LOCAL GOVERNMENT
HEALTH INSURANCE PROGRAM

ADMINISTRATIVE PROCEDURES GUIDE 2024

SERVICE EXCELLENCE INNOVATION

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The Local Government Health Insurance Board (LGHIB) 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, the LGHIB has been able to offer a robust set of benefits at a cost well below the average premium of other plans in Alabama and the southeast. 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, Teladoc and Wondr Health are just a few of the programs offered through the LGHIP that have positively impacted our members' health and helped premiums stay affordable. The LGHIB is constantly researching other programs that could have a significant, positive impact on our members' well-being and will keep the LGHIB as a leader in providing health insurance for local government entities.

The LGHIB will soon implement a new benefit administration system that will allow us to take a technological leap in how we administer the plan. This system will allow members to take control of their healthcare by providing all the benefits and programs of the LGHIP in one central location, which can be accessed by a computer, tablet or smart phone. For our units, this means allowing members to manage more of the enrollment process, thereby lessening the administrative burden that has previously been on the unit. Information, training and more will become available as we prepare for a 'go-live' in the near future.

This guide walks you through the eligibility and enrollment process, wellness program, premium descriptions, and billing procedure. If you have any questions or if we can be of further service, please visit the 'Contact Us' section of our website, www.lghip.org, or contact a member of the LGHIB staff at 334-851-6802 or 1-866-836-9137.

We thank you for allowing the LGHIB to be a part of your employee's benefit package and for allowing the LGHIP to provide for their health insurance needs.

Sincerely,

David C. Hilyer,
Chief Executive Officer

Local Government Health Insurance Board
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2024 LGHIB ADMINISTRATIVE GUIDE

Summary of Changes

The information below is a summary of changes to the 2024 Administrative Guide. This may not contain all revisions to the Administrative Guide. The LGHIB recommends you review the entire Administrative Guide each year for a full and complete understanding of all updates.

- Updated mailing address and phone number for the LGHIB.
- Ability to cancel subscribers through the online cancellation portal on my.lghip.
- Revised date for the wellness screening period.
- Units who are late on premiums can remain in the preferred premium category if they enroll in ACH payment.
- Date of notification of the following year's premiums will be no later than September 30.
- The Transfer Rule for employees who transfer from one unit to another in the same calendar month has been updated. Under the new policy, if an employee terminates from one LGHIP unit and begins working for another LGHIP unit, the employee's coverage with the LGHIP will follow the new unit's date of coverage.
- Enrollment for Southland will now be the same as the medical plan and enrollment will only be allowed during Open Enrollment or when the employee begins employment with the unit.
- The 12-month rule for Southland participation is no longer required.
- Effective January 1, 2024, SelectQuote or Empower Brokerage will no longer offer benefits to LGHIP Medicare retirees.

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CHAPTER 1

Coverage Details

Coverage for Active Employees and Non-Medicare Retirees

The LGHIP's medical benefits are administered by Blue Cross and Blue Shield of Alabama (BCBS) and prescription drug benefits are administered by OptumRx. A unit may also choose to offer dental coverage administered by BCBS in addition to medical coverage.

Coverage for Medicare Retirees

The LGHIB currently offers a Medicare Advantage plan through UnitedHealthcare for units that elect to provide coverage for their Medicare retirees.

Voluntary Plans

The LGHIB also offers voluntary dental and vision coverage, administered by Southland Benefit Solutions, which may be elected individually by eligible employees. (See the Southland Voluntary Insurance Plan chapter later in this Guide for more information).

More Information

You can find more information about these plans by visiting the LGHIB'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

Employee Participation Requirement

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 within 30 days of employment. Other acceptable coverage includes but is not limited to: Affordable Care Act (ACA) qualified group and individual plans that meet minimum essential coverage standards, Marketplace, Medicare, Medicaid, and Tricare.

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. If the unit does not notify the LGHIB of the loss of other 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 employee should have been enrolled (i.e. the date the other acceptable coverage ended). If the premiums are not paid, the unit will be in violation of the LGHIP's enrollment rules and may be terminated from participation in the LGHIP.

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

All units must have at least one full-time employee enrolled in the LGHIP. A unit cannot offer any other health insurance coverage for eligible employees 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 decides when it joins the LGHIP whether it will allow eligible retirees to continue coverage with the LGHIP and whether it will only provide coverage until Medicare entitlement or continue coverage after Medicare entitlement. 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
  - 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 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 LGHIB 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 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. 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 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 LGHIB 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 legal and physical custody granted 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 26 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

Ineligible Employees

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

Affordable Care Act (ACA) Exception

Under the ACA, a temporary, part-time, 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. The LGHIB 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, part-time, seasonal, intermittent, or emergency employees, you must verify 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.

In addition, a unit must submit an ACA Verification Form (LG23) with 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 acceptable proof of 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 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 or other dependents 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
- 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 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 custody
- Grandparents
- Parents
- A fiancé or live-in girlfriend or boyfriend

RETIRED PARTICIPANTS RETURNING TO WORK

Retired participants that return to work averaging 30 or more hours per week 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 retiree coverage through another unit. For example, John Smith is enrolled in LGHIP 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 retiree coverage through Unit A.

Please note that retirees must transition from active employee coverage to retiree coverage with the same unit. If a retiree cancels retiree coverage with a participating unit and enrolls as an active employee with a new unit, the retiree will not be able to return to retiree coverage with the previous unit. The retiree will be able to continue retiree coverage with the new unit if the new unit provides retiree coverage.

In the example above, if John cancels coverage through Unit A to enroll as an active employee through Unit B, he will not be able to re-enroll in retiree coverage through Unit A; however, he will be able to enroll in retiree coverage through Unit B if Unit B covers retirees.

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. The LGHIB 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.

NATIONAL MEDICAL SUPPORT NOTICES

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

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 specified by the LGHIB, but not earlier than the first day of the month following the LGHIB's determination the Notice is qualified. If a unit is not able to withhold the necessary contribution from the employee's paycheck, the LGHIB 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, the LGHIB 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.

NOTIFICATION OF ELIGIBILITY CHANGES

Participant

It is the participant's responsibility to notify the LGHIB 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 the LGHIB of a change in the enrollment status, or the eligibility, of a covered dependent.

Unit

It is the unit's responsibility to notify the LGHIB of any change in eligibility of a participant or a participant's dependent.

CHAPTER 4

Enrollment Rules

NEW ELIGIBLE EMPLOYEES

All new eligible employees must either enroll in the LGHIP or decline coverage by submitting a Declination of Coverage form (LG04) with proof of other acceptable coverage within 30 days of employment. 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
- Front and back copy of current Military ID

NOT ACCEPTABLE PROOF

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

EFFECTIVE DATE OF COVERAGE

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

- Date of Hire: The effective date of coverage for new employees 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 for all new employees will be the first day of the second full month following the new employee's date of hire. For example, if an employee's date of hire 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-B) during the annual open enrollment period in November. Upon approval by the LGHIB, 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 acceptable proof of 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 acceptable proof of 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) or if an eligible dependent qualifies for special enrollment by submitting a New Dependent form (LG02-B) 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 the LGHIB.

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

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
  - and a New Dependent form is submitted to the LGHIB within 60 days of the incapacitated child's loss of other coverage.

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

*The 60-day time limit does not apply to enrollment in a Southland Voluntary Plan.

OPEN ENROLLMENT

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

During open enrollment, eligible employees may enroll by submitting an LGHIP Enrollment form (LG01) and participants may add dependents or family coverage by submitting a New Dependent form (LG02-B).

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):

- 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 BCBS dental coverage

Submission of an 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 those affected for a period of 18 months.

SPECIAL ENROLLMENT

Special enrollment allows eligible employees and dependents who previously declined health coverage to enroll in coverage upon the loss of other coverage, and participants may add new dependents due to certain qualifying events (marriage, birth, etc.). Special enrollment rights arise regardless of the LGHIP's open enrollment period. The participant must request enrollment and provide proof of the qualifying event within 60 days of the event triggering the special enrollment. The effective date will be the date the other coverage was lost or the date of the qualifying event.

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

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

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. Proof of loss of eligibility must be provided within 60 days of the event. 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 other acceptable coverage; or
- eligible employees and their dependents who lose coverage under Medicaid or the state Children's Health Insurance Program (CHIP).

To request special enrollment, a participant must submit an Enrollment form (LG01) within 60 days of losing other coverage and:

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

SPECIAL ENROLLMENT TO ADD FAMILY COVERAGE OR ADD A NEW DEPENDENT

Participants are permitted to special enroll a new dependent because of 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 (LG02-B), and:

- proof of gaining a new dependent (e.g. marriage certificate, birth certificate, adoption papers); or
- documentation listing the name, reason and date of loss or change in coverage (e.g. employment termination on company letterhead)

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 participant's coverage include, but are not limited to:

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

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. Their 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 from the termination of their employment and the employee 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 their coverage will be effective based on the unit's effective date for all 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 their individual or dependent coverage for as long as they are receiving compensation and serving on active duty. 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 second qualifying events. 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 of the last day of the month after the unit notifies the LGHIB of the change.

If the participant performs an act or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, coverage may be terminated retroactively to the date of the act or omission. The LGHIB 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; or

- if the dependent becomes eligible for coverage as an employee.

In many cases, the participant and/or their dependent(s) will have the option to choose COBRA continuation coverage. (See COBRA Chapter 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 their 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 for 12 months, the unit must notify the LGHIB. 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 the LGHIB indicating the reason for cancellation. The participant may be eligible for COBRA at that time.

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.

The earliest a participant on LWOP can be canceled due to non-payment is the last day of the month following notification to the LGHIB.

FAMILY AND MEDICAL LEAVE ACT

The LGHIB 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.), the Local Government Health Insurance Board 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:

- Complies with the Alabama Uniform Electronic Transaction Act;
- 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

The LGHIB's website includes a secure portal for units and participants to access important information about their LGHIP coverage.

Unit Administrators

Unit administrators must create an online account for their unit to enroll eligible employees and dependents, terminate an employee's coverage when their employment ends, view their unit's current and prior year's wellness participation, view and pay invoices, and register for the LGHIB's annual conferences.

Each unit must have an account on my.lghip.

LGHIP Participants

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

ONLINE ENROLLMENT

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

When a unit enrolls eligible employees through the online enrollment system, it will receive emails from the LGHIB notifying the unit of the status of the enrollment including whether it was submitted, not submitted, rejected, or completed. Training opportunities for online enrollment are available on the LGHIB'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 the LGHIB to offer participants and their covered dependents who lose their LGHIP coverage the opportunity for a temporary extension of coverage. The continuation of coverage is offered at group rates in certain instances where coverage under the LGHIP would otherwise end.

All participants have the right to choose continuation of coverage if the participant loses group health coverage due to a reduction in hours of employment or because of a resignation 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 the LGHIB within 30 days of the following qualifying events:

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

Under federal law, employers are subject to a penalty of $100 per day for every day they are past the 30-day notification deadline.

COBRA ELECTION NOTIFICATION

It is the participant or dependent's responsibility to elect COBRA within 60 days from the date the COBRA election 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 the LGHIB 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 submit 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 LGHIB Planbook.

IF AN EMPLOYEE HAS ANY QUESTIONS

Questions concerning COBRA continuation coverage rights may be addressed by calling the LGHIB at 1-866-836-9137 or 334-851-6802 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 the Health Insurance Marketplace, visit www.healthcare.gov.

LGHIB CONTACT INFORMATION

All notices and requests for information should be sent to the following address:
Local Government Health Insurance Board
LGHIB COBRA
Post Office Box 304901
Montgomery, AL 36130

CHAPTER 7

Employee Eligibility Audit

All participating units will be periodically audited to ensure all participants enrolled in the LGHIP are eligible employees and that all eligible employees of the unit have either enrolled or declined in the LGHIP. The LGHIB 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

- The LGHIB 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 to the LGHIB.
- If deemed necessary, the LGHIB will conduct an onsite visit.
- At the conclusion of the audit, the LGHIB will provide the unit with the findings from the audit.

TREATMENT OF AUDIT RESULTS

If the LGHIB discovers eligibility or enrollment violations, the LGHIB may impose one or more of the following actions, depending upon the nature and severity of the 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.

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

CHAPTER 8

Wellness Program

The LGHIP's wellness program is designed to help support each member's wellness journey and assist them with their own personal health management. The principal component of the LGHIP's wellness program is the wellness screening. The wellness screening includes taking the individual's blood pressure, and measuring their height and weight. It also includes taking a blood sample to check cholesterol levels (HDL, LDL and total), triglycerides, and glucose. The individual will be asked whether they have or have had a history of high cholesterol, high blood pressure, or diabetes and whether medication is taken for those conditions. The wellness screening is a voluntary program available to active employees, non-Medicare retirees, and spouses, who are covered by the LGHIP (Group 30000).

The screening is intended to identify whether our members are at risk for certain medical conditions resulting from high blood pressure, obesity, high cholesterol, or diabetes. Members are also encouraged to share the results or any concerns with their medical provider. Early detection is a key to reducing or eliminating the risk of developing hypertension, prediabetes, diabetes, heart disease and obesity. Eligible members will be provided information during their biometric screening on programs available through the LGHIP including Virta, the type 2 diabetic reversal program. Members may enroll in Virta at their leisure. This program is available to eligible members at no cost and offers a health care professional to assist them in managing and improving their quality of life.

Screenings can be performed at the unit's worksite during a scheduled screening; by the provider (copays may apply); a BCBS participating pharmacy; or at a county health department. If the individual receives a screening at their provider, they must take the Provider Screening form, located on the LGHIB website and included in this Guide. The Wellness Program will only accept biometric screenings performed by the approved methods listed above. For a listing of all available screening sites and participating pharmacies, please visit our website at www.lghip.org.

The screening results will be maintained by the LGHIB and will not be disclosed either publicly or to the unit. A participant cannot be discriminated against because of the medical information they provide during the wellness screening, nor can they be subjected to retaliation by choosing not to participate.

Units that have 80% or greater wellness participation by their active employees within the wellness qualifying period, which is August 1 – July 31, will be eligible for the preferred premium category if the other conditions for the preferred premium are met. Although the wellness screening is available to non-Medicare retirees and spouses, only active employees who are employed and have participated in the wellness program as of July 31, will be counted toward a unit's participation percentage. The screening must be completed by July 31 and submitted to the LGHIB by August 15.

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

Should you have any questions or need further information regarding the LGHIB's Wellness Program, please contact our wellness 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 two complete years 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. The LGHIB 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 two complete years 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.

*The LGHIB's monthly billing indicates the active employees that have been screened during the current and previous screening period. You can view your billing by logging into your unit's account at www.lghip.org.

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
    - If a unit sponsors an additional retiree health plan for its eligible retirees that is approved by the LGHIB, the unit's retirees covered under its non-LGHIP retiree health plan will count toward the 5% requirement above.
- Unit has certified that all employees eligible to retire under the LGHIP's retiree rules were offered LGHIP retiree coverage.
    - Units must submit a list of all employees who left employment during the certification period of August 1 through July 31. The LGHIB will use this information to ensure all former eligible employees were offered coverage by the unit.

The following forms must be provided for each participant leaving service who is eligible to continue LGHIP coverage under the LGHIP's retiree rules:

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

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 have a rate increase and a change

in rate category in the same year. Following the wellness qualifying period, the LGHIB will begin the premium category assignment process. Wellness screening forms will not be accepted after August 15. Units will be notified of their premium category that will be effective January 1, no later than August 31.

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

Appeal of Premium Category Assignment

Units may appeal to the LGHIB to change their premium category. An appeal must be received by the LGHIB within seven calendar days following the date of your 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. The LGHIB 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 the LGHIB. Failure to remit your payment for the full invoice amount before the due date may result in cancellation of coverage.

(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, 2024

Premiums reflect single or family coverage per month

Employee Premiums

Standard Rates with Dental	
Single	$666
Family	$1,681

Standard Rates no Dental	
Single	$639
Family	$1,614

Preferred Rates with Dental	
Single	$608
Family	$1,483

Preferred Rates No Dental	
Single	$581
Family	$1,416

COBRA Premiums

Standard COBRA Rates with Dental	
Single	$679
Family	$1,714

Standard COBRA Rates without Dental	
Single	$652
Family	$1,647

Preferred COBRA Rates with Dental	
Single	$620
Family	$1,513

Preferred COBRA Rates without Dental	
Single	$593
Family	$1,445

COBRA Disabled Premiums

Standard COBRA Subscriber Disabled Rates with Dental	
Single	$999
Family	$2,034

Standard COBRA Subscriber Disabled Rates without Dental	
Single	$959
Family	$1,954

Preferred COBRA Subscriber Disabled with Dental	
Single	$912
Family	$1,805

Preferred COBRA Subscriber Disabled without Dental	
Single	$872
Family	$1,724

CHAPTER 10

Billing Procedures

INVOICE

The LGHIB 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 includes a summary of the total single and family participants covered, the previous balance owed, if any, along with 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 on the LGHIB website. Units will not be mailed invoices or billing details.

The invoices also show which participants have completed their 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.

INVOICE CHANGES

All LGHIB approved corrections and adjustments 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

Units have the following payments 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 or after the first day of the following month. For example, a bill issued October 18 would provide the new balance that will be drafted from the unit's account on November 1. Automatic drafts may be canceled at any time. However, draft cancellations must be made at least five business days prior to the last business day of the month.
- **Electronic Check (e-check) Service** - Payment by e-check is available through the LGHIB's website, www.lghip.org, or by calling the LGHIB'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 Government Health Insurance Board
  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 the LGHIB, via certified mail to the following address, at least six months prior to the effective date of withdrawal:

Local Government Health Insurance Board
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 the LGHIB 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

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

- Failure to comply with the LGHIB's policies and procedures;
- Purposely submitting incorrect or fraudulent information; or
- Delinquent payment of premiums.

If the LGHIB 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 by the LGHIB 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 the LGHIB 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 BCBS plan books, summary of benefits and more.

Form LG11
Reviewed 8/23

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
Unit Change Form

Local Government Unit			Unit #
Mailing Address	City	State	ZIP Code
Physical Address	City	State	ZIP Code

Unit Contacts

Health Insurance Administrator	Title		
Phone Number	Email Address		
Primary Contact (If Different)	Title		
Phone Number	Email Address		
Additional Contact (If Different)	Title		
Phone Number	Email Address		
Additional Contact (If Different)	Title		
Phone Number	Email Address		
Wellness Contact (If Different)	Title		
Phone Number	Email Address		
Physical Address	City	State	ZIP Code
Delete Contact			

Updates to Coverage

Submit during Open Enrollment for a January 1 effective date

Dental Coverage for all employees	☐ Add	☐ Drop
Coverage for Non-Medicare Retirees	☐ Add	☐ Drop
Coverage for Medicare Retirees	☐ Add	☐ Drop
Coverage for Elected Officials *Only applicable to municipalities and counties	☐ Add	☐ Drop
Effective Date of Coverage	☐ Date of Hire	☐ 1st Day of 2nd Month

_____ 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	_____ Date

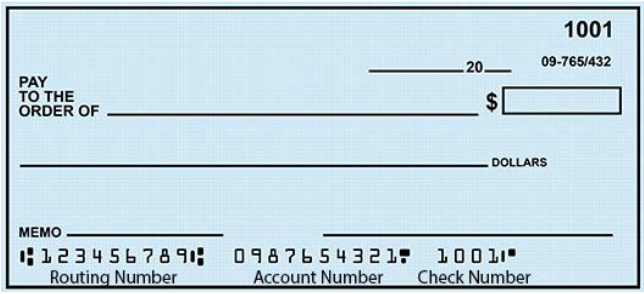
Local Government Health Insurance Board
(334) 851-6802 • enrollments@lghip.org

LG13
Revision Date: 8/23

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

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

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



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

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

Form LG23
Reviewed 8/23

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

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

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

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

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

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

Name (First, Middle Initial, Last)		Social Security Number
Measurement Period	(Start Date) Month/ Date/ Year	(End Date) Month/ Date/ Year
Average number of hours employee worked per week or per month during Measurement Period: _____		
Administrative Period	(Start Date) Month/ Date/ Year	(End Date) Month/ Date/ Year
Stability Period	(Start Date) Month/ Date/ Year	(End Date) Month/ Date/ Year

TO BE COMPLETED BY EMPLOYER

I affirm the information on this form is true and correct. I also acknowledge that it is the unit's sole responsibility to comply with the Affordable Care Act Employer Shared Responsibility rules and regulations.

Unit Name: _____ **Unit Number:** _____

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:** _____

Local Government Health Insurance Program
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 LGHIB rules outlined in the Administrative Guide.

Signature: ___________________________________ **Date:**____________________________________

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
334-851-6802 • 1-866-836-9137
Enrollments@lghip.org

Local Government Health Insurance Program
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 LGHIB rules outlined in the Administrative Guide.

Signature: _____ **Date:**_____

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
(334) 851-6802 or 1-866-836-9137
Enrollments@lghip.org

Local Government Health Insurance Program Supply Order

Date: _____

To: Blue Cross Blue Shield
Rodney Hill

Email Address: rhill@bcbsal.org

From: _____

_____

Quantity	Group 30000 Supplies
_____	2024 Blue Cross Benefit Plan Book (MKT-231)
_____	2024 Blue Cross Dental Benefit Plan Book (MKT-232)
_____	2024 Blue Cross Summary of Benefits – Health (MKT-180)
_____	2024 Blue Cross Summary of Benefits – Dental (MKT-181)

For your convenience, the above listed items may be downloaded at www.lghip.org.

The following directories are available for viewing online on the Blue Cross website (**AlabamaBlue.com**):
Preferred Provider Directory (PRO-66)
Preferred Dental Directory (PRO-128)
Directory of Participating Chiropractors (PRO-142)

Ship To:

Name of Local Government Unit _____

Contact Person _____

Street Address (No P.O. Boxes) _____

City _____

State _____Zip_____

Telephone Number (_____)_____

Please email the completed order form to (rhill@bcbsal.org), Blue Cross and Blue Shield of Alabama.

CHAPTER 13

LGHIP Member Forms

Form #	Form Name	Form Uses
LG01	Employee Enrollment	Enroll eligible employee into the LGHIP.
LG04	Declination of Coverage Must submit form within 30 days of eligibility.	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	Status Change Form	Change participant's or dependent's name, address, date of birth, telephone number and email address.
LG02-B	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.
LG02-C	Dependent Cancellation Form Must submit form within 60 days of qualifying event for cancellation.	Change participant's coverage from family to single coverage. Cancel dependents from participant's coverage.
LG03	Cancellation Form Must submit cancellation within 30 days of termination or as soon as possible. Cancellations can be processed online.	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 their 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.
Claims Forms Claims forms are available on the LGHIB website, www.lghip.org		
	OptumRx Prescription Reimbursement Request Form	Submit for reimbursement for Tier 2 or 3 covered prescription drugs.
	BCBS Medical Expense Claim Form	Submit to file a claim for any eligible medical expense that was not filed by provider.

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), COBRA Automatic Payment Authorization Form (LG14), and claim forms.

Form LG01
Revised 8/23

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	State	ZIP Code
Physical Address *Must be completed by Medicare Retiree Enrollee		City	State	ZIP Code
Primary Phone Number	Work Phone Number	E-mail Address:		

Employment Status (Check One)

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

Note: If 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.

Dependent's Name (First, Middle, Last)	Relationship to Employee (Male or Female Spouse, Son, Daughter, Stepson, Stepdaughter, Male or Female Custodial Dependent)	Date of Birth	Social Security Number

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

_____ _____

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 the LGHIB rules outlined in the Administrative Guide.

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

Local Government Health Insurance Board

(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 will be considered for coverage 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 or other dependents 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
Reviewed 8/23

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

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

My other insurance carrier is:

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

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

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

NOTICE: 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 the LGHIB 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 Government Health Insurance Board
(334) 851-6802 • 1-866-836-9137
Enrollments@lghip.org

Form LG02
Revised 8/23

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
STATUS CHANGE FORM

PARTICIPANT INFORMATION (Please print or type.)

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

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

☐ MAILING ADDRESS _____
Street Address or Post Office Box

_____
City State Zip

☐ PARTICIPANT'S / ☐ DEPENDENT'S NAME* From: _____ To: _____

**Documentation Required*

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

☐ TELEPHONE NUMBER: Primary (_____)_____ Work: (_____)_____

☐ E-MAIL ADDRESS _____

Other Group Health Insurance Information

Do you have additional insurance coverage other than LGHIP coverage? ☐ Yes ☐ No
If yes, you must complete Other Group Health Insurance Addendum

Retirement
Check applicable boxes

Retiree: ☐ Not Medicare ☐ Medicare

Must select one
☐ Retired due to Social Security Disability (provide disability determination letter)

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

Dependent: ☐ Not Medicare ☐ Medicare

Physical address of Medicare members must be provided.

_____
Physical Street Address

_____
City State Zip

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

AFFIRMATION AND RELEASE

I 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 LGHIB's behalf.

_____ _____
Participant Signature **Date**

TO BE COMPLETED BY EMPLOYER

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

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:** _____

Local Government Health Insurance Board
(334) 851-6802 • 1-866-836-9137
enrollments@lghip.org

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 LG02-B
Revised 8/23

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
NEW DEPENDENT FORM

PARTICIPANT INFORMATION (Please print or type.)

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

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

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

Reason for Addition (Must Select One)
Documentation is required before dependents can be added to coverage. See back of form for details.

	MONTH/DAY/YEAR		MONTH/DAY/YEAR
☐ Marriage	_____	☐ Open Enrollment	01/01/2024
☐ Birth of Child	_____	☐ Special Enrollment due to loss of coverage	_____
☐ Adoption of Child	_____		
☐ Legal and Physical Custody	_____	☐ Other	_____

Explain: _____

First Name **Initial** **Last Name**	**Relationship to Participant** (Spouse, Son, Daughter, Stepson, Stepdaughter, Male or Female Custodial Dependent)	**Date of Birth**	**Social Security Number**

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

AFFIRMATION AND RELEASE

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

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

_____ _____
Employee Signature Date

TO BE COMPLETED BY EMPLOYER

Requested Effective Date of Addition*: _____ **Unit Name:** _____ **Unit No.:** _____

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

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:** _____

Local Government Health Insurance Board
(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 will be considered for coverage 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 or other dependents 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 LG02-C
Revised 8/23

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
DEPENDENT CANCELLATION FORM

PARTICIPANT INFORMATION (Please print or type.)

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

DROP DEPENDENT COVERAGE (Must select one)

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

REASON FOR CANCEL- Must select one reason for cancelling dependent coverage.
If requesting to drop a dependent outside of Open Enrollment, proof of the qualifying event must be submitted.
Death is the only exception to this policy.

	MONTH/DAY/YEAR		MONTH/DAY/YEAR
Death	_____	☐ Dependent no longer resides in household/ Dependent has a change of address	_____
Divorce Attach divorce decree	_____	☐ Dependent obtained employment	_____
Loss of custody Attach court documents	_____	☐ Open Enrollment	Effective January 1, 2024
Medicare/Medicaid entitlement	_____	☐ Dependent employed by a unit in the LGHIP	_____
Retirement of Participant	_____	Name of Unit: _____	
Significant change of premiums / benefits	_____	☐ Other Qualifying Event	_____
		Explain _____	

First Name	Initial	Last Name	Relationship to Participant: (Spouse, Son, Daughter, Stepson, Stepdaughter, Male or Female Custodial Dependent)	Date of Birth	Social Security Number

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 and acknowledge that only eligible dependents may be covered under the Local Government Health Insurance Plan and I will be personally responsible for all claims for ineligible dependents.

_____ Participant Signature

_____ Date

TO BE COMPLETED BY EMPLOYER

Requested Effective Date of Change: _____Unit Name: _____ Unit Number: _____
**LGHIP may revise this date without notifying the unit if the requested date is incorrect*

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: _____

Local Government Health Insurance Board
(334) 851-6802 • 1-866-836-9137
Enrollments@lghip.org

Form LG03
Revised 8/23

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
CANCELLATION FORM

PARTICIPANT INFORMATION (Please print or type)

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

CANCEL ALL INSURANCE COVERAGE FOR THE FOLLOWING REASONS:
Participant's signature is not required for the following cancel reasons:

☐ Termination _____ (Last Day in Pay Status) ☐ Voluntary ☐ Involuntary
☐ Terminated due to gross misconduct

COBRA will not be offered if terminated due to gross misconduct

☐ Reduction of hours to less than 30 hours per week

☐ Declination of Coverage _____ (Name of Insurance Company)

Must provide proof of other acceptable coverage. Cannot submit copy of insurance card as proof.

_____ (Name of Employer (if applicable))

☐ Military Leave Date _____ Attach military papers.

☐ Leave Without Pay - Non-Payment _____

☐ Death _____ (Date of Death)

☐ Retirement Date _____ Unit does not allow retiree coverage

☐ Date Retiree became eligible for Medicare _____ Unit does not allow Medicare Coverage

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

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

☐ Other _____ Date _____

Participant's signature is required to cancel coverage for the following reasons:

☐ Retiree Requested Cancellation _____

☐ Other _____ Date _____

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

☐ Retirement Date _____

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

AFFIRMATION

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 correct and I understand by submitting this form my coverage will be cancelled.

_____ (Participant Signature) _____ (Date)

TO BE COMPLETED BY EMPLOYER

Requested Effective Date of Cancellation*: _____ **Unit Name:** _____ **Unit Number:** _____
**LGHIP may revise this date without notifying the unit if the requested date is incorrect*

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:** _____

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
(334) 851-6802 • 1-866-836-9137 • Enrollments@lghip.org

Form LG12
Revised 9/23

Local Government Health Insurance Board
Provider Screening Form

Prior Authorization (Must complete before the Screening)

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

Participant Signature _____

SECTION 1 (To Be Completed by Participant)

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

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

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

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

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

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

SECTION 2 (To Be Completed by Provider)

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

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

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

Provider's Name: (Please print) _____

Provider Signature: _____

Provider Address: _____

Provider Phone Number: _____

Please return completed forms to:

LGHIB WELLNESS
PO BOX 304901
MONTGOMERY, AL 36130
wellness@lghip.org

Phone: 1-866-836-9137, option 4
Fax: (334) 851-6808

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
WELLNESS PROGRAM PRIVACY NOTICE

The Local Government Health Insurance Board (LGHIB) Wellness Program is a voluntary wellness program available to all active employees, non-Medicare retirees, and spouses, who are covered under the Local Government Health Insurance Plan (LGHIP), Group 30000. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

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

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

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

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

If you are unable to participate in any of the health-related activities, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the LGHIB Wellness Division at 1-866-838-9137, option 4.

*Wellness qualifying period information is located within the Wellness Program section of www.lghip.org.

Protections from Disclosure of Medical Information

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

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

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the LGHIB Wellness Division at 1-866-836-9137, option 4.

Please return completed forms to:

LGHIB WELLNESS
PO BOX 304901
MONTGOMERY, AL 36130
wellness@lghip.org

Phone: 1-866-836-9137, option 4
Fax: (334) 851-6808

LOCAL GOV
health + wellness

Michael Gillespie CHAIRMAN
David C. Hilyer CHIEF EXECUTIVE OFFICER

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS AFTER YOU SIGN IT.			
Member's Name:	Date of Birth: (mm/dd/yyyy)		Contract # (As it appears on your card)
Address:			
City:	State:	Zip Code:	Telephone Number:

I _____authorize the disclosure of my Protected Health Information to the following Individual:

Name:		Telephone Number:
Address:		
City:	State:	Zip Code:

Check the applicable plan or policy: (must select at least one)

☐ LGHIP Group 30000 ☐ Southland Dental – Vision ☐ Medicare Advantage (UHC)

The type of information to be disclosed: (must select at least one)

☐ All of my Protected Health Information ☐ Other (please specify) _____

Purpose of this disclosure of my Protected Health Information (must select at least one)

☐ At my request ☐ Other (please specify) _____

Date of Expiration of this Authorization (must select at least one)

If no expiration date is indicated, this authorization will expire in 90 days from the date of this authorization.

☐ Until coverage under my health plan terminates or ☐ Expiration Date _____

By signing this authorization, I understand that my Protected Health Information described herein may be re-disclosed by the person(s) I have authorized to receive and use my Protected Health Information and that my Protected Health Information described herein may no longer be protected by federal privacy laws.

I understand that I may revoke this authorization at any time by giving written notice of my revocation to the address listed above. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before you receive my written notice of revocation.

Signature: _____ Date: _____

Printed Name: _____ Relationship to Member: _____

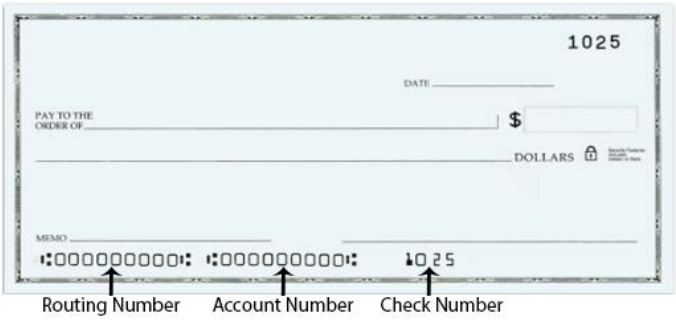
If signed as a Personal Representative, you must provide documentation of your authority to act as the Personal Representative of the individual who is the subject of the Protected Health Information described in this authorization (e.g., Parent, Power of Attorney, Guardianship, or Conservatorship).

P.O. BOX 304901 • MONTGOMERY, AL 36130 • PH: (334) 851-6802 or 1-866-836-9137 • **lghip.org**

Local Government Health Insurance Plan
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:

Name of Financial Institution
Routing Transit Number
Checking/Savings Account Number



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

SUBSCRIBER INFORMATION	**ACCOUNT HOLDER INFORMATION**
Subscriber's Number	
Subscriber's Name (please print)	**Account Holder Name (please print)**
Subscriber's Signature	**Account Holder Signature**
Date	**Date**

Please staple your voided check to this form to verify account information for withdrawals from your checking account or a deposit slip for withdrawals from a savings account. Form may be returned with your payment.

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

Optum Rx®

Prescription Drug Reimbursement Program
Local Government Health Insurance Plan

If you paid 100% for an eligible prescription drug, you must submit this form to file for 80% reimbursement.

You can submit this form for eligible claims:

- You paid 100% of cost of Tier 2 and Tier 3 brand-name drugs
- You had an emergency outside of where you live and didn't have your prescription ID card

Read carefully before submitting your completed form.

- If a drug copay coupon was used to pay for this medication, only complete a reimbursement form for the amount you paid out-of-pocket.
- You must include the original prescription label receipt(s) and credit card or cash register receipts as proof of purchase.
- Submitting ineligible claims may increase processing times.
- Submitting this form doesn't guarantee that you will be reimbursed.
- The annual plan deductible may apply
- Any refund or mailings will be sent to the primary plan member.
- The form will be returned if it is not completed and signed by the plan member.

Your receipt(s) must have the following information:

- Pharmacy name
- Drug name, strength and quantity
- Prescribing doctor's name
- Prescription number and date filled
- The amount you paid for the prescription(s)

If we can't read your receipts, your payment could be delayed or result in claims rejection, requiring resubmission.

Complete the reimbursement claim form online at www.optumrx.com or mail the completed form and receipt(s) to:

Optum Rx
P.O. Box 650334
Dallas, TX 75265-0334

Questions?
Call (844) 785-1603

Optum Rx®

LOCAL GOV health + wellness

Prescription reimbursement request form

Use this form to request reimbursement for covered medications purchased at the point-of-sale from a participating pharmacy. Complete one form per patient. Additional necessary information and instructions are on the back, please read carefully.

1 Member information

RxGroup *(see ID card)*	Contract ID *(see ID card)*	Telephone #	
Last name	First name	MI	
Mailing street address		Apt. #	
City		State	ZIP
Prescription is for O Self O Spouse O Dependent		Date of birth *(mm/dd/yyyy)*	

If prescription is for spouse or dependent:

Patient last name	Patient first name	MI	Patient date of Birth *(mm/dd/yyyy)*

2 Other insurance information

Is the patient covered by other health insurance? O YES O NO If yes, complete the following:

Policy or contract number	Name of policy holder	Effective date

Name and address of other insurance carrier

PLEASE ATTACH A COPY OF THE OTHER INSURER'S BENEFIT PAYMENT NOTICE.

3 Payment options

Please select your preferred reimbursement payment option.
O Paper check by mail
O Direct deposit (checking or savings)

Name of financial institution

Routing number	Depositor account number
_____	_____

O Checking O Savings

The above fields are required for direct deposit.
If we are unable to process the direct deposit, a check will be mailed within 14 days to the subscriber's address on file with Optum Rx.

4 Acknowledgement

I certify that the medication(s) for which reimbursement is requested were received for use by the patient above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medications received were not for treatment of an on-the-job injury. I recognize reimbursement will be paid directly to me and assignment of these benefits to a pharmacy or any other party is void.

If direct deposit is selected, I authorize Optum to initiate entries to my checking/savings account at the financial institution noted above, and if necessary, initiate adjustments for any transactions credited/debited in error.

Signature: _____ **Date:** _____

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Instructions for submitting form

1. Read the Acknowledgement (section 4) on the front of this form carefully. Then sign and date.
2. Either complete Section A OR attach pharmacy receipts. Print the front and back pages and send completed form to:
   Optum Rx Claims Department, PO Box 650334, Dallas, TX 75265-0334.

If submitting a receipt, the receipt provided by the pharmacist must provide the following: Drug name and strength, date filled, amount charged and prescription number.

Note: Cash and credit card receipts are not proof of purchase. Incomplete forms may be returned and delay reimbursement. Reimbursement is not guaranteed. Claims are subject to your plan's limits, exclusions and provisions.

Section A – Prescription drugs

Print numbers carefully as shown

1	2	3	4	5	6	7	8	9	0

Please see back page for instructions. It is not necessary to attach receipts if this form is filled out correctly.

1	Drug name and strength		Date filled	Month	Day	Year		
	Amount charged		Prescription number (Rx#)					
2	Drug name and strength		Date filled	Month	Day	Year		
	Amount charged		Prescription number (Rx#)					
3	Drug name and strength		Date filled	Month	Day	Year		
	Amount charged		Prescription number (Rx#)					
4	Drug name and strength		Date filled	Month	Day	Year		
	Amount charged		Prescription number (Rx#)					
5	Drug name and strength		Date filled	Month	Day	Year		
	Amount charged		Prescription number (Rx#)					

CL-94 (Rev. 4-2015) Front

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.*

*__Arizona:__ For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment or a loss is subject to criminal and civil penalties.

*__California:__ For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

MEDICAL EXPENSE CLAIM

FILL OUT A SEPARATE FORM FOR EACH PATIENT.
Use this form to file a claim for any eligible medical expenses when your physician or other provider does not file a claim.
Please **print** clearly with black ink or **type.**

1. Patient's Name (only one Patient per form)

Last First Middle Initial

2. Contract Number as shown on your I.D. Card (include any letters, if applicable)

3. Group Number (as shown on I.D. Card) or Place of employment

4. Patient's Date of Birth mm dd yyyy

5. Patient's Sex ☐ **Male** ☐ **Female**

6. Patient's Relationship to Contract Holder
☐ **Self** ☐ **Child** ☐ **Spouse** ☐ **Other** (explain)

7. Contract Holder Information (name as shown on your I.D. card)

Last First Middle Initial

Street

City State Zip ( ) Daytime telephone number and extension

8. Is patient covered under any other group health insurance plan? (including any other Blue Cross and Blue Shield coverage).
☐ YES ☐ NO If **yes,** complete the following:

Name of Policy Holder
Last First Middle Initial

Name and Address of Insuring Company **I.D. Number**

Is the patient entitled to Medicare benefits? **Policy Effective Date** mm dd yyyy

Part A ☐ YES ☐ NO ☐ Part B ☐ YES ☐ NO **Medicare Number**

9. Was condition related to:
a. Patient's Employment ☐ **YES** ☐ **NO**
b. Auto Accident ☐ **YES** ☐ **NO**
c. Other Accident/Injury ☐ **YES** ☐ **NO**

(If **yes**,give date of accident or onset of illness): mm dd yyyy

10. Diagnoses (type of illness or injury)

11. Ordering Physician
Phone ( )
Last Name First Name
Address City State Zip

INSTRUCTIONS: Attach the original bill or statement from the physician or supplier and **keep a copy for your records. Make sure the bill contains all required information** (see back of form for required information). **Sign this form.**

I, the undersigned, furnished the above information to enable Blue Cross and Blue Shield of Alabama to consider this claim for payment, and I certify that such information is true and correct and that the expenses were incurred by the above named patient. **I understand that any payment will be made to me.**

Signature Date

SEE BACK OF CLAIM FORM FOR EASY CLAIM FILING INSTRUCTIONS

CL-438 (Rev. 3-2014)

FILING YOUR CLAIM IS EASY

1. Fill out the Medical Expense Claim form (include all requested information).

2. Attach the bill (or clear copy of the bill) to this form.

Your bill should include the following information: (do not attach a balance forward bill)

- Patient's full name.
- Date of treatment.
- A description of the treatment provided (i. e. office visit, x-ray, surgery etc.)
- A diagnosis (type of illness or injury).
- Charge for each treatment.
- Place of treatment (i.e. doctor's office, hospital, one day surgery clinic, etc.)
- Date of accident (if applicable).
- Any Medical Equipment and/or supplies purchased. (Supply the invoice and be sure to complete box 11, Ordering Physician, on the front of this form.)

Note: The above information is usually provided on an itemized bill from the provider.)

THIS INFORMATION IS NEEDED TO PROPERLY FILE PRESCRIPTION DRUG CLAIMS.
(NOTE: FOR FILING POINT-OF-SALE PRESCRIPTION DRUG CLAIMS, USE CLAIM FORM CL-94.)

Attach the receipt or legible copy of receipt given by the pharmacist. The receipt should list the following information:

- The patient's name.
- The National Drug Code (NDC).
- The name of the prescription drug and manufacturer.
- The amount of the prescription drug.
- The name of the Pharmacy along with the telephone number and address.
- The name of the Doctor that prescribed the drug.
- Please indicate on the receipt the reason for taking each prescription.

Members can mail the completed claim to:		Members can also fax claims to:
Blue Cross and Blue Shield of Alabama **Claims Department** **Post Office Box 995** **Birmingham, Alabama 35298-0001**	**OR**	**205-220-2146** **800-526-8529**

CL-438 (Rev. 3-2014) Back

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.

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 the LGHIB, regardless of age, or
- 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 a participating unit 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. Terminated employees 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 Status Change form to continue coverage.

SERVICE RETIREMENTS

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

DISABILITY RETIREMENTS

Retirees must provide proof that an application for a disability determination from the Social Security Administration (SSA) was made prior to retiring. 18 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 the LGHIB will be offered. If the retiree receives a SSA approved disability determination and provides a copy of the determination letter to the LGHIB during the 18-month COBRA period, the retiree's COBRA coverage will be converted to LGHIP non-Medicare retiree coverage effective the first day of the next month.

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 the LGHIB with proof of Medicare Parts A and B coverage within 24 months of the SSA disability approval to maintain LGHIP retiree coverage. Once a copy of the SSA disability approval letter and proof of Medicare Parts A and B is provided, the participant 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 the LGHIB to cancel coverage. The coverage will be canceled on the last day of the month following receipt of the Cancellation or Dependent Cancellation form.

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. A Status Change form (form LG02) must be submitted to the LGHIB 30 days prior to the retirement date, indicating a change from active to retired status and the effective date of retirement.

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 canceled retroactively.

RETIREE PREMIUMS

MONTHLY PREMIUMS

EFFECTIVE JANUARY 1, 2024

Non-Medicare Retiree – With Dental	Single	Family
Retiree	$1,257	
Retiree & dependent (not Medicare)	$1,257	$2,317
Retiree & dependent (Medicare)	$1,257	$1,459
Retiree and 2 dependents (Medicare)	$1,257	$1, 661

Non-Medicare Retiree – Without Dental	Single	Family
Retiree	$1,230	
Retiree & dependent (not Medicare)	$1,230	$2,250
Retiree & dependent (Medicare)	$1,230	$1,405
Retiree & 2 dependents (Medicare)	$1,230	$1,580

Medicare Retiree – With Dental	Single	Family
Retiree	$202	
Retiree & dependent (not Medicare)	$202	$1,074
Retiree & dependent (Medicare)	$202	$404
Retiree & 2 dependents (Medicare)	$202	$606

Medicare Retiree – Without Dental	Single	Family
Retiree	$175	
Retiree & dependent (not Medicare)	$175	$1,007
Retiree & dependent (Medicare)	$175	$350
Retiree & 2 dependents (Medicare)	$175	$525

MONTHLY PREMIUMS

EFFECTIVE JANUARY 1, 2024

RETIREE COBRA PREMIUMS

Non-Medicare COBRA Retiree – With Dental	Single	Family
Retired COBRA subscriber	$1,282	
Retired COBRA subscriber & dependent (not Medicare)	$1,282	$2,362
Retired COBRA subscriber & dependent (Medicare)	$1,282	$1,488
Retired COBRA subscriber & 2 dependents (Medicare)	$1,282	$1,694

Non-Medicare COBRA Retiree – Without Dental	Single	Family
Retired COBRA subscriber	$1,255	
Retired COBRA subscriber & dependent (not Medicare)	$1,255	$2,295
Retired COBRA subscriber & dependent (Medicare)	$1,255	$1,434
Retired COBRA subscriber & 2 dependents (Medicare)	$1,255	$1,612

Medicare COBRA Retiree – With Dental	Single	Family
Retired COBRA subscriber	$206	
Retired COBRA subscriber & dependent (not Medicare)	$206	$1,096
Retired COBRA subscriber & dependent (Medicare)	$206	$412
Retired COBRA subscriber & 2 dependents (Medicare)	$206	$618

Medicare COBRA Retiree – Without Dental	Single	Family
Retired COBRA subscriber	$179	
Retired COBRA subscriber & dependent (not Medicare)	$179	$1,028
Retired COBRA subscriber & dependent (Medicare)	$179	$358
Retired COBRA subscriber & 2 dependents (Medicare)	$179	$536

CHAPTER 15

Medicare

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

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

Upon receipt of a Status Change form indicating entitlement to Medicare and a copy of the Medicare card, Medicare retirees and/or their Medicare dependent(s) will be automatically enrolled in the UnitedHealthcare Group Medicare Advantage (PPO) Plan (Medicare Advantage), a Medicare health and Part D plan. The form must be sent 30 days prior to the Medicare effective date, or for an active employee, prior to their retirement date and should check "Medicare" under the Retirement section of the Status Change form.

Medicare Advantage enrollment cannot be backdated. If the LGHIB does not receive 30 days' notice of a Medicare employee's retirement, the retiree cannot be enrolled in 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 the LGHIB 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 the LGHIB to be eligible for the reduced premiums and to ensure that claims are paid properly.

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 Open Enrollment period, 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 Open Enrollment period, the participant's coverage will be cancelled, and the participant will not be allowed to re-enroll in coverage through the LGHIB.

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 the LGHIB by submitting a Cancellation form (LG03). Upon receipt, the LGHIB will disenroll the member from the Medicare Advantage plan. Notice to the LGHIB must be provided on or before the 25th of the month prior to the participant's disenrollment date. 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 to the participant.

The LGHIB 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 the LGHIB for such premiums, the unit will be deemed in violation of the LGHIB's rules and procedures.

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

PROVISION FOR MEDICARE FOR COBRA BENEFICIARIES

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

CHAPTER 16

LGHIP Retirement Forms

Form #	Form Name	Form Uses
LG02	Status Change Form	Change status of participant to retiree, non-Medicare retiree or dependent to Medicare retiree or dependent.
LG03	Cancellation Form	Must be completed if the participant retires and is not enrolling in retiree coverage.
LG22	Retiree Years of Service Verification Form	Verifying years of service with an LGHIP unit or approved non-LGHIP employer to go toward eligibility for 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.

Form LG02
Revised 8/23

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
STATUS CHANGE FORM

PARTICIPANT INFORMATION (Please print or type.)

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

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

☐ MAILING ADDRESS _____
Street Address or Post Office Box

_____
City State Zip

☐ PARTICIPANT'S / ☐ DEPENDENT'S NAME* From: _____ To: _____

**Documentation Required*

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

☐ TELEPHONE NUMBER: Primary (_____)_____ Work: (_____)_____

☐ E-MAIL ADDRESS _____

Other Group Health Insurance Information

Do you have additional insurance coverage other than LGHIP coverage? ☐ Yes ☐ No
If yes, you must complete Other Group Health Insurance Addendum

Retirement
Check applicable boxes

Retiree: ☐ Not Medicare ☐ Medicare

Must select one
☐ Retired due to Social Security Disability (provide disability determination letter)

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

Dependent: ☐ Not Medicare ☐ Medicare

Physical address of Medicare members must be provided.

_____
Physical Street Address

_____
City State Zip

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

AFFIRMATION AND RELEASE

I 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 LGHIB's behalf.

_____ _____
Participant Signature **Date**

TO BE COMPLETED BY EMPLOYER

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

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:** _____

Local Government Health Insurance Board
(334) 851-6802 • 1-866-836-9137
enrollments@lghip.org

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 LG03
Revised 8/23

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
CANCELLATION FORM

PARTICIPANT INFORMATION (Please print or type)

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

CANCEL ALL INSURANCE COVERAGE FOR THE FOLLOWING REASONS:
Participant's signature is not required for the following cancel reasons:

☐ Termination _____ ☐ Voluntary ☐ Involuntary
Last Day in Pay Status
☐ Terminated due to gross misconduct

COBRA will not be offered if terminated due to gross misconduct

☐ Reduction of hours to less than 30 hours per week

☐ Declination of Coverage _____
Name of Insurance Company

Must provide proof of other acceptable coverage. Cannot submit copy of insurance card as proof.

_____
Name of Employer (if applicable)

☐ Military Leave Date _____ Attach military papers.

☐ Leave Without Pay - Non-Payment _____

☐ Death _____
Date of Death

☐ Retirement Date _____ Unit does not allow retiree coverage

☐ Date Retiree became eligible for Medicare _____ Unit does not allow Medicare Coverage

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

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

☐ Other _____ Date _____

Participant's signature is required to cancel coverage for the following reasons:

☐ Retiree Requested Cancellation _____

☐ Other _____ Date _____

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

☐ Retirement Date _____

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

AFFIRMATION

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 correct and I understand by submitting this form my coverage will be cancelled.

_____ _____
Participant Signature Date

TO BE COMPLETED BY EMPLOYER

Requested Effective Date of Cancellation*: _____ **Unit Name:** _____ **Unit Number:** _____
**LGHIP may revise this date without notifying the unit if the requested date is incorrect*

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:** _____

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
(334) 851-6802 • 1-866-836-9137 • Enrollments@lghip.org

Form LG22
Reviewed 8/23

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
RETIREE YEARS OF SERVICE VERIFICATION

PARTICIPANT INFORMATION (Please print or type.)

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

Years of Service with a Governmental Entity
Proof of full-time employment must be attached to this form

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

Date of Hire: ______/_______/__________	Employer:	Employer Telephone:
Date of Termination: ______/_______/__________	Employer Address:	Employer HR Contact:
____ Years _____ Months		☐ Unit participated in the LGHIP at the time of service
Date of Hire: ______/_______/__________	Employer:	Employer Telephone:
Date of Termination: ______/_______/__________	Employer Address:	Employer HR Contact:
____ Years _____ Months		☐ Unit participated in the LGHIP at the time of service
Date of Hire: ______/_______/__________	Employer:	Employer Telephone:
Date of Termination: ______/_______/__________	Employer Address:	Employer HR Contact:
____ Years _____ Months		☐ Unit participated in the LGHIP at the time of service
Date of Hire: ______/_______/__________	Employer:	Employer Telephone:
Date of Termination: ______/_______/__________	Employer Address:	Employer HR Contact:
____ Years _____ Months		☐ Unit participated in the LGHIP at the time of service

Is employee converting accrued leave days to retirement service credit? ☐ **Yes (If yes, insert number of months below)**

_____________ **Months** (12 months of maximum leave) ☐ **No**

______ **Total Years** ______ **Total Months**	***If additional space is needed, please include other previous employers on a separate document.**

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.

____ Participant Signature

___________________________________ Date

TO BE COMPLETED BY EMPLOYER

Unit Name: ____ **Unit No.:** __________________________

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:** _____________________________

Form LG18
Revised 8/23

UnitedHealthcare Medicare Advantage Opt-Out Form

Welcome to the UnitedHealthcare Group Medicare Advantage plan (UHC Medicare Advantage) provided by the Local Government Health Insurance Board (LGHIB). You will be automatically enrolled in this plan unless you complete this form and return it to the LGHIB at the address shown below.

If you have a Medicare Advantage or Medicare Part D prescription drug plan and want to disenroll from the LGHIB's UHC Medicare Advantage Plan, please complete this form and return it to the LGHIB prior to the date you want to disenroll from the UHC Medicare Advantage Plan. If you are enrolled in any other Medicare Advantage plan or Medicare Part D prescription drug plan and you want to stay on that plan, you must complete and return this UHC Medicare Advantage Opt-Out form.

If you do not want to be enrolled in this plan provided by the LGHIP, please complete and return this form.

I am a (please check one of the following): _____Medicare retiree _____Medicare dependent of retiree

Participant's Name:		
Participant's Contract Number:	Participant's Social Security Number:	Participant's Telephone Number:

I understand that the coverage available to Medicare retirees is the UHC Medicare Advantage Plan provided by the LGHIB. If I choose to disenroll from the UHC Medicare Advantage Plan, I will not have any health insurance coverage with the LGHIB and will not be allowed to re-enroll into the UHC Medicare Advantage Plan provided by the LGHIB. I further understand that if I chose to disenroll from the UHC Medicare Advantage Plan, I may be subject to a Late Enrollment Penalty if I later chose to enroll in another Medicare Part D prescription drug plan depending on how long there is a gap in my prescription drug coverage.

I understand that I can only be enrolled in one Medicare Advantage plan or Medicare Part D prescription drug plan at a time.

I certify that I have completely read and fully understand the terms and conditions of submitting this form. I also attest that all representations made by me on this form are true and correct.

_____ _____

Participant's Signature Date

Remember: Each member with Medicare who wishes to disenroll must submit a separate form.

If signed as a Personal Representative, you must provide documentation of your authority to act as the Personal Representative of the individual who is the subject of the Protected Health Information described in this authorization (e.g., Parent, Power of Attorney, Guardianship, or Conservatorship).

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
PO BOX 304901
MONTGOMERY, ALABAMA 36130
(334) 851-6802 • 1-866-836-9137 • Enrollments@lghip.org

CHAPTER 17

Southland Voluntary Insurance Plan

SUMMARY OF BENEFIT PLANS

Eligible employees may choose dental or vision coverage through the Southland Voluntary Insurance Plan (Southland).

ELIGIBLE EMPLOYEES

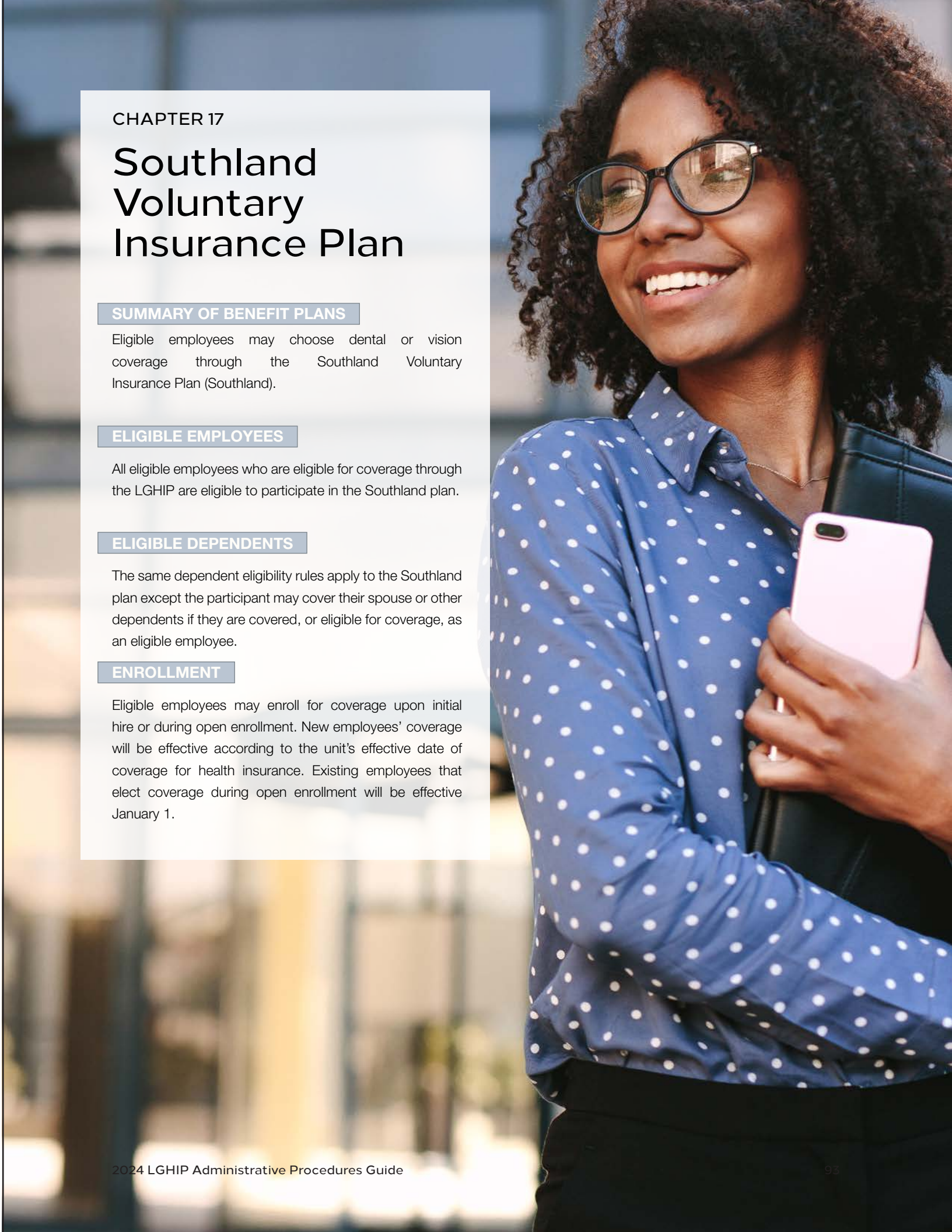
All eligible employees who are eligible for coverage through the LGHIP are eligible to participate in the Southland plan.

ELIGIBLE DEPENDENTS

The same dependent eligibility rules apply to the Southland plan except the participant may cover their spouse or other dependents if they are covered, or 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 that elect coverage during open enrollment 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 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 the LGHIB.

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

OPEN ENROLLMENT

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

CANCELLATION OF DEPENDENT/ FAMILY COVERAGE

Outside open enrollment, dropping dependent coverage requires a qualifying event (death, divorce, or otherwise losing dependent status). Coverage will be canceled at the end of the month of the qualifying event. The LGHIB requires proof of the qualifying event.

LEAVE WITHOUT PAY/MILITARY LEAVE

If an eligible employee returns to work and did not continue their coverage while on leave without pay or military leave, they will be re-enrolled in the Southland plan to satisfy the 12-month requirement.

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.

SOUTHLAND VOLUNTARY INSURANCE PREMIUMS

Employee	
Vision Single	$12.00
Vision Family	$20.00
Dental Single	$44.00
Dental Family	$44.00

COBRA	
Vision Single	$12.00
Vision Family	$20.00
Dental Single	$46.00
Dental Family	$46.00

MONTHLY PREMIUMS

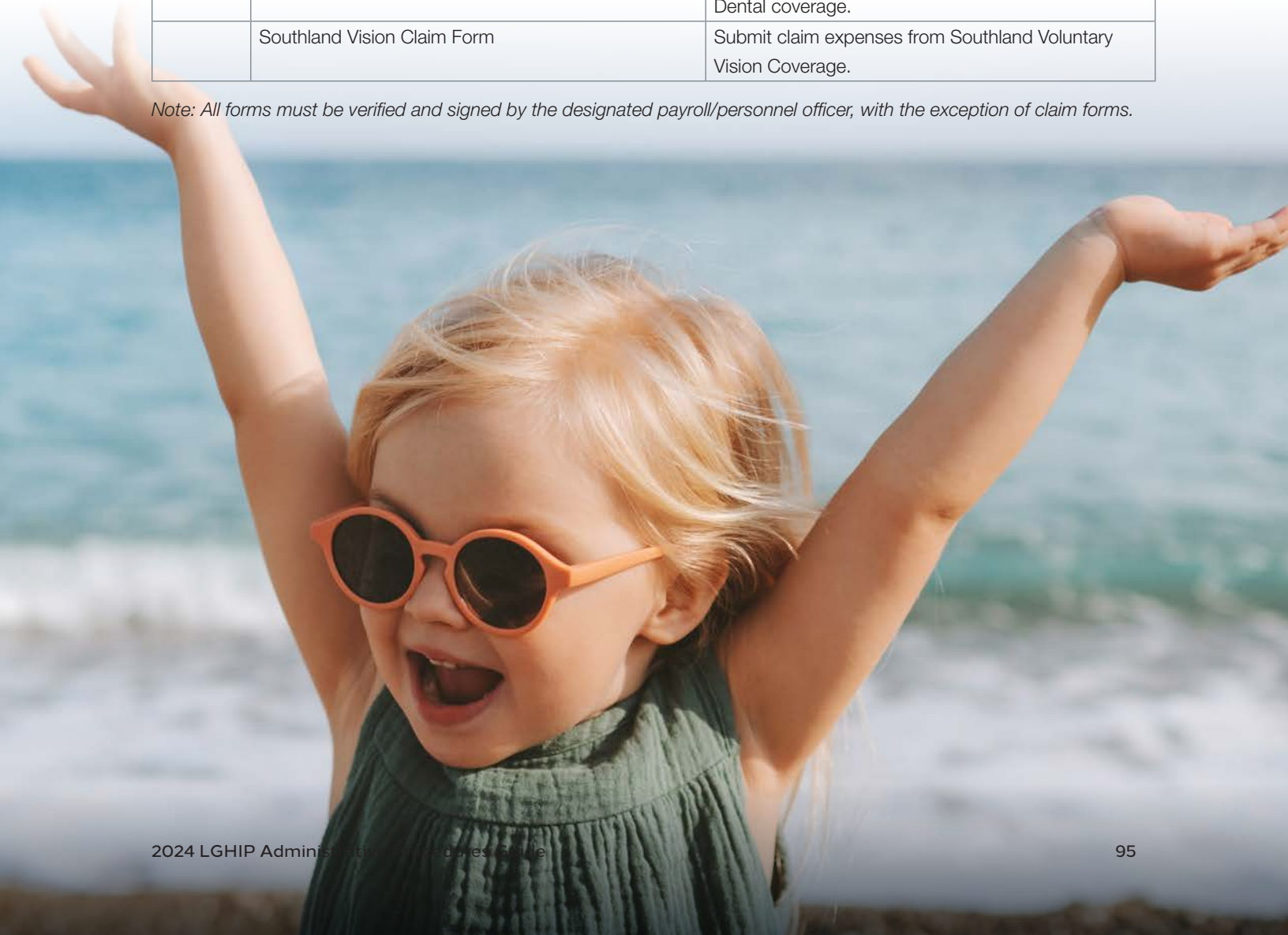
EFFECTIVE JANUARY 1, 2024

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 Form	Add dependent coverage or cancel dependent coverage due to death, divorce, loss of eligibility or during open enrollment.
LG09	Southland Voluntary Coverage Cancellation Form Form must be submitted during Open Enrollment for January 1 effective date.	Cancel Southland coverage during open enrollment if met enrollment period requirement.
Southland Claims Forms Claims forms are available on the LGHIB website, 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.

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



Form LG07
Revised 8/23

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
- ☐ Vision and Dental — $56/ Single $64/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.

First Name Initial Last Name	Relationship to Employee (Male or Female Spouse, Son, Daughter, Stepson, Stepdaughter, Male or Female Custodial Dependent)	Date of Birth	Social Security Number

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

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 the LGHIB 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 25 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:

- A participant's spouse or other dependents if they are independently eligible for coverage as an employee of a participating unit
- 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.

*The 60-day time limit does not apply to enrollment in a Southland Voluntary Plan.

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Form LG08
Revised 8/23

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
CHANGE FORM
SOUTHLAND VOLUNTARY INSURANCE

PARTICIPANT INFORMATION (Please print or type.)

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

Please indicate the Southland Plan to which you are requesting a change:

☐ Vision ☐ Dental ☐ Vision & Dental

Must have a qualifying event to drop dependent coverage outside Open Enrollment. A "qualifying event" is birth, marriage, adoption, death, divorce, or otherwise losing dependent status. Dependent documentation is required before dependents can be added or dropped due to a qualifying event. Notification must be submitted to the LGHIB within 60 days of the qualifying event.

DROP DEPENDENT COVERAGE
(Must select one)

☐ Change from Family to Single Coverage

☐ Cancel dependent(s) listed below from Family Coverage

ADDITIONS
(Must select one). Please read important information on the back.

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

☐ Add dependent(s) listed below to Family Coverage

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

☐ Open Enrollment 01/01/2024

☐ Death _____

☐ Divorce _____
Attach divorce decree

☐ Dependent no longer eligible _____

Explain: _____

☐ Other qualifying event: _____

Explain: _____

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

☐ Open Enrollment 01/01/2024

☐ Marriage _____

☐ Birth/Adoption of Child _____

☐ Other: _____

Explain: _____

If adding dependent due to a qualifying event, effective date of coverage will be the date of the qualifying event. If there is no qualifying event, the effective date of coverage will be the first day of the month following receipt of this form by the LGHIB.

First Name Initial Last Name	Relationship to Participant (Male or Female Spouse, Son, Daughter, Stepson, Stepdaughter, Male or Female Custodial Dependent)	Date of Birth	Social Security Number

AFFIRMATION AND RELEASE

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

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

_____ _____
Participant Signature Date

TO BE COMPLETED BY EMPLOYER

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

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:** _____

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 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:

- A participant's spouse or other dependents if they are independently eligible for coverage as an employee of a participating unit
- 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.

*The 60-day time limit does not apply to enrollment in a Southland Voluntary Plan.

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
(334) 851-6802 • 1-866-836-9137 • Enrollments@lghip.org

Form LG09
Revised 8/23

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

PARTICIPANT INFORMATION (Please print or type)

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

If employee was terminated, a Cancellation form (LG03) must be completed.

☐ Vision	☐ Dental	☐ Vision and Dental

AFFIRMATION

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 correct and I understand by submitting this form my Southland Voluntary Insurance coverage will be cancelled.

_____ _____
Participant Signature Date

TO BE COMPLETED BY EMPLOYER

Effective Date of Cancellation: **01/01/2024** **Unit Name:** _____ **Unit No.:** _____

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:** _____

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
(334) 851-6802 • 1-866-836-9137
Enrollments@lghip.org

ADA Dental Claim Form

P. O. Box 1250
Tuscaloosa, AL 35403-1250
Tel: 1.800.476.3010
Fax: 1.205.343.1239

Southland BENEFIT SOLUTIONS

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination / Preauthorization
☐ EPSDT / Title XIX

2. Predetermination / Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)

33. Total Fee 0

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44) | 44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) – | 52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56A. Provider Specialty Code

57. Phone Number ( ) – | 58. Additional Provider ID

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

Mailing Address:
P.O. Box 1250
Tuscaloosa, Alabama 35403

Southland BENEFIT SOLUTIONS

VISION CLAIM FORM

CLAIMS MUST BE RECEIVED IN OUR OFFICE WITHIN 365 DAYS FROM DATE OF SERVICE.

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) GROUP ☐ HEALTH PLAN (SSN or ID) OTHER ☐ (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRES (No., Street)	6. PATIENT'S RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Child ☐ Other
7. INSURED'S ADDRESS (No., Street)	
CITY STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐
CITY STATE	
ZIP CODE TELEPHONE (Include area code)	Employed ☐ Full-Time Student ☐ Part Time Student ☐
ZIP CODE TELEPHONE (Including Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. EMPLOYERS NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, return to and complete item 9 a-d
11. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____	12. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of benefits to the undersigned physician or supplier for services described below. SIGNED _____
COMMENTS	

PHYSICIAN OR SUPPLIER INFORMATION

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3, OR 4 TO ITEM 24E BY LINE)

1. _____ 3. _____
2. _____ 4. _____

	24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. Place of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	I. ID QUAL.	J. RENDERING PROVIDER ID #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO.	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED_____ DATE _____	32. SERVICE FACILITY LOCATION INFORMATION A. B.	33. BILLING PROVIDER INFO & PH. # ( ) A. B.		

DIRECTORY

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(334) 851-6802

OPERATIONS

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(334) 851-6802
rrobison@lghip.org

Jason Graham | Assistant Chief Operating Officer
(334) 851-6802
jgraham@lghip.org

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(334) 851-6802
cbrodie@lghip.org

ACCOUNTING

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(334) 851-6802, Option 3
dcraik@lghip.org

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(334) 851-6802
auditor@lghip.org

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(334) 851-6828
mwalden@lghip.org

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(334) 851-6802
mmchutchison@lghip.org

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(334) 851-6802
rpasley@lghip.org

Craig Tucker | IT Director: Business Systems
(334) 851-6802
ctucker@lghip.org

WELLNESS

Jessica O'Donnell | Benefit Services Director
(334) 851-6802, Option 4
wellness@lghip.org

MEMBER SERVICES

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

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

OptumRx Member Services
1-844-785-1603

Southland Member Services
205-343-1250

UnitedHealthcare Member Services
1-866-950-6558

LOCAL GOV

health + wellness