applying unit an Excel template to complete.
    - A list of COBRA participants: All current COBRA subscribers must be identified on a separate list as "COBRA." Include their name, the last four of their Social Security number, address, qualifying event, and the date COBRA coverage originally began. Local Gov may accept the COBRA report from the previous insurance carrier. We will administer the COBRA benefits through the end of the participant's COBRA election period. Do not fill out an enrollment form for COBRA subscribers. We will send them a letter and a COBRA application.
    - For cities, towns and counties, a listing of elected officials, which includes office and term of each elected official. This must be submitted even if the unit does not elect coverage for elected officials.
- Business Associate Agreement: This agreement is a requirement of the Health Insurance Portability and Accountability Act (HIPAA) and must be signed by the unit.
- Preauthorized Payment Service Agreement: To enroll in ACH payment, the unit will complete the form and include a copy of a voided check.

Effective Dates

New units must select one of the following two options for the effective date of coverage for new eligible employees:

- Date of Hire: The effective date of coverage will be the first day of employment. If the unit selects this option, a prorated premium will be billed for new employees on the next billing cycle.
- First Day of the Second Month: The effective date of coverage will be the first day of the second full month following the 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.

Units may change their selection for the effective date of coverage by submitting a Unit Change form (LG11) during the annual open enrollment period (Nov.1 – Nov. 30). Upon approval by Local Gov, the new effective date of coverage will begin January 1.

Retirees (For Units Offering Coverage for Retirees)

A retiree is an individual who retires from active employment and meets Local Gov's eligibility requirements. Please see the Administrative Guide for eligibility requirements. Involuntarily terminated employees are not eligible for retiree coverage in the Plan. Eligible retirees must enroll on the first day they become eligible for retiree coverage. If coverage is declined, enrollment will not be allowed at a later date. Also, if existing retirees decline coverage at the unit's initial enrollment, they cannot enroll in the Plan at a later date.

A unit has the option to offer non-Medicare retiree coverage and Medicare coverage. However, to offer Medicare coverage, the unit must offer non-Medicare coverage to their retirees. Election of these coverage options can be changed during open enrollment for a January 1 effective date.

Elected Officials (For Units Offering Coverage for Elected Officials)

An elected official is an individual elected to public office by the vote of the people at the state, county or municipal level of government.

If a new unit chooses to cover elected officials, all elected officials of the unit have the following options:

- Enroll in the Plan: Elected officials may enroll in the Plan when the unit initially joins the Plan, or at the beginning of a new term.

APPLICATION PROCESS

The Application and documentation may be emailed to Local Gov via secure email to enrollments@lghip.org (please contact our enrollments division for the secure email to be initiated) or mailed to Local Gov to the address below:

Mail

Local Gov Health and Wellness
Post Office Box 304901
Montgomery, Alabama 36130

After the Application has been approved, Local Gov will ask the unit to send Enrollment or Declination forms for all eligible employees. After review, Local Gov will send an invoice with the correct application fee amount. The application fee is $50 per employee, with a minimum of $100. Once this is paid, the unit will receive a certificate of participation in the Program. Local Gov will also create an online account for the new unit to access the online enrollment system. During this process, the unit may use the online enrollment system to submit Enrollment and Declination of Coverage forms along with proof of other acceptable coverage. (See the Enrollment Rules section for additional information).

For units with fewer than 300 employees:

- If you submit the Enrollment/Declination of Coverage forms through the online system by the 20th of the month, your coverage will start on the first day of the second full month after submission.
  - Example: Submit by January 20th and coverage will start March 1st.
- If you submit the forms on or after the 21st, your coverage will begin on the first day of the third full month.
  - Example: Submit on January 21st or later and your coverage starts April 1st.

For units with 300 or more employees:

- You will be notified separately about your coverage start date.

FUTURE UNIT CONTACT AND COVERAGE CHANGES

After units are enrolled in the Plan, a Unit Change form (LG11) must be submitted to revise the unit's contact information, including changes to an address, telephone number, email address, or updates to any of the unit's contacts.

See Enrollment and Eligibility chapters for more information.



CHAPTER 20

New Unit Enrollment Forms

FORM #	FORM NAME	FORM USES
LG13 LG15 LG16 BAA	New Unit Application Package	A new unit must complete this package to apply for coverage in the Plan. The package includes information regarding type of participation, coverage election, effective date of coverage, contact information, a resolution required for enrollment, the MOU, business associate agreement, an employee information sheet for current employees, and Pre-Authorized Payment Service Authorization Agreement (ACH enrollment). If applicable, please include a list of COBRA participants.
LG01	Employee Enrollment Form	Enroll eligible employee into the Plan Coverage. Form must be signed by employee and unit administrator.
LG04	Declination of Coverage Form	Employee must complete to decline coverage in the Plan. Must submit proof of other coverage when submitting this form.
LG07	Southland Voluntary Coverage Enrollment	Enroll eligible employee into the Southland Voluntary Coverage.
LG28	Municipal Unit Elected Officials Form	Municipal units with elected officials must complete this form, regardless of whether the unit offers coverage to its elected officials.
LG29	County Unit Elected Officials Form	County units with elected officials must complete this form, regardless of whether the unit offers coverage to its elected officials.

To view all new unit enrollment forms, visit www.lghip.org/employer/unit-lghib-forms-premiums.

CHAPTER 20
Appendix

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

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

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

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

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

(2) Subject to acceptance by the board, any of the following entities or organizations not already employer participants in the program pursuant to subdivision (1) which by resolution legally conforming to rules prescribed by the board elects to have its elected officials, full-time employees, and retired employees become eligible for health care coverage under the program:
Any county, any municipality, any municipal foundation, any fire or water district, authority, or cooperative, any regional planning and development commission established pursuant to Sections 11-85-50 through 11-85-73; the Association of County Commissions of Alabama; the Alabama League of Municipalities; the Alabama Retired State Employees' Association; the Alabama State Employees Credit Union; Easter Seals Alabama; Alabama State University; the Alabama Rural Water Association; Rainbow Omega, Incorporated; The Arc of Alabama, Incorporated, and any of the affiliated local chapters of The Arc of Alabama, Incorporated; United Ways of Alabama and its member United Ways; the Alabama Network of Children's Advocacy Centers and its member Children's Advocacy Centers; the Care Assurance System for the Aging and Homebound and its affiliated local centers; any railroad authority organized pursuant to Chapter 13 of Title 37; or any solid waste disposal authority organized pursuant to Chapter 89A of Title 11.

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

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

(g) Any entities or organizations added to the Local Government Health Insurance Program on or after June 1, 2018, which were not identified as employer participants eligible for participation in the Local Government Health Insurance Program pursuant to subdivisions (1) and (2) of subsection (d) prior to June 1, 2018, shall be treated as separate entities and their premiums shall be established independently from employer participants that entered the program prior to this date.

(h) The board shall adopt rules as may be necessary for the effective administration of this section.

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MEMBER SERVICES

LGHIB Member Services
(334) 851-6802, Option 1

Blue Cross and Blue Shield of Alabama
Member Services
1-800-321-4391

Prime Therapeutics Member Services
1-800-321-4391

Accredo Specialty Pharmacy
1-833-715-0965

Southland Member Services
205-951-4455

UnitedHealthcare Member Services
1-866-950-6558


SERVICE EXCELLENCE INNOVATION
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