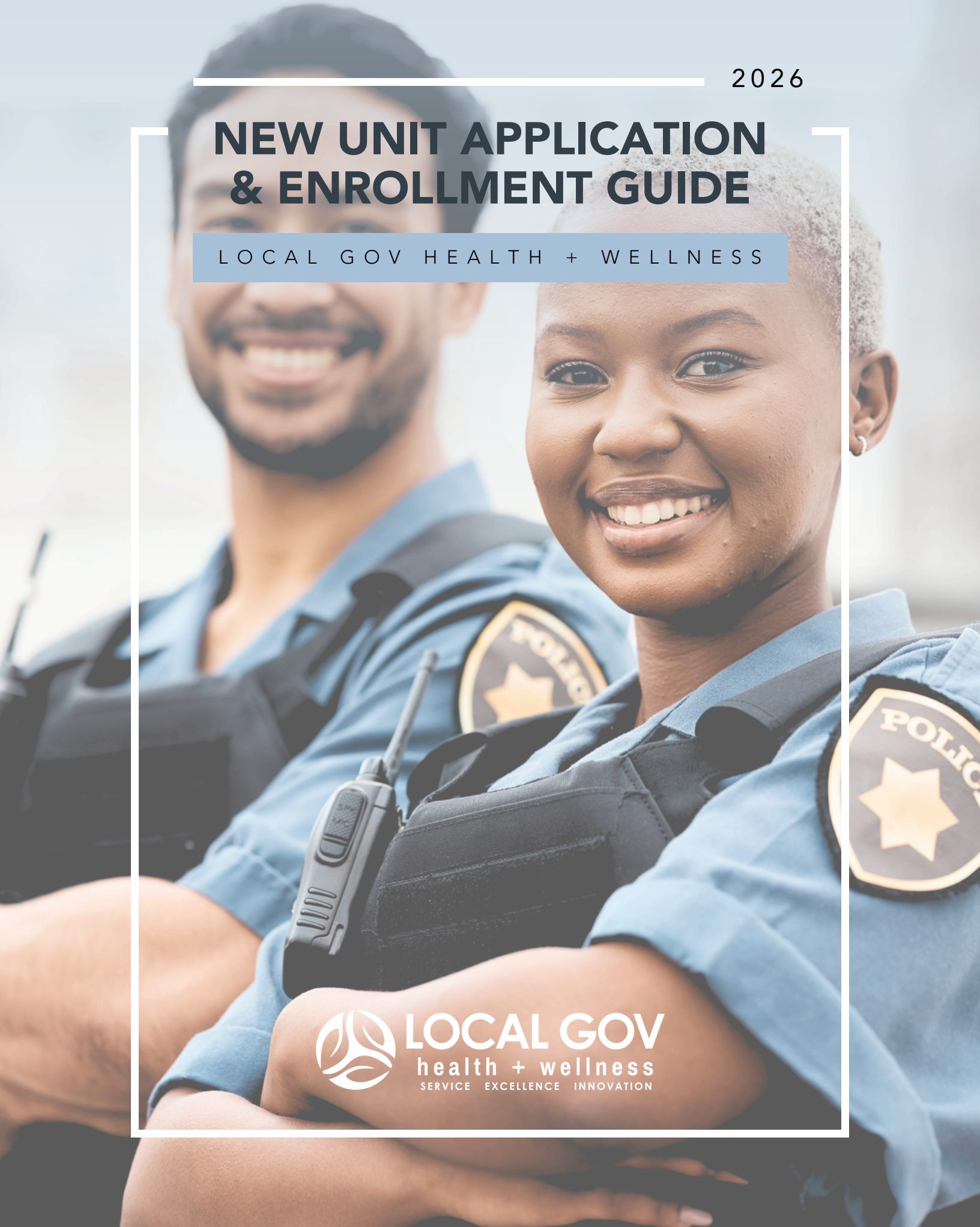
2026

NEW UNIT APPLICATION & ENROLLMENT GUIDE

LOCAL GOV HEALTH + WELLNESS



LOCAL GOV
health + wellness
SERVICE EXCELLENCE INNOVATION

Revised: December 2025

Welcome to the Local Government Health and Wellness Program! 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 imbedded in everything we do.

For years, our program has been able to offer a robust set of benefits at a cost well below the average premium of other plans in Alabama, the Southeast, and nationwide. This is due, in part, to our wellness program which identifies members who may be at-risk of certain serious health conditions and provides those members initiatives to address the conditions. Virta, Doctor on Demand, Hinge Health are just a few of the programs offered through the plan that have positively impacted our members' health and helped premiums stay affordable. We are constantly researching other programs that could have a significant, positive impact on our members' well-being that will allow our program to remain a leader in providing health insurance for local government entities.

This guide walks you through the application, eligibility and enrollment process and provides information on premiums. 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 team at 334-851-6802 or 1-866-836-9137.

We thank you for considering Local Gov to be a part of your employees' benefit package and providing for their health insurance needs.

David C. Hilyer,
Chief Executive Officer

SERVICE EXCELLENCE INNOVATION
LOCAL GOV
health + wellness

Local Government Health Insurance Board
PO Box 304901 | Montgomery, AL 36130
Phone: 334-851-6802 or 1-866-836-9137 | www.lghip.org

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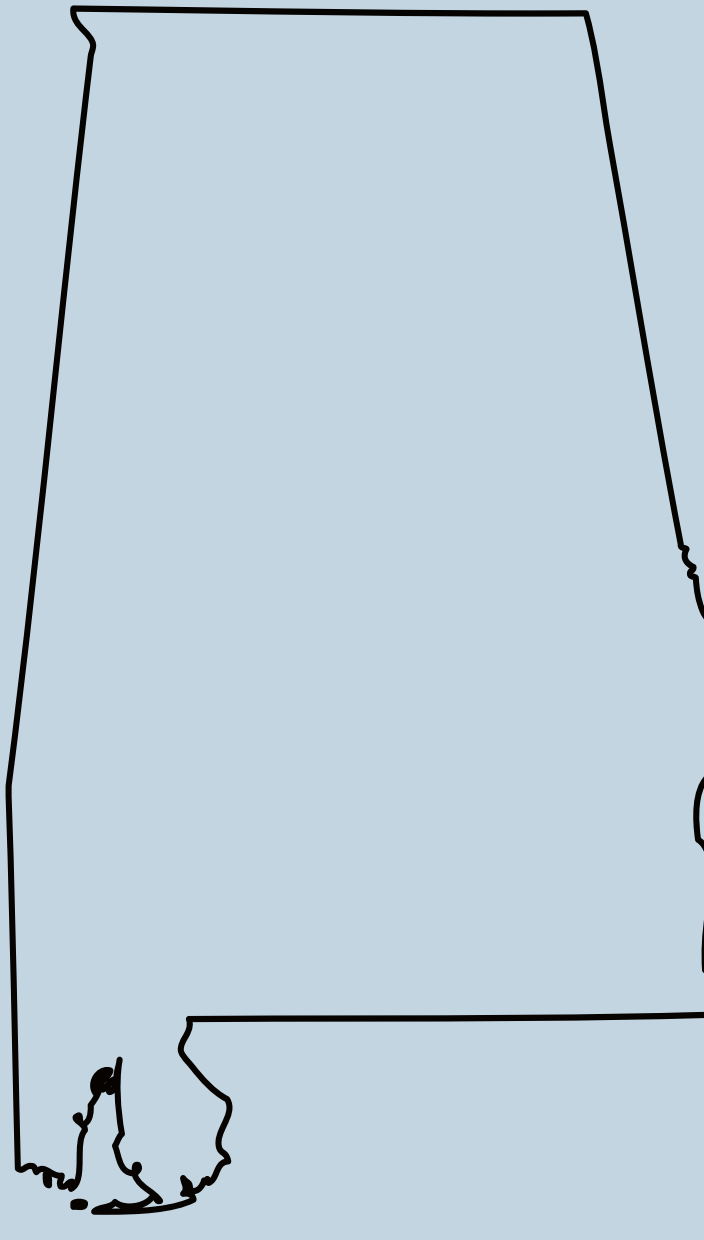

CHAPTER 1

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.

A unit participating in the Local Government Health insurance Plan (LGHIP) cannot offer health insurance coverage for eligible employees or non-Medicare retirees, if covered under the plan, in competition to the LGHIP.

Coverage for Medicare Retirees

Local Gov offers a Medicare Advantage plan through UnitedHealthcare for units that elect to provide coverage for their Medicare retirees. A unit participating in the LGHIP cannot offer health insurance coverage for eligible Medicare retirees, if covered under the plan, in competition to the LGHIP.

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 plan, including plan books, the wellness program, rates, forms, and other information related to the administration of the Plan.

CHAPTER 2
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: The unit, or its governing body, must adopt and approve the Resolution to enroll 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, and their dependents, 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.

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 Plan. 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.

ENROLLMENT INFORMATION FOR EMPLOYEES

All eligible full-time employees (an employee who receives a W-2, is in an employee/employer relationship and regularly works 30 hours or more per week) must either enroll in the Plan or decline coverage and provide proof of other acceptable coverage within 30 days of employment. This other acceptable coverage must comply with the Affordable Care Act (ACA) providing minimum value or otherwise provide minimum essential coverage as defined in the ACA. Other acceptable coverage includes but is not limited to: ACA qualified group and individual plans, Marketplace, Medicare, Medicaid and Tricare.. Acceptable proof is current documentation from an employer/insurance carrier verifying current coverage. If Local Gov discovers that a unit failed to 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. For more information, please see the Local Gov Health and Wellness Administrative Guide.

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 • Front and back copy of current Military ID
NOT ACCEPTABLE PROOF
• Insurance card • Explanation of Benefits Documentation (EOB) • Paystub • Form 1095

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.

- Decline coverage in the Plan: Elected officials may decline coverage in the Plan by submitting a declination form with proof of other acceptable coverage. An elected official who declines coverage may enroll in the Plan later upon loss of other acceptable coverage or at open enrollment.
- Opt-out of the Plan: If the elected official opts not to enroll in the Plan and does not submit a declination form with proof of other acceptable coverage, the elected official may only be allowed to enroll in the Plan upon election to a new term of office.
- An elected official who is covered as a dependent in the Plan 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 Plan.

Audit

Local Gov will periodically conduct reviews of all units to ensure units are complying with the rules and regulations governing the Plan. See the Audit section of the Local Gov Health and Wellness Administrative Guide for more information.

ENROLLMENT INFORMATION FOR 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
  - A child 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 dependent 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 contract. For example, if a dependent is eligible under a parent's coverage and is also eligible under their spouse's coverage, the dependent must choose one to enroll in and cannot be enrolled in both.

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

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

Please review the following Dependent Definitions and Documentation Requirements prior to submitting dependent enrollment information.

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 natural (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.

ELECTRONIC SIGNATURE POLICY

Local Gov Health and Wellness will accept electronic signatures for coverage requests provided the unit certifies that its electronic signature process complies with the Alabama Uniform Electronic Transaction Act (Ala. Code § 8-1A-1et seq.) 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 techologies 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 3

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.

All units must join at the standard rate for the first 90 days.

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.
- Has failed to pay its premium payment within 30 days from the due date 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 at 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 by either submitting a Retiree Enrollment form (LG22) to enroll the retiree in coverage, or by submitting a Cancellation form (LG03) indicating the retiree was offered but declined retiree coverage.

RETIREES

Local Gov non-Medicare and Medicare retiree premiums do not have standard or preferred categories.

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.

Local Gov bills in advance for the upcoming month's coverage. Each unit must pay the invoice as written by the due date indicated on the invoice. Partial payments will not be accepted and changes to the invoice are not allowed. Additions, deletions and changes by Local Gov will be reflected on the next invoice, provided the proper forms (cancellation, change or enrollment) are received and approved by Local Gov. Failure to remit payment for the full invoice amount before the due date may result in cancellation of coverage or may impact the unit's premium category classification.

PREMIUM SCHEDULES

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

MONTHLY PREMIUMS

EFFECTIVE JANUARY 1, 2026

EMPLOYEE PREMIUMS

STANDARD RATES WITH DENTAL	
Single	$730
Family	$1,844

STANDARD RATES NO DENTAL	
Single	$701
Family	$1,771

SOUTHLAND VOLUNTARY INSURANCE PLAN

Premiums reflect single or family coverage per month.

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

RETIREE PREMIUMS

NON-MEDICARE RETIREE WITH DENTAL	SINGLE	FAMILY
Retiree	$1,378	
Retiree & dependent (not Medicare)	$1,378	$2,542
Retiree & dependent (Medicare)	$1,378	$1,599
Retiree & 2 dependents (Medicare)	$1,378	$1,820
NON-MEDICARE RETIREE WITHOUT DENTAL	**SINGLE**	**FAMILY**
Retiree	$1,349	
Retiree & dependent (not Medicare)	$1,349	$2,469
Retiree & dependent (Medicare)	$1,349	$1,541
Retiree & 2 dependents (Medicare)	$1,349	$1,733
MEDICARE RETIREE WITH DENTAL	**SINGLE**	**FAMILY**
Retiree	$221	
Retiree & dependent (not Medicare)	$221	$1,178
Retiree & dependent (Medicare)	$221	$442
Retiree & 2 dependents (Medicare)	$221	$663
MEDICARE RETIREE WITHOUT DENTAL	**SINGLE**	**FAMILY**
Retiree	$192	
Retiree & dependent (not Medicare)	$192	$1,105
Retiree & dependent (Medicare)	$192	$384
Retiree & 2 dependents (Medicare)	$192	$576

COBRA PREMIUMS

EFFECTIVE JANUARY 1, 2026

STANDARD RATES WITH DENTAL	
Single	$745
Family	$1,881

STANDARD RATES NO DENTAL	
Single	$715
Family	$1,806

COBRA DISABLED PREMIUMS

STANDARD COBRA SUBSCRIBER DISABLED RATES WITH DENTAL	
Single	$1,095
Family	$2,231

STANDARD COBRA SUBSCRIBER DISABLED RATES NO DENTAL	
Single	$1,052
Family	$2,143

SOUTHLAND VOLUNTARY INSURANCE PLAN

Premiums reflect single or family coverage per month.

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

RETIREE PREMIUMS

COBRA NON-MEDICARE RETIREE WITH DENTAL	SINGLE	FAMILY
Retired COBRA subscriber	$1,406	
Retired COBRA subscriber & dependent (not Medicare)	$1,406	$2,592
Retired COBRA subscriber & dependent (Medicare)	$1,406	$1,631
Retired COBRA subscriber & 2 dependents (Medicare)	$1,406	$1,856
COBRA NON-MEDICARE RETIREE WITHOUT DENTAL	**SINGLE**	**FAMILY**
Retired COBRA subscriber	$1,376	
Retired COBRA subscriber & dependent (not Medicare)	$1,376	$2,518
Retired COBRA subscriber & dependent (Medicare)	$1,376	$1,572
Retired COBRA subscriber & 2 dependents (Medicare)	$1,376	$1,768
COBRA MEDICARE RETIREE WITH DENTAL	**SINGLE**	**FAMILY**
Retired COBRA subscriber	$225	
Retired COBRA subscriber & dependent (not Medicare)	$225	$1,201
Retired COBRA subscriber & dependent (Medicare)	$225	$450
Retired COBRA subscriber & 2 dependents (Medicare)	$225	$675
COBRA MEDICARE RETIREE WITHOUT DENTAL	**SINGLE**	**FAMILY**
Retired COBRA subscriber	$196	
Retired COBRA subscriber & dependent (not Medicare)	$196	$1,127
Retired COBRA subscriber & dependent (Medicare)	$196	$392
Retired COBRA subscriber & 2 dependents (Medicare)	$196	$588

CHAPTER 4

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, 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.

RESOLUTION

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

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

WHEREAS, pursuant to the requirements of the HIPAA privacy rules and LGHIB policies, _____ acknowledges it will not have access to claims data; and
(Name of Local Government Unit)

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

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

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

ADOPTED AND APPROVED THIS DATE: _____

If signed electronically, I acknowledge and certify the electronic signature process complies with the Alabama Uniform Electronic Transaction Act and the LGHIB rules outlined in the Administrative Guide.

_____
Authorized Person's Signature

_____
Type or Print Name

_____
Type or Print Title

Local Gov Health & Wellness

LOCAL GOV health + wellness SERVICE EXCELLENCE INNOVATION

PARTICIPATION FORM: FORM LG15

Local Government Unit: _____ Federal ID Number: _____

Mailing Address: _____

City: _____ County: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ County: _____ State: _____ Zip: _____

UNIT CONTACTS

Health Insurance Administrator

Name: _____ Title: _____

Phone: _____ Email: _____

☐ Check this box if the Administrator requires a separate login for the unit's my.lghip account. If selected, the Administrator will receive an email with login details from the Local Gov team.

Primary or Billing Contact (if different)

Name: _____ Title: _____

Phone: _____ Email: _____

☐ Check this box if the Administrator requires a separate login for the unit's my.lghip account. If selected, the Administrator will receive an email with login details from the Local Gov team.

☐ Check this box if this contact is the same as the Health Insurance Administrator.

Additional Contact (if different)

Name: _____ Title: _____

Phone: _____ Email: _____

☐ Check this box if the Administrator requires a separate login for the unit's my.lghip account. If selected, the Administrator will receive an email with login details from the Local Gov team.

☐ Check this box if this contact is the same as the Health Insurance Administrator.

Wellness Contact (if different)

Name: _____ Title: _____

Phone: _____ Email: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

☐ Check this box if the Administrator requires a separate login for the unit's my.lghip account. If selected, the Administrator will receive an email with login details from the Local Gov team.

☐ Check this box if this contact is the same as the Health Insurance Administrator.

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COVERAGE SELECTIONS

New units must select coverage allowances and effective date of coverage for all new eligible employees.
Units may change these selections during Open Enrollment (Nov. 1- Nov. 30).

BCBS Dental Coverage	☐	Yes	☐	No
Coverage for Non-Medicare Retirees	☐	Yes	☐	No
Coverage for Medicare Retirees	☐	Yes	☐	No
Coverage for Elected Officials	☐	Yes	☐	No
(for Cities, Towns, or Counties)				
Effective Date of Coverage	☐	Date of Hire	☐	1st Day of 2nd Month

ENROLLMENTS/DECLINATIONS

	Enroll:	Decline:	Not Applicable:
Active Employees			
Elected Officials			
Retired			
Total Number of Individuals Currently on COBRA			
Total Eligible Participants			

CONTRIBUTION AMOUNT

Single Coverage Participants	Number of Participants:	
	% Paid by Unit:	% Paid by Employee:
Family Coverage Participants	Number of Participants	
	% Paid by Unit:	% Paid by Employee:

Attach to this application package an alphabetical listing, by department, of all eligible employees' names and last four of their Social Security numbers. Please also include a list of all individuals currently enrolled in COBRA.

_____ _____

Name of Benefit Administrator Title

If signed electronically, I acknowledge and certify the electronic signature process complies with the Alabama Uniform Electronic Transaction Act and the LGHIB rules outlined in the Administrative Guide.

_____ _____

Signature of Benefit Administrator Date

FOR LGHIB USE ONLY

Date Coverage Will Begin: _____ Unit #: _____

Form LG01
Revised 7/25

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
ENROLLMENT FORM

EMPLOYEE INFORMATION (Please print or type)

Name (First, Middle Initial, Last)		Social Security Number		Date of Birth		Gender
Mailing Address		City	County	State	ZIP Code	
Physical Address *Must be completed by Medicare Retiree Enrollee		City	County	State	ZIP Code	
Primary Phone Number	Work Phone Number	Email Address:				

Employment Status (Check One)

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

Note: If you or your covered dependent(s) are covered by Medicare, you must submit a copy of your Red, White, and Blue Medicare Card and a physical address. Your name must match the name listed on your Medicare card.

Dependent Information - Documentation is required before dependents can be added to coverage. See back of form.

Name of Dependent First, Middle Initial, Last	Relationship to Participant	Gender	Date of Birth	Social Security Number
	☐ Spouse Date Married:	☐ M ☐ F		
	☐ Biological ☐ Adopted ☐ Step ☐ Custodial	☐ M ☐ F		
	☐ Biological ☐ Adopted ☐ Step ☐ Custodial	☐ M ☐ F		
	☐ Biological ☐ Adopted ☐ Step ☐ Custodial	☐ M ☐ F		
	☐ Biological ☐ Adopted ☐ Step ☐ Custodial	☐ M ☐ F		
	☐ Biological ☐ Adopted ☐ Step ☐ Custodial	☐ M ☐ F		
	☐ Biological ☐ Adopted ☐ Step ☐ Custodial	☐ M ☐ F		

Other Group Health Insurance Information

Do you have additional insurance coverage other than LGHIP coverage? ☐ Yes ☐ No

If yes, you must complete the Other Group Health Insurance Addendum on Page 3.

AFFIRMATION AND RELEASE

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

I understand and acknowledge that only eligible dependents may be added to my coverage. I understand and acknowledge that it is my responsibility to notify Local Gov immediately when the eligibility of a covered dependent changes. If it is determined that an act on my part (such as adding an ineligible person to coverage) or omission (such as failing to remove a person no longer eligible for coverage) results in or contributes to the payment of claims for persons ineligible for coverage, I will be personally responsible for all such overpayments and may be subject to disqualification from coverage under the plan.

_____ _____

Employee Signature **Date**

TO BE COMPLETED BY EMPLOYER

Full-Time Date of Hire: _____ **Local Government Unit Name:** _____ **Unit Number:** _____

If signed electronically, I acknowledge and certify the electronic signature process complies with the Alabama Uniform Electronic Transaction Act and Local Gov rules outlined in the Administrative Guide.

Signature of Benefit Administrator: _____ **Date:** _____

Local Gov Health and Wellness
(334) 851-6802 • 1-866-836-9137
Enrollments@lghip.org

GENERAL INFORMATION

Eligible Dependent

(Appropriate documentation must be attached.)

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

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

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

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

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 if they are 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 age 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 child has been adopted by someone other than their spouse and the participant has been relieved of their parental rights and responsibilities
- A daughter-in-law or son-in-law
- Grandchildren or other individuals related to the participant by blood or marriage for which the participant does not have legal and physical custody
- Grandchildren, nieces, or nephews aged 19 and older regardless of whether the participant has legal and physical custody
- Grandparents
- Parents
- A fiancé or live-in girlfriend or boyfriend

Enrolling an Incapacitated Child

To apply, contact the LGHIB to obtain an Incapacitated Child Certification form. A completed Incapacitated Child Certification form and proof of incapacity must be provided to the LGHIB no more than 60 days after the dependent's 26th birthday*. If the form and proof of incapacity is not submitted within the required time, 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 the LGHIB within 60 days of the incapacitated child's loss of other coverage, and
  - Medical review approved incapacitation status.

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

Other Group Health Insurance Addendum

Must be completed if you, your spouse and/or dependents have any other coverage.

LIST EACH INSURANCE COMPANY SEPARATELY (ATTACH ADDITIONAL SHEETS IF NECESSARY)			
Name of Contract Holder	Contract Holder Date of Birth	Group #	Insurance Contract #
Name of Insurance Company		Types of coverage (Check all that apply) ☐ Hospitalization ☐ Doctor's Visits ☐ Prescription Drugs ☐ Dental	
Name of Employer			
If other coverage includes prescription drug coverage, please complete the below (information can be found on your other coverage insurance card)			
Rx BIN Number	Rx ID		

Are you or any of your dependents covered on this insurance policy? ☐ Yes (list each covered individual below) ☐ No

Name(s) (First, Middle Name, Last)	Date of Birth	Coverage Effective Date(s)

LIST EACH INSURANCE COMPANY SEPARATELY (ATTACH ADDITIONAL SHEETS IF NECESSARY)			
Name of Contract Holder	Contract Holder Date of Birth	Group #	Insurance Contract #
Name of Insurance Company		Types of coverage (Check all that apply) ☐ Hospitalization ☐ Doctor's Visits ☐ Prescription Drugs ☐ Dental	
Name of Employer			
If other coverage includes prescription drug coverage, please complete the below (information can be found on your other coverage insurance card)			
Rx BIN Number	Rx ID		

Are you or any of your dependents covered on this insurance policy? ☐ Yes (list each covered individual below) ☐ No

Name(s) (First, Middle Name, Last)	Date of Birth	Coverage Effective Date(s)

LIST OF EMPLOYEES

Please list all full-time employees employed by your unit.

LOCAL GOV
health + wellness
SERVICE EXCELLENCE INNOVATION

NAME	LAST FOUR OF SSN	ENROLL	DECLINE

LIST OF EMPLOYEES

Please list all full-time employees employed by your unit.

If more than 20 employees, we will provide an Excel template to complete.

LOCAL GOV health + wellness
SERVICE EXCELLENCE INNOVATION

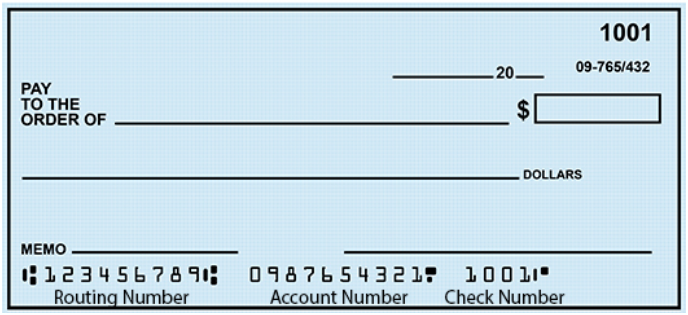
NAME	LAST FOUR OF SSN	ENROLL	DECLINE

LG13
Revision Date: 1/25

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

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

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



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

LGHIB Unit Name (please print)	**LGHIB Unit Number**
Account Holder Name (If different from unit)	

If signed electronically, I acknowledge and certify the electronic signature process complies with the Alabama Uniform Electronic Transaction Act and the LGHIB rules outlined in the Administrative Guide.

_____ _____

Account Holder Authorized Signature **Date**

_____ _____

Printed Name **Title**

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

Return this form to: **Local Government Health Insurance Board**
Accounting Department
PO Box 304901
Montgomery, AL 36130
accounting@lghip.org

BUSINESS ASSOCIATE AGREEMENT
BETWEEN
THE LOCAL GOVERNMENT HEALTH INSURANCE BOARD AND

_____

This Agreement as made and entered into this __TH day of _____, 20__, by and between the Local Government Health Insurance Board (475 Technacenter Drive, Montgomery, Alabama 36117), on behalf of the Local Government Health Insurance Plan, hereinafter collectively designated as "Covered Entities", and _____ _____ hereinafter designated as "Business Associate".

WHEREAS, Covered Entities and Business Associate desire and are committed to complying with all relevant federal and state law with respect to the confidentiality and security of Protected Health Information (PHI), including, but not limited to, the federal Health Insurance Portability and Accountability Act of 1996, and accompanying regulations, as amended from time to time (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH), and any regulations promulgated thereunder.

NOW, THEREFORE, for valuable consideration, the receipt of which is hereby acknowledged, and intending to establish a business associate relationship under 45 C.F.R. § 164, the parties hereby agree as follows:

I. Definitions

a. "Business Associate" shall have the same meaning as the term "business associate" at 45 C.F.R. § 160.103, and in reference to the party to this agreement, shall mean _____.

b. "Breach" shall have the same meaning as the term "breach" set out in 45 C.F.R. § 164.402.

c. "C.F.R." means the Code of Federal Regulations. A reference to a C.F.R. section means that section as amended from time to time; provided that if future amendments change the designation of a section referred to herein, or transfer a substantive regulatory provision referred to herein to a different section, the section references herein shall be deemed to be amended accordingly.

d. “Compliance Date(s)” shall mean the date(s) established by the Secretary or the United States Congress as the effective date(s) of applicability and enforceability of the Privacy Rule, Security Rule and HITECH Standards.

e. “Designated Record Set” shall have the same meaning as the term “designated record set” in 45 C.F.R. § 164.501 and shall include a group of records that is: (i) the enrollment, payment, claims adjudication and case or medical management record systems maintained by or for Covered Entities or (2) used, in whole or in part, by or for Covered Entities to make decisions about Individuals.

f. “Electronic Protected Health Information” (EPHI) shall have the same meaning as the term “electronic protected health information” in 45 C.F.R. § 160.103, limited to the information received from, or created on behalf of, Covered Entities by Business Associate.

g. “HITECH Standards” shall mean the privacy, security and security breach notification provisions applicable to a Business Associate under Subtitle D of the Health Information Technology for Economic and Clinical Health Act, which is Title XIII of the American Recovery and Reinvestment Act of 2009, and any regulations promulgated thereunder.

h. “Individual” shall have the same meaning as the term “individual” in 45 C.F.R. § 160.103, and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

i. “Privacy Rule” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. parts 160 and 164, subparts A and E.

j. “Protected Health Information” (PHI) shall have the same meaning as the term “protected health information” in 45 C.F.R. § 160.103, limited to the information received from, or created on behalf of, Covered Entities by Business Associate.

k. “Required by Law” shall have the same meaning as the term “required by law” in 45 C.F.R. § 164.103.

l. “Security Incident” shall have the same meanings as the term “security incident” in 45 C.F.R. § 164.304.

m. “Security Rule” shall mean the Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. parts 160 and 164, subparts A and C.

Terms used, but not otherwise defined, shall have the same meaning as those terms in the Privacy Rule, Security Rule and HITECH Standards.

II. Obligations of Business Associate

a. Business Associate agrees not to use or disclose PHI other than as permitted or required by this Agreement or as Required by Law. Business Associate will take reasonable efforts to limit requests for, use and disclosure of PHI to the minimum necessary to accomplish the intended request, use or disclosure and comply with 45 C.F.R. §§ 164.502(b) and 514(d).

b. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement. Business Associate shall implement administrative, physical, and technical safeguards (including written policies and procedures) that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI that it creates, receives, maintains, or transmits on behalf of the Covered Entities as required by the Security Rule.

c. Business Associate agrees to report to Covered Entities any use or disclosure of PHI, other than as provided for by this Agreement, promptly after Business Associate has actual knowledge of such use or disclosure, and to report promptly to the Covered Entities all Security Incidents of which it becomes aware as determined by Business Associate except that, for purposes of this Security Incident reporting requirement, the term “Security Incident" shall not include unsuccessful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system of which it becomes aware as determined by Business Associate. Following the discovery of a breach of unsecured PHI, Business Associate shall notify Covered Entities of such breach without unreasonable delay, and in no event later than 30 calendar days after such discovery. The notification will include the identification of each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired or disclosed during the breach. A breach shall be treated as discovered as of the first day on which such breach is known or reasonably should have been known to Business Associate. Any notices required to be delivered by Covered Entities hereunder shall be at the expense of the Business Associate.

d. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of this agreement or applicable regulations.

e. Business Associate agrees to ensure access to ePHI is limited to workforce members who require such access because of their role or function.

f. Business Associate agrees to implement safeguards to prevent its workforce members who are not authorized to have access to such ePHI from obtaining access and to otherwise ensure compliance by its workforce with the Security Rule.

g. Within 15 business days of receiving a request from Covered Entities, Business Associate agrees to implement restrictions on use or disclosure of PHI agreed to by the Covered Entities on behalf of an Individual in accordance with 45 C.F.R. § 164.522(a).

h. Within 15 business days of receiving a request from Covered Entities, Business Associate agrees to honor requests for alternative communications agreed to by Covered Entities on behalf of an individual in accordance with 45 C.F.R. § 164.522(b).

i. In accordance with 45 C.F.R. § 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, Business Associate agrees to ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information, including agreeing in writing to implement the same reasonable and appropriate safeguards that apply to Business Associate to protect the Covered Entities' ePHI.

j. If Business Associate maintains PHI in a Designated Record Set, Business Associate agrees to make available to Covered Entities, within a reasonable time, such information as Covered Entities may require to fulfill Covered Entities' obligations to respond to a request for access to PHI as provided under 45 C.F.R. § 164.524 or to respond to a request to amend PHI as required under 45 C.F.R. § 164.526. Business Associate shall refer to Covered Entities all such requests that Business Associate may receive from Individuals. If Covered Entities request Business Associate to amend PHI in Business Associate's possession in order to comply with 45 C.F.R. § 164.526, Business Associate shall effectuate such

amendments no later than the date they are required to be made by 45 C.F.R. § 164.526; provided that if Business Associate receives such a request from Covered Entities less than 10 business days prior to such date, Business Associate will effectuate such amendments as soon as is reasonably practicable.

k. If applicable, Business Associate agrees to provide to Covered Entities, within a reasonable time, such information necessary to permit Covered Entities to respond to a request by an Individual for an accounting of disclosures as provided under 45 C.F.R. § 164.528. Business Associate shall refer to Covered Entities all such requests which Business Associate may receive from individuals.

l. Upon reasonable notice, Business Associate agrees to make its internal practices, books, and records relating to the use and disclosure of PHI available to the U.S. Secretary of Health and Human Services, or an officer or employee of that Department to whom relevant authority has been delegated, at Covered Entities' expense in a reasonable time and manner, for purposes of the Secretary determining Covered Entities' compliance with the Privacy Rule.

m. Notwithstanding any other provision in this agreement, Business Associate hereby acknowledges and agrees that to the extent it is functioning as a Business Associate of Covered Entities, Business Associate will comply with the HITECH Business Associate provisions and with the obligations of a Business Associate as prescribed by HIPAA and the HITECH Act. Business Associate and the Covered Entities further agree that the provisions of HIPAA and the HITECH Act that apply to Business Associates, and that are required to be incorporated by reference in a Business Associate Agreement, are incorporated into this agreement between Business Associate and Covered Entities as if set forth in this agreement in their entirety.

III. Permitted uses and disclosures by Business Associate

Except as otherwise limited in this Agreement, Business Associate may:

a. Use or disclose PHI on behalf of the Covered Entities, if such use or disclosure of PHI would not violate the Privacy Rule, including the minimum necessary standard, if done by the Covered Entities.

b. Use or disclose PHI to perform the services outlined in any and all services agreements, or other contracts, entered into between Covered Entities and Business Associate.

c. Use PHI for the proper management and administration of Business Associate or to fulfill any present or future legal responsibilities of Business Associate.

d. Disclose PHI for the proper management and administration of Business Associate, or to fulfill any present or future legal responsibilities of Business Associate, provided that such disclosure is either required by law or Business Associate obtains reasonable assurances from any person to whom PHI is disclosed that such person will: (i) keep such information confidential, (ii) use or further disclose such information only for the purpose for which it was disclosed to such person or as required by law, and (iii) notify Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

e. Use PHI to provide data aggregation services relating to the health care operations of the Covered Entities, as provided in 45 C.F.R. § 164.501.

f. To create de-identified data, provided that the Business Associate de-identifies the information in accordance with the Privacy Rule. De-identified information does not constitute PHI and is not subject to the terms and conditions of this Agreement.

g. Use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. § 164.502(j)(1).

IV. Obligations of Covered Entities

a. Covered Entities shall notify Business Associate of any facts or circumstances that affect Business Associate's use or disclosure of PHI. Such facts and circumstances include, but are not limited to: (i) any limitation or change in Covered Entities' notice of privacy practices, (ii) any changes in, or withdrawal of, an authorization provided to Covered Entities by an Individual pursuant to 45 C.F.R. § 164.508; and (iii) any restriction to the use or disclosure of PHI that Covered Entities has agreed to in accordance with 45 C.F.R. § 164.522.

b. Covered Entities warrant that they will not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule or is not otherwise authorized or permitted under this Agreement.

c. Covered Entities acknowledge and agree that the Privacy Rules allow the Covered Entities to permit Business Associate to disclose or provide access to PHI, other than Summary Health Information, to the Plan Sponsor only after the Plan

documents have been amended to provide for the permitted and required uses and disclosures of PHI and to require the Plan Sponsor to provide a certification to the Plan that certain required provisions have been incorporated into the Plan documents before the Plan may disclose, either directly or through a Business Associate, any PHI to the Plan Sponsor.

d. Covered Entities agree that they will have entered into Business Associate Agreements with any third parties to whom Covered Entities direct and authorize Business Associate to disclose PHI.

V. Effective date: termination

a. The effective date of this agreement shall be the date this agreement is signed by the parties.

b. This agreement shall terminate on the date Business Associate ceases to be obligated to perform the functions, activities, and services described in Article III Sections A and B.

c. Upon Covered Entities' knowledge of a material breach by Business Associate of this Agreement, Covered Entities shall notify Business Associate of such breach and Business Associate shall have 30 days to cure such breach. In the event Business Associate does not cure the breach, or cure is infeasible, Covered Entities shall have the right to immediately terminate this Agreement and any underlying services agreement. If cure of the material breach is infeasible, Covered Entities shall report the violation to the Secretary.

d. Upon termination of this agreement, Business Associate will return to Covered Entities, or if return is not feasible, destroy, any and all PHI that it created or received on behalf of Covered Entities and retain no copies thereof. If the return or destruction of the PHI is determined by Business Associate not to be feasible, or if Business Associate is required by law to retain such information or copies thereof, Business Associate will maintain the PHI for the period of time required under applicable law, or in accordance with Business Associate's internal record retention schedule as in effect from time to time, whichever is longer, after which time Business Associate shall return or destroy the PHI.

e. Business Associate's obligations under Sections II and III above shall survive the termination of this agreement with respect to any PHI so long as it remains in the possession of Business Associate.

VI. Other provisions

a. The parties acknowledge that the foregoing provisions are designed to comply with the mandates of the Privacy and Security Rules and the HITECH Standards. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law. If the parties are unable to reach agreement regarding an amendment within 30 days of the date that Business Associate receives any written objection from Covered Entities, either party may terminate this Agreement upon 90 days written notice to the other party. Any other amendment to the Agreement unrelated to compliance with applicable law and regulations shall be effective only upon execution of a written agreement between the parties.

b. Except as it relates to the use, security and disclosure of PHI and electronic transactions, this agreement is not intended to change the terms and conditions, or the rights and obligations, of the parties under any other services agreement between them.

c. Business Associate agrees to defend, indemnify and hold harmless Covered Entities, their affiliates and directors, officers, employees, agents or assigns from and against any and all actions, causes of action, claims, suits and demands whatsoever, and from all damages, liabilities, costs, charges, debts, fines, government investigations, proceedings, and expenses whatsoever (including reasonable attorneys' fees and expenses related to any litigation or other defense of any claims), which may be asserted, or for which it may now or hereafter become subject, arising in connection with (i) any misrepresentation, breach of warranty or non-fulfillment of any undertaking on its part under this agreement; and (ii) any claims, demands, awards, judgments, actions, and proceedings made by any person or organization arising out of, or in any way connected with, Business Associate's performance under this agreement.

d. Nothing express or implied in this agreement is intended to confer, nor shall anything herein confer, upon any person other than Covered Entities, Business

Associate, and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

e. The parties are and shall be independent contractors to one another, and nothing in this agreement shall be deemed to cause this agreement to create an agency, partnership, or joint venture between the parties. Except as expressly provided herein, neither party shall be liable for any debts, accounts, obligations, or other liabilities of the other party.

f. Any ambiguity in this agreement shall be resolved in favor of a meaning that permits the Covered Entities to comply with the Privacy and Security Rules and the HITECH Standards.

g. If any provision of this Agreement is held illegal, invalid, prohibited or unenforceable by a court of competent jurisdiction, that provision shall be limited or eliminated in that jurisdiction to the minimum extent necessary so that this agreement shall otherwise remain in full force and effect and enforceable.

h. This Agreement shall be governed by and construed in accordance with the laws of the state of Alabama to the extent not preempted by the privacy or security or other applicable federal law.

i. This Agreement replaces and supersedes in its (their) entirety any prior Business Associate Agreement(s) between the parties.

In witness whereof, this agreement has been signed and delivered as of the date first set forth above.

Local Government Health Insurance Board

_____

_____ _____

By: David C. Hilyer **By:**

As its: Chief Executive Officer **As its:**_____

Form LG01
Revised 7/25

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
ENROLLMENT FORM

EMPLOYEE INFORMATION (Please print or type)

Name (First, Middle Initial, Last)		Social Security Number		Date of Birth		Gender
Mailing Address		City	County	State	ZIP Code	
Physical Address *Must be completed by Medicare Retiree Enrollee		City	County	State	ZIP Code	
Primary Phone Number	Work Phone Number	Email Address:				

Employment Status (Check One)

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

Note: If you or your covered dependent(s) are covered by Medicare, you must submit a copy of your Red, White, and Blue Medicare Card and a physical address. Your name must match the name listed on your Medicare card.

Dependent Information - Documentation is required before dependents can be added to coverage. See back of form.

Name of Dependent First, Middle Initial, Last	Relationship to Participant	Gender	Date of Birth	Social Security Number
	☐ Spouse Date Married:	☐ M ☐ F		
	☐ Biological ☐ Adopted ☐ Step ☐ Custodial	☐ M ☐ F		
	☐ Biological ☐ Adopted ☐ Step ☐ Custodial	☐ M ☐ F		
	☐ Biological ☐ Adopted ☐ Step ☐ Custodial	☐ M ☐ F		
	☐ Biological ☐ Adopted ☐ Step ☐ Custodial	☐ M ☐ F		
	☐ Biological ☐ Adopted ☐ Step ☐ Custodial	☐ M ☐ F		
	☐ Biological ☐ Adopted ☐ Step ☐ Custodial	☐ M ☐ F		

Other Group Health Insurance Information

Do you have additional insurance coverage other than LGHIP coverage? ☐ Yes ☐ No

If yes, you must complete the Other Group Health Insurance Addendum on Page 3.

AFFIRMATION AND RELEASE

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

I understand and acknowledge that only eligible dependents may be added to my coverage. I understand and acknowledge that it is my responsibility to notify Local Gov immediately when the eligibility of a covered dependent changes. If it is determined that an act on my part (such as adding an ineligible person to coverage) or omission (such as failing to remove a person no longer eligible for coverage) results in or contributes to the payment of claims for persons ineligible for coverage, I will be personally responsible for all such overpayments and may be subject to disqualification from coverage under the plan.

_____ _____

Employee Signature **Date**

TO BE COMPLETED BY EMPLOYER

Full-Time Date of Hire: _____ **Local Government Unit Name:** _____ **Unit Number:** _____

If signed electronically, I acknowledge and certify the electronic signature process complies with the Alabama Uniform Electronic Transaction Act and Local Gov rules outlined in the Administrative Guide.

Signature of Benefit Administrator: _____ **Date:** _____

Local Gov Health and Wellness
(334) 851-6802 • 1-866-836-9137
Enrollments@lghip.org

GENERAL INFORMATION

Eligible Dependent

(Appropriate documentation must be attached.)

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

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

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

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

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 if they are 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 age 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 child has been adopted by someone other than their spouse and the participant has been relieved of their parental rights and responsibilities
- A daughter-in-law or son-in-law
- Grandchildren or other individuals related to the participant by blood or marriage for which the participant does not have legal and physical custody
- Grandchildren, nieces, or nephews aged 19 and older regardless of whether the participant has legal and physical custody
- Grandparents
- Parents
- A fiancé or live-in girlfriend or boyfriend

Enrolling an Incapacitated Child

To apply, contact the LGHIB to obtain an Incapacitated Child Certification form. A completed Incapacitated Child Certification form and proof of incapacity must be provided to the LGHIB no more than 60 days after the dependent's 26th birthday*. If the form and proof of incapacity is not submitted within the required time, 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 the LGHIB within 60 days of the incapacitated child's loss of other coverage, and
  - Medical review approved incapacitation status.

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

Other Group Health Insurance Addendum

Must be completed if you, your spouse and/or dependents have any other coverage.

LIST EACH INSURANCE COMPANY SEPARATELY (ATTACH ADDITIONAL SHEETS IF NECESSARY)			
Name of Contract Holder	Contract Holder Date of Birth	Group #	Insurance Contract #
Name of Insurance Company		Types of coverage (Check all that apply) ☐ Hospitalization ☐ Doctor's Visits ☐ Prescription Drugs ☐ Dental	
Name of Employer			
If other coverage includes prescription drug coverage, please complete the below (information can be found on your other coverage insurance card)			
Rx BIN Number	Rx ID		

Are you or any of your dependents covered on this insurance policy? ☐ Yes (list each covered individual below) ☐ No

Name(s) (First, Middle Name, Last)	Date of Birth	Coverage Effective Date(s)

LIST EACH INSURANCE COMPANY SEPARATELY (ATTACH ADDITIONAL SHEETS IF NECESSARY)			
Name of Contract Holder	Contract Holder Date of Birth	Group #	Insurance Contract #
Name of Insurance Company		Types of coverage (Check all that apply) ☐ Hospitalization ☐ Doctor's Visits ☐ Prescription Drugs ☐ Dental	
Name of Employer			
If other coverage includes prescription drug coverage, please complete the below (information can be found on your other coverage insurance card)			
Rx BIN Number	Rx ID		

Are you or any of your dependents covered on this insurance policy? ☐ Yes (list each covered individual below) ☐ No

Name(s) (First, Middle Name, Last)	Date of Birth	Coverage Effective Date(s)

Form LG04
Revised 7/25

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
NEW EMPLOYEE DECLINATION OF COVERAGE FORM

EMPLOYEE INFORMATION (Please print or type.)

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

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

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

My other insurance carrier is:

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

**** You must attach proof of coverage from your insurance carrier or letter from employer verifying coverage with the above-named carrier.***

Acceptable Proof of Other Acceptable Coverage	Not 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 • Front and back copy of current Military ID	• Insurance Card • Explanation of Benefits Documentation (EOB) • Paystub • Form 1095

NOTICE: Eligible employees who decline coverage due to other acceptable coverage and then lose their other coverage must immediately notify the unit and enroll in the Local Government Health Insurance Plan. Coverage will be effective the date the other acceptable coverage ended. If the unit does not notify Local Gov of the loss of other acceptable coverage and does not enroll the employee in the LGHIP, the unit will be responsible for any premiums due and will be billed retroactively to the date the eligible employee should have been enrolled (i.e. the date the other acceptable coverage ended).

Full-time Date of Hire:	**Employee Signature:**
Local Government Unit Name:	
Unit Number:	**Date:**
If signed electronically, I acknowledge and certify the electronic signature process complies with the Alabama Uniform Electronic Transaction Act and the LGHIB rules outlined in the Administrative Guide.	
Signature of Benefit Administrator:	

LOCAL GOV HEALTH AND WELLNESS
(334) 851-6802 • 1-866-836-9137
Enrollments@lghip.org

Form LG07
Revised 7/25

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
ENROLLMENT FORM
SOUTHLAND VOLUNTARY INSURANCE

SUBSCRIBER INFORMATION (Please print or type.)

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

CHECK PLAN ELECTED

- ☐ Vision — $12/ Single $20/Family
- ☐ Dental — $44/ Single $44/Family
- ☐ Cancer — $12/ Single $24/Family

Employment Status (Check One)

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

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

Name of Dependent First, Middle Initial, Last	Relationship to Participant	Gender	Date of Birth	Social Security Number
	☐ Spouse Date Married:	☐ M ☐ F		
	☐ Biological ☐ Adopted ☐ Step ☐ Custodial	☐ M ☐ F		
	☐ Biological ☐ Adopted ☐ Step ☐ Custodial	☐ M ☐ F		
	☐ Biological ☐ Adopted ☐ Step ☐ Custodial	☐ M ☐ F		
	☐ Biological ☐ Adopted ☐ Step ☐ Custodial	☐ M ☐ F		
	☐ Biological ☐ Adopted ☐ Step ☐ Custodial	☐ M ☐ F		
	☐ Biological ☐ Adopted ☐ Step ☐ Custodial	☐ M ☐ F		

AFFIRMATION AND RELEASE

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

I understand and acknowledge that only eligible dependents may be added to my coverage. I understand and acknowledge that it is my responsibility to notify Local Gov Health and Wellness immediately when the eligibility of a covered dependent changes. If it is determined that an act on my part (such as adding an ineligible person to coverage) or omission (such as failing to remove a person no longer eligible for coverage) results in or contributes to the payment of claims for persons ineligible for coverage, I will be personally responsible for all such overpayments and may be subject to disqualification from coverage under the plan.

_____ _____

Employee Signature Date

TO BE COMPLETED BY EMPLOYER

Requested Effective Date*: _____

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

Local Government Unit Name: _____ **Unit Number:** _____

If signed electronically, I acknowledge and certify the electronic signature process complies with the Alabama Uniform Electronic Transaction Act and Local Gov rules outlined in the Administrative Guide.

Signature of Benefit Administrator: _____ **Date:** _____

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

GENERAL INFORMATION

Eligible Dependent

(Appropriate documentation must be attached.)

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

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

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

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

Ineligible Dependents

An individual who does not meet the definition of an eligible dependent shall not be allowed to be covered as a dependent under the LGHIP. Examples include, but are not limited to:

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

Enrolling an Incapacitated Child

To apply, contact the LGHIB to obtain an Incapacitated Child Certification form. A completed Incapacitated Child Certification form and proof of incapacity must be provided to the LGHIB no more than 60 days after the dependent's 26th birthday*. If the form and proof of incapacity is not submitted within the required time, 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.

In these two situations, the child must meet all the Incapacitated Child eligibility requirements and submit an Incapacitated Child Certification form and a New Dependent form to the LGHIB within 60 days of the incapacitated child's loss of other coverage. The LGHIB will decide whether an application for incapacitated status will be accepted and final approval of incapacitation will be determined by medical review conducted by BCBS.

Local Gov Health and Wellness
Listing of Elected Officials for a City or Town

City or Town of:______________________________ **Unit Number:** ________________

Unit Allows for Coverage of Elected Officials ☐ **Yes** ☐ **No**

A list of elected officials is required, regardless of whether the unit offers coverage to its elected officials.
Please complete the fields below with the elected official's information.

Mayor				
Elected Official Legal Name	**Term Starts**	**Term Ends**	**Last 4 of SSN/Contract**	**Enroll** ☐ **Decline** ☐ **Opt-Out** ☐
Council				
Elected Official Legal Name	**Term Starts**	**Term Ends**	**Last 4 of SSN/Contract**	**Enroll** ☐ **Decline** ☐ **Opt-Out** ☐
Council				
Elected Official Legal Name	**Term Starts**	**Term Ends**	**Last 4 of SSN/Contract**	**Enroll** ☐ **Decline** ☐ **Opt-Out** ☐
Council				
Elected Official Legal Name	**Term Starts**	**Term Ends**	**Last 4 of SSN/Contract**	**Enroll** ☐ **Decline** ☐ **Opt-Out** ☐
Council				
Elected Official Legal Name	**Term Starts**	**Term Ends**	**Last 4 of SSN/Contract**	**Enroll** ☐ **Decline** ☐ **Opt-Out** ☐
Council				
Elected Official Legal Name	**Term Starts**	**Term Ends**	**Last 4 of SSN/Contract**	**Enroll** ☐ **Decline** ☐ **Opt-Out** ☐
Council				
Elected Official Legal Name	**Term Starts**	**Term Ends**	**Last 4 of SSN/Contract**	**Enroll** ☐ **Decline** ☐ **Opt-Out** ☐
Council				
Elected Official Legal Name	**Term Starts**	**Term Ends**	**Last 4 of SSN/Contract**	**Enroll** ☐ **Decline** ☐ **Opt-Out** ☐

Form Completed By:

Name: ____ **Title:**______________________________________

If signed electronically, I acknowledge and certify the electronic signature process complies with the Alabama Uniform Electronic Transaction Act and the Local Gov rules outlined in the Administrative Guide.

Signature: ____________________________________ **Date:**______________________________________

LG29
9/24

Local Gov Health and Wellness
Listing of Elected Officials for a County Commission

_____County Commission _____Unit Number

Unit Allows for Coverage of Elected Officials ☐ Yes ☐ No

A list of elected officials is required, regardless of whether the unit offers coverage to its elected officials. Please complete the fields below with the elected official's information. If more space is needed, please complete an additional form.

Elected Official Legal Name	Term Starts	Term Ends	Last 4 of SSN/Contract	Enroll	Decline	Opt-Out
Probate Judge						
				☐	☐	☐
Sheriff						
				☐	☐	☐
Tax Assessor						
				☐	☐	☐
Tax Collector						
				☐	☐	☐
Revenue Commissioner						
				☐	☐	☐
Coroner						
				☐	☐	☐
Chairman						
				☐	☐	☐
Commissioner 1						
				☐	☐	☐
Commissioner 2						
				☐	☐	☐
Commissioner 3						
				☐	☐	☐
Commissioner 4						
				☐	☐	☐
Commissioner 5						
				☐	☐	☐
Commissioner 6						
				☐	☐	☐

Name: _____ **Title:**_____

If signed electronically, I acknowledge and certify the electronic signature process complies with the Alabama Uniform Electronic Transaction Act and the Local Gov rules outlined in the Administrative Guide.

Signature: _____ **Date:**_____

Local Gov Health and Wellness
(334) 851-6802 or 1-866-836-9137
Enrollments@lghip.org

CHAPTER 5
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.

DIRECTORY

David Hilyer | Chief Executive Officer
(334) 851-6802

OPERATIONS

Jason Graham | Chief Operating Officer
(334) 851-6802

BENEFITS

Jessica O'Donnell | Chief Benefits Officer
(334) 851-6802, Option 4

LEGAL

Chris Brodie | General Counsel
(334) 851-6802

ACCOUNTING

Dustin Craik | Chief Financial Officer
(334) 851-6802, Option 3

AUDITING

Tara Holloman | Auditor
(334) 851-6802

COMMUNICATIONS & MARKETING

Jessica Barefoot
Marketing Specialist
(334) 851-6851

ENROLLMENTS

Meg McHutchison | Program Integrity Manager
(334) 851-6802

INFORMATION TECHNOLOGY

Richard Pasley | IT Director: Infrastructure and Operations
(334) 851-6802

Craig Tucker | IT Director: Business Systems
(334) 851-6802

WELLNESS

Marie James | Wellness Manager
(334) 851-6802, Option 4

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
LOCAL GOV
health + wellness