

**MOUNTAIN BROOK CITY COUNCIL
MEETING AGENDA**

**CITY HALL COUNCIL CHAMBER
56 CHURCH STREET
MOUNTAIN BROOK, AL 35213**

JANUARY 12, 2015, 7:00 P.M.

1. Consideration: Resolution expressing gratitude to Patrick Davis for his service on the Planning Commission.
2. Approval of the minutes of the December 8, 2014 regular meeting of the City Council.
3. Approval of the minutes of the December 16, 2014 special meeting of the City Council.
4. Consideration: Resolution setting a public hearing for February 9, 2014 to consider an ordinance adopting the 2015 International Building Code, 2015 International Residential Code, 2015 International Fuel Gas Code, 2015 International Mechanical Code, 2015 International Plumbing Code, the 2015 International Fire Code (all to become effective April 1, 2015).
5. Consideration: Resolution amending and restating the City of Mountain Brook Section 115 Trust Agreement with respect to "GASB 45 Other Post-Employment Benefits" (retiree medical insurance).
6. Consideration: Resolution authorizing the execution of a Notice of Assignment between Ajlouny Investments, LLC, and the City of Mountain Brook with respect to the assignment by Ajlouny Investments, LLC of the Development Agreement (2014-170) and Parking Agreement (2014-172) as collateral for its Iberia Bank loan.
7. Consideration: Resolution awarding the [Fire Department] uniform bid (pricing guaranteed for one year with up to two annual renewals).
8. Consideration: Resolution authorizing the execution of a service agreement between the City and All In Mountain Brook to promote educational programs, speakers, communications, and related activities intended to raise community awareness regarding substance use/abuse, high risk behavior, preventable accidents, and mental health issues in consideration of \$10,000.
9. Consideration: Resolution approving the [service] conditional use application for the operation of a fitness center in a Local Business District at 2703 Culver Road (formerly Little Hardware).
10. Consideration: Ordinance amending Chapter 14 of the City Code with respect to Storm Water plans review fees and Storm Water permit fees.
11. Announcement: The next meeting of the City Council is January 26, 2015, at 7:00 p.m. in the Council Chamber of City Hall located at 56 Church Street, Mountain Brook, AL 35213.
12. Comments from residents.
13. Adjourn.

RESOLUTION

WHEREAS, Patrick B. Davis, Jr., has served with distinction on the Mountain Brook Planning Commission from July 23, 2001, through December 31, 2014, having served as Vice-Chairman from 2003-2009 and Chairman from 2010-2014; and

WHEREAS, Patrick B. Davis, Jr., proved to be invaluable as Vice-Chairman of the Zoning Ordinance Review Committee, Vice-Chairman of the Land Use Plan Project Steering Committee and the committee to revise the City's Master Plan; his expert architectural insight and strategic leadership capabilities being invaluable in establishing a legacy of sound city planning for years to come; and

WHEREAS, Patrick B. Davis, Jr.'s, sense of humor was an added benefit to the Planning Commission's regular meetings; and

WHEREAS, it is the desire of the residents of Mountain Brook to express their gratitude to Patrick B. Davis, Jr., for his unselfish service and tireless efforts while serving on numerous ad-hoc committees.

NOW, THEREFORE, BE IT RESOLVED that the City Council and Mayor, on behalf of the residents of Mountain Brook, do publicly thank Patrick B. Davis, Jr., for his exemplary service and wish him well in future endeavors.

ADOPTED: This 12th day of January 2015.

Virginia C. Smith
Council President

APPROVED: This 12th day of January 2015.

Lawrence T. Oden
Mayor

**MOUNTAIN BROOK CITY COUNCIL
PRE-MEETING DISCUSSION
DECEMBER 8, 2014**

The City Council of the City of Mountain Brook, Alabama met in public session in the Pre-council Room (A106) of City Hall at 6:00 p.m. on Monday, the 8th day of December. The Council President called the meeting to order and the roll was called with the following results:

Present: Virginia C. Smith, Council President
William S. Pritchard, III, Council President Pro Tempore
Jack D. Carl
Lloyd C. Shelton
Lawrence T. Oden, Mayor

Absent: Alice B. Womack

Also present were City Attorney Whit Colvin, City Manager Sam Gaston, and City Clerk Steven Boone.

1. AGENDA

1. Beech Street/Circle drainage study presentation – Walter Schoel of Schoel Engineering (Appendix 1).
The suggested improvements can be performed by the City's Public Works crews in spring 2015.
2. All-In Mountain Brook Committee to make a presentation on their mission and request funds from the city – Leigh Ann Sisson. (Contract to be presented for consideration at the January 12, 2015 meeting.)
3. Variance request from the 2012 International Building Code – Perry Given at 3819 Forest Glen Drive. (Resolution No. 2014-168 was added to the formal agenda.)
4. Proposed modifications to the City's IRC Section 115 Retiree Medical Trust document – Steven Boone. (Amended Trust document to be presented for adoption at the January 12, 2015 meeting.)
5. Review and discussion of the 7 p.m. City Council formal meeting agenda topics.

Upon conclusion of the City Council's review of the other formal [7 p.m.] agenda issues, Council President Smith adjourned the meeting.

Steven Boone, City Clerk

**MINUTES OF THE REGULAR MEETING OF THE
CITY COUNCIL OF THE CITY OF MOUNTAIN BROOK, ALABAMA
DECEMBER 8, 2014**

The City Council of the City of Mountain Brook, Alabama met in public session in the City Hall Council Chamber at 7:00 p.m. on Monday, the 8th day of December, 2014. The Council President called the meeting to order and the roll was called with the following results:

Present: Virginia C. Smith, Council President
William S. Pritchard, III, Council President Pro Tempore
Jack D. Carl
Lloyd C. Shelton
Lawrence T. Oden, Mayor

Absent: Alice B. Womack

Also present were City Attorney Whit Colvin, City Manager Sam Gaston, and City Clerk Steven Boone.

The City Council President stated that a quorum was present and that the meeting was open for the transaction of business.

1. CONSENT AGENDA

Council President Smith announced that the following matters will be considered at one time on the consent agenda provided no one in attendance objects:

Approval of the minutes of the November 24, 2014 regular meeting of the City Council

- | | | |
|-----------------|---|-------------------------|
| 2014-163 | Reappoint Ken Key to serve on the Tree Commission, to serve without compensation, with the term of office to end December 12, 2017. | Exhibit 1 |
| 2014-164 | Appoint Stacey Turner to serve on The MR/DD 310 Authority, to serve without compensation, with the term of office to end December 8, 2020. | Exhibit 2
Appendix 1 |
| 2014-165 | Rename "Cahaba Park" to "Cahaba River Walk". | Exhibit 3
Appendix 2 |
| 2014-166 | Recommend to the State of Alabama, Alcoholic Beverage Control Board, the issuance of an 050 - Retail Beer (Off Premises Only) and 070 - Retail Table Wine (Off Premises Only) licenses to Alabama CVS Pharmacy, LLC (dba\CVS Pharmacy 2505) located at 93 Euclid Avenue, Mountain Brook AL. | Exhibit 4
Appendix 3 |
| 2014-167 | Authorize the conditional (service) use by Mountain Brook Trading to establish a drop-off/pick-up and show room for Mountain Brook Trading at 2 Dexter Avenue. | Exhibit 5
Appendix 4 |
| 2014-168 | Authorize the execution of an Acknowledgment, Release, and Indemnification instrument with respect to the City's approval of an exemption to specified building code regulations for the residence located at 3819 Forest Glen Drive. | Exhibit 6
Appendix 5 |

Thereupon, the foregoing minutes and resolutions were introduced by Council President Smith and their immediate adoption was moved by Council member Shelton. The minutes and resolutions were then considered by the City Council. Council President Pro Tempore Pritchard seconded the motion to adopt the foregoing minutes and resolutions. Then, upon the question being put and the roll called, the vote was recorded as follows:

Ayes: Virginia C. Smith, Council President
William S. Pritchard, III, Council President Pro Tempore
Jack D. Carl
Lloyd C. Shelton

Nays: None

Council President Smith thereupon declared that said minutes and Resolution Nos. 2014-163 through 2014-168 are adopted by a vote of 4–0.

2. CONSIDERATION: RESOLUTION (NO. 2014-169) DE-ANNEXING A PARTIAL PARCEL ON OLD TRACE (APPENDIX 6)

Council President Smith introduced the resolution writing and invited comments and questions from the audience.

Whit Colvin:

- The subject property was owned by the Bruno family (now the Bruno family trust)
- The subject property represents a portion of a much larger (43-acre) parcel partially located in the City of Vestavia Hills
- The petitioner has secured a buyer for the Mountain Brook/Vestavia properties (“property”)
- There have been many development plans considered for the property. The current proposal is very good for the surrounding neighbors in that it restricts the development of the 43-acre parcel to seven single-family homes.
- The development plan has taken two years to work out and represents a “win-win-win” for all parties and the surrounding neighbors.
- An easement that runs along the creek will ultimately be extinguished (to the benefit of Mr. Montgomery).
- Covenants will be executed to protect the surrounding neighbors.

Trip Galloway, representative of adjacent property owners:

- The proposal also prevents a cut-through from Rocky Ridge Road through an existing Vestavia neighborhood which would have been disastrous to the Abington area.

Steve Brickman , representative of the Bruno family:

- There are some minor modifications to the exhibits to the protective covenants.
- The access to be constructed into the development will be the only means of ingress/egress, however, Mr. Montgomery will allow the developer to use the existing easement (described above) for a period of 90-days during the construction of the new access bridge/road after which the easement will be terminated.
- There will also be some modifications to the [enlarged] buffer area.

There being no further comments or discussion, Council President Smith called for motion regarding the proposal. Council President Pro Tempore Pritchard then moved for the adoption of said resolution subject to the incorporation of the changes described by Mr. Brickman to be reviewed by the City’s attorney, Whit Colvin. The motion was seconded by Council member Shelton. Thereupon, Council President Smith called for vote with the following results:

Ayes: Virginia C. Smith, Council President
William S. Pritchard, III, Council President Pro Tempore
Jack D. Carl
Lloyd C. Shelton

Nays: None

Council President Smith thereupon declared that said Resolution Nos. 2014-169 is adopted by a vote of 4-0.

3. ANNOUNCEMENTS REGARDING THE NEXT REGULAR MEETING OF THE CITY COUNCIL

Council President Smith announced that the next meeting of the Mountain Brook City Council will be held on Tuesday, December 16, 2014 at 5:30 p.m. in the Council Chamber of City Hall located at 56 Church Street, Mountain Brook, AL 35213. Please visit the City's web site (www.mtnbrook.org) for more information.

4. ADJOURNMENT

There being no further business to come before the City Council, President Smith adjourned the meeting.

Steven Boone, City Clerk

EXHIBIT 1

RESOLUTION NO. 2012-163

BE IT RESOLVED by the City Council of the City of Mountain Brook, Alabama, that Ken Key is hereby reappointed to serve on the Tree Commission, to serve without compensation, with the term of office to end December 12, 2017.

EXHIBIT 2

RESOLUTION NO. 2014-164

BE IT RESOLVED by the City Council of the City of Mountain Brook, Alabama, that Stacey Turner is hereby appointed to The MR/DD 310 Authority, to will serve without compensation through December 8, 2020.

APPENDIX 1

EXHIBIT 3

RESOLUTION NO. 2014-165

DECLARATION OF NON-COMMERCIAL PUBLIC RECREATIONAL USE OF LAND

WHEREAS, the City of Mountain Brook (the "City") previously has purchased approximately 4.7 acres of real property in Jefferson County, Alabama abutting the Cahaba River, River Run Drive, and Overton

**MINUTES OF THE SPECIAL MEETING OF THE
CITY COUNCIL OF THE CITY OF MOUNTAIN BROOK, ALABAMA
DECEMBER 16, 2014**

The City Council of the City of Mountain Brook, Alabama met in public session in the City Hall Council Chamber at 5:30 p.m. on Tuesday, the 16th day of December, 2014. The Council President called the meeting to order and the roll was called with the following results:

Present: Virginia C. Smith, Council President
William S. Pritchard, III, Council President Pro Tempore
Jack D. Carl
Lloyd C. Shelton
Alice B. Womack
Lawrence T. Oden, Mayor

Absent: None

Also present were City Attorney Whit Colvin, City Manager Sam Gaston, and City Clerk Steven Boone.

The City Council President stated that a quorum was present and that the meeting was open for the transaction of business.

1. PUBLIC HEARING: CONSIDERATION OF AN ORDINANCE (1925) REZONING CERTAIN PARCELS ON VINE STREET FROM PROFESSIONAL AND RESIDENCE D DISTRICTS TO LOCAL BUSINESS DISTRICT WITH RESPECT TO THE PROPOSED PIGGLY WIGGLY DEVELOPMENT (EXHIBIT 1, APPENDICES 1-3)

Council President Smith introduced the ordinance in writing. She then invited Jeffrey Brewer forward to describe the project.

Jeffrey Brewer with Goodwyn, Mills & Cawood of 94 Crestview Drive:

- Representing Naseem Ajlouny and Andy Vercigio (“developer(s)”)
- The task of relocating the Piggly Wiggly grocery store has been ongoing for over one year
- After studying multiple sites, the location along Vine Street has been selected
- The development team has met with the City’s Planning Department, police and fire officials, Mountain Brook Board of Education and Villages Design Review Committee. There was also a prior formal presentation to the City Council on November 24, 2014.
- The site was reviewed using a PowerPoint presentation (Appendix 4)
- Regarding traffic, there will be a “School Only Traffic” sign posted at the entrance to West Jackson leading into the school, West Jackson will be one way only from its entrance to the grocery store parking lot at all times, and Vine Street from the grocery store entrance to Dexter Avenue will be one way only between the hours of 7:20 a.m. – 4 p.m. during the school year.
- The service access, originally on Vine Street, has been relocated to the other side of the building along the alley between the building and Church Street. This change eliminates [grocery store] delivery trucks traveling along West Jackson/Vine Street and exiting Vine Street.
- A number of safety measures will be implemented (see Power Point presentation)
- Recently, it was decided to restrict [grocery store] delivery times to after 10:30 a.m. and there will be no deliveries scheduled between 7:30 a.m. to 8:15 a.m.
- The parking lot has full circular access facilitating ingress and egress from the main entrance from Church Street

- A crosswalk will be installed allowing pedestrian access to and from the grocery store to the playing field across Vine Street
- There will be 93 parking spaces on the site
- There will be a corner plaza near the crosswalk (as suggested by the Village Design Review Committee or “VDRC”)
- Developer is offering to install a new fence and hedge between the Vine Street sidewalk and the playing field to provide a buffer to the people on the field as well as the residents along Elm Street (should the Board of Education want it)
- The old store had a public area of 11,400 square feet and backroom storage of 3,600 square feet with 45 parking spaces. The proposed new store will have 18,000 square feet of retail floor area, 10,250 square feet of backroom storage area (which will reduce the number of truck deliveries to the store), and 93 parking spaces.
- A typical suburban grocery store is 40,000—50,000 square feet in area
- The site plan will provide 27 surplus parking spaces over the 66 required parking spaces (as illustrated in the PowerPoint presentation)
- A new sidewalk will be constructed along Vine Street in front of the store which will complement the existing sidewalk that runs from Dexter Avenue to West Jackson
- The plan complies with the Village Overlay Standards
- Turned the presentation over to Richard Caudle

Richard Caudle with Skipper Consulting, Inc. located at 3644 Vann Road, Suite 100:

- The study area is illustrated in the PowerPoint presentation
- Recommendations include:
 - 1) Initially, Skipper Consulting recommended the installation a traffic signal at the intersection of Dexter Avenue and Church Street to alleviate congestion that currently exists. However upon further review, Skipper Consulting no longer recommends this signal due to concerns about safety for motorists attempting to back-out of Church Street parking spaces into traffic turning onto Church Street from Dexter Avenue with a green light signal.
 - 2) Reverse the stop sign at the Dexter Avenue and Vine Street intersection (stop traffic on Dexter Avenue instead of Vine Street)—this plan could later be changed by installing a traffic signal if the desired outcome is not achieved by reversing the stop signs,
 - 3) Leave the Vine Street access open to relieve pressure on the main Church Street entrance/exit to the store,
 - 4) Make West Jackson and the first block of Vine Street (up to the grocery store access) one way all the time and leave the remainder of Vine Street one way between the hours of 7:20 a.m. — 4 p.m. during the school year, and
 - 5) Install “Do Not Enter” signs at West Jackson (as this section will be one way)
- The Vine Street access is needed:
 - 1) as there will be certain times of the day where there are not sufficient gaps in traffic to allow motorists to exit onto Church Street thereby causing congestion back to the alley which will lead motorists to pursue other means of leaving the site (e.g., using the alley),
 - 2) as motorists will need a way to exit Vine when driving toward the school and encounter the “Do Not Enter” signs at West Jackson during two-way traffic flow times of the day,
 - 3) to facilitate emergency access to the site, and
 - 4) to prevent residents that live north of the development from having to travel along Church Street to access the grocery store.
- In order to relocate the loading dock to the alley-side of the store, modifications to the site plan were required. The radii at the street corners will have to be cut back or made as mountable concrete to allow delivery trucks to make the turns and backing maneuvers into the loading area.
- An independent analysis of truck traffic was conducted by Mr. Caudle and he sees no negative implications with respect to truck access or Church Street traffic as a result of moving the loading area to the alley-side of the store

- The development team considers the Vine Street access an important part of this development. If, however, the City Council elects to close this access, such closure will not “kill” this development but there will be some negative implications or trade-offs as a result

Jeffrey Brewer:

- The developers met with school officials early on in the planning phase of this development
- Out of this meeting, the School Board outlined about ten (10) safety and other concerns
- The developer studied these concerns and has addressed each one to the School Board’s satisfaction with the exception of opening the CVS parking lot access. This matter is still in negotiation with the property owner and the developer is optimistic that this last issue may still be resolved (see also slide).
- Formal presentation was concluded

Council member Shelton asked Mr. Brewer which type of delivery trucks the time restrictions will apply. Mr. Brewer stated that the delivery time restrictions will only apply to tractor trailer trucks.

Council President Pro Tempore Pritchard asked Mr. Brewer about the possibility of adding a speed bump near the proposed crosswalk on Vine Street. Mr. Brewer replied that this suggestion is a viable option and will be considered.

City Manager, Sam Gaston, asked Mr. Brewer when construction would begin if the Ordinance is adopted. Mr. Brewer replied that construction could begin as early as February 2015 and would take approximately 8 months to complete.

In response to a question by Council President Smith concerning construction buffers, Mr. Brewer responded:

- First the Girl Scout house will be moved and the lots cleared. Then a construction fence will be erected along Vine Street to prevent access from that side
- Improvements to Vine Street will hopefully be made during the summer while school is in recess

Michael Krump of 3904 Memory Brook Circle:

- Would like to see more green space and trees associated with the new parking lot and suggested that perhaps some of the parking could be located under the new Piggly Wiggly and that either an underground tunnel or an above-ground, enclosed walkway be constructed from the elementary school to the store

Kim Fasking of 3701 Forest Run Road:

- Voiced concern about pedestrian safety in the proposed crosswalk in the alley where delivery trucks will be backing up
- Asked about the procedure for background checks for construction workers due to the proximity to Crestline Elementary School. Mr. Brewer stated he did not know but had great confidence in Brasfield and Gorrie (general contractor who will be constructing the store)

Susan Pitts of 8 Montcrest Drive:

- Asked whether access through the Regions Parking Lot be through a lease agreement? If so, what is the duration of the lease?
- Noted that the crosswalk through the alley diverts foot traffic onto private (CVS) property
- What variances will be needed for this project?
- Will there be a tax abatement agreement?

Council member Pritchard:

- No lease will be needed, the City will be acquiring the parking lot from Regions Bank
- The only variance needed is in relation to (window) transparency requirement along Vine Street

- The development incentives will be discussed in the next public hearing should this rezoning be approved

There being no further comments or discussion, Council President Smith closed the public hearing. She then introduced the ordinance in writing. Council President Pro Tempore Pritchard made a motion that all rules and regulations which, unless suspended, would prevent the immediate consideration and adoption of said ordinance be suspended, and that unanimous consent to the immediate consideration of said ordinance is given and that the reading of the ordinance at length be waived. The motion was seconded by Council member Carl and was carried, as follows:

Ayes: Virginia Smith, Council President
William S. Pritchard, III, Council President Pro Tempore
Jack D. Carl
Lloyd C. Shelton
Alice B. Womack

Nays: None

The President of the Council declared the motion carried by a vote of 5—0.

After said ordinance had been considered in full by the Council, Council President Pro Tempore Pritchard then moved for the adoption of said ordinance. The motion was seconded by Council member Carl. Thereupon, Council President Smith called for vote with the following results:

Ayes: Virginia Smith, Council President
William S. Pritchard, III, Council President Pro Tempore
Jack D. Carl
Lloyd C. Shelton
Alice B. Womack

Nays: None

The President of the Council declared that the ordinance (No. 1925) is hereby adopted by a vote of 5—0 and, as evidence thereof, she signed the same.

2. PUBLIC HEARING: CONSIDERATION OF A RESOLUTION (2014-170) AUTHORIZING THE EXECUTION AND DELIVERY OF A DEVELOPMENT AGREEMENT PURSUANT TO AMENDMENT NO. 772 TO THE CONSTITUTION OF THE STATE OF ALABAMA (1901) (SECTION 94.01(a)(3) OF THE RECOMPILED CONSTITUTION OF ALABAMA) WITH RESPECT TO THE PROPOSED PIGGLY WIGGLY DEVELOPMENT (APPENDIX 5)

Council President Smith introduced the ordinance in writing. She then invited Council President Pro Tempore Pritchard to summarize the proposed resolution.

Council President Pro Tempore Pritchard:

- This development agreement is similar to those adopted for the Publix and Piggly Wiggly at River Run projects
- Depending on the performance of the facility, the owner(s) are entitled to earn certain tax abatements on sales taxes collected, up to \$4 million over a 20 year period, whichever comes first. 75% of sales taxes will be paid to the developer during the first 5 years and 50% thereafter
- They can also earn an abatement of a portion of ad valorem taxes for 15 years (on taxes over and above \$15,000 baseline) if they exceed [specified] sales projections.
- Once all improvements are complete and the store is open for business, the owners of Piggly Wiggly will convey to the City of Mountain Brook, property acquired from Regions Bank and a vacant lot on Vine Street adjacent to a lot currently owned by the City. Ownership will be fee simple and includes

all parking and access to parking. In exchange, the City will pay the developer \$1.2 million – much less than its value.

- These incentives are only available if this becomes a neighborhood grocery store. If anything changes, these incentives are null and void
- The Mountain Brook Board of Education will get its full portion of the property taxes collected for this site. Only the City's portion will be subject to the abatement.

Leigh Ann Putnam of 3518 South Brookwood Road

- Stated she was at the December 5, 2014 morning work session
- Asked how ad valorem taxes are projected
- Complemented Judge Carl for voicing concern about certain language pertaining to the tax abatement should this project fail
- What is the budget for this project?
- Can this transaction go forward without the tax abatement component?
- Where can the public see the signed agreement?

Steven Boone, Finance Director:

- The value of the building will be determined by the Jefferson County Board of Equalization. Assuming a \$10 million valuation, the Board of Education's portion at 44 mils would be approximately \$89,000 and the City's portion at 26.1 mils would be \$52,000. Only the City's portion will be abated
- All prior sales tax abatement agreements have been satisfied. There are two years remaining on two ad valorem abatement agreements with Publix and Piggly Wiggly at River Run

Council member Shelton:

- The City's General Fund budget is \$34 million
- The incentives provided for in this agreement will not hurt the City's operations but rather be of benefit as the City will be increasing its General Fund budget from the operation of this new grocery store

Council member Pritchard:

- This project would not be possible without the tax incentives

Council member Carl:

- This is how we attract new development
- None of the abatements are coming out of the budget

Adria Graham of 19 Crestview Circle:

- When will a proposed floor plan be available?
- Will the store have a restaurant?

Jeffrey Brewer:

- The inside floor plans are not complete at this time
- There will not be a restaurant

Susan Pitts of 8 Montcrest Dr.:

- Asked for a definition of a Community Grocery Store
- Will this store always be a "Piggly Wiggly"

Council President Smith:

- Community Grocery Store is not officially defined but meets certain criteria related to design, size and content
- Store owners are not locked in to the "Piggly Wiggly" name but at least one of the principals are to retain a majority interest in the business

Abe Schuster of 205 Euclid Ave.:

- Is 56 years old
- When he grew up here, most merchants in the area had a stake in this community
- Appreciates that he will once again have a local place to [grocery] shop and that the owners seem to care about this community and can be reached for questions and comments
- He wishes them much success

Randall Pitts of 225 Beech Circle:

- Asked if there is a conveyance provision in the contract whereby the City would retain an absolute right, but not an obligation, to exercise an option to acquire the property should majority ownership change in the next 20 years
- Could this be made an obligation rather than an option?

Council President Pro Tempore Pritchard:

- Yes, this [option to acquire] provision is in the contract

Council President Smith:

- The Council did consider whether the option to acquire should be elective or an obligation and the City does not want to make this an obligation

Council member Carl stated that one of the things he views about the [former] Piggly Wiggly that made it a community grocery store is that the owner/operator employed young people and others who may have found it difficult to find employment elsewhere. Considering, this store will be owned and operated by the same people as the old Piggly Wiggly, he views this store as being good for the community.

Council President Smith closed the public hearing

There being no more questions or comments, Council President Smith introduced the resolution in writing. Council member Shelton made a motion that all rules and regulations which, unless suspended, would prevent the immediate consideration and adoption of said resolution be suspended, and that unanimous consent to the immediate consideration of said resolution is given and that the reading of the resolution at length be waived. The motion was seconded by Council President Pro Tempore Pritchard and was carried, as follows:

Ayes: Virginia Smith, Council President
William S. Pritchard, III, Council President Pro Tempore
Jack D. Carl
Lloyd C. Shelton
Alice B. Womack

Nays: None

The President of the Council declared the motion carried by a vote of 5—0.

After said resolution had been considered in full by the Council, Council President Pro Tempore Pritchard then moved for the adoption of said resolution. The motion was seconded by Council member Womack. Thereupon, Council President Smith called for vote with the following results:

Ayes: Virginia Smith, Council President
William S. Pritchard, III, Council President Pro Tempore
Jack D. Carl
Lloyd C. Shelton
Alice B. Womack

Nays: None

The President of the Council declared that the resolution (No. 2014-170) is hereby adopted by a vote of 5—0 and, as evidence thereof, she signed the same.

3. CONSIDERATION OF A RESOLUTION (2014-171) AUTHORIZING A MUNICIPAL PROPERTY TAX ABATEMENT WITH RESPECT TO THE PIGGLY WIGGLY DEVELOPMENT (APPENDIX 6)

Council President Smith introduced the resolution in writing. [City Attorney Whit Colvin explained the terms of the agreement to the audience.] Council President Pro Tempore Pritchard made a motion that all rules and regulations which, unless suspended, would prevent the immediate consideration and adoption of said resolution be suspended, and that unanimous consent to the immediate consideration of said resolution is given and that the reading of the resolution at length be waived. The motion was seconded by Council member Carl and was carried, as follows:

Ayes: Virginia Smith, Council President
William S. Pritchard, III, Council President Pro Tempore
Jack D. Carl
Lloyd C. Shelton
Alice B. Womack

Nays: None

The President of the Council declared the motion carried by a vote of 5—0.

After said resolution had been considered in full by the Council, Council President Pro Tempore Pritchard then moved for the adoption of said resolution. The motion was seconded by Council member Womack. Thereupon, Council President Smith called for vote with the following results:

Ayes: Virginia Smith, Council President
William S. Pritchard, III, Council President Pro Tempore
Jack D. Carl
Lloyd C. Shelton
Alice B. Womack

Nays: None

The President of the Council declared that the resolution (No. 2014-171) is hereby adopted by a vote of 5—0 and, as evidence thereof, she signed the same.

4. CONSIDERATION OF A RESOLUTION (2014-172) AUTHORIZING A PARKING AGREEMENT BETWEEN THE CITY OF MOUNTAIN BROOK AND AJLOUNY INVESTMENTS, LLC (EXHIBIT 2, APPENDIX 7)

Council President Smith introduced the resolution in writing.

City Attorney Whit Colvin explained the major terms of the agreement:

- The agreement provides the Piggly Wiggly with certain rights and obligations including:
 - Easements for patron parking in the City-owned public parking lot
 - The grocery store must improve and maintain the parking lots
 - The previously described restrictions on product deliveries
 - Use restrictions—this agreement will become void should the store cease to be a Community Grocery Store unless the City agrees to the successor use
 - Indemnification provisions to the benefit of the City

Council member Shelton made a motion that all rules and regulations which, unless suspended, would prevent the immediate consideration and adoption of said resolution be suspended, and that unanimous consent to the immediate consideration of said resolution is given and that the reading of the resolution at length be waived. The motion was seconded by Council President Pro Tempore Pritchard and was carried, as follows:

Ayes: Virginia Smith, Council President
William S. Pritchard, III, Council President Pro Tempore
Jack D. Carl
Lloyd C. Shelton
Alice B. Womack

Nays: None

The President of the Council declared the motion carried by a vote of 5—0.

After said resolution had been considered in full by the Council, Council President Pro Tempore Pritchard then moved for the adoption of said resolution. The motion was seconded by Council President Smith. Thereupon, Council President Smith called for vote with the following results:

Ayes: Virginia Smith, Council President
William S. Pritchard, III, Council President Pro Tempore
Jack D. Carl
Lloyd C. Shelton
Alice B. Womack

Nays: None

The President of the Council declared that the resolution (No. 2014-172) is hereby adopted by a vote of 5—0 and, as evidence thereof, she signed the same.

5. ANNOUNCEMENTS REGARDING THE NEXT REGULAR MEETING OF THE CITY COUNCIL

Council President Smith announced that the next meeting of the Mountain Brook City Council will be held on Monday, January 12, 2015 at 7:00 p.m. in the Council Chamber of City Hall located at 56 Church Street, Mountain Brook, AL 35213. Please visit the City's web site (www.mtnbrook.org) for more information.

6. ADJOURNMENT

There being no further business to come before the City Council, President Smith adjourned the meeting at approximately 6:45 p.m..

Steven Boone, City Clerk

EXHIBIT 1

ORDINANCE NO. 1925

AN ORDINANCE TO REZONE CERTAIN PARCELS OF LAND IN THE CITY OF MOUNTAIN BROOK, ALABAMA FROM PROFESSIONAL DISTRICT AND RESIDENCE D DISTRICT TO LOCAL BUSINESS DISTRICT

WHEREAS, certain real property located at 48 Vine Street, more particularly described as Lot 28A, according to a resurvey of Lots 28 and 29, Block 25, Crestline Heights, as recorded in Map Book 174, Page 38 in the Office of the Judge of Probate of Jefferson County, Alabama is presently zoned Professional District under the Zoning Ordinance of the City of Mountain Brook; and

RESOLUTION NO. 2015-002

BE IT RESOLVED by the City Council of the City of Mountain Brook that, at the meeting of the City Council to be held on Monday, February 9, 2015 at 7:00 p.m., in the Council Chamber of the Mountain Brook City Hall, the City Council will hold a public hearing regarding the adoption of an ordinance repealing Sections 109-31, 109-32, 109-195, 109-227, and 18-20 of the City Code and adopting 2015 versions of specified technical codes relating to inspection activities, enforcement of building provisions as provided in said codes and fire prevention.

BE IT FURTHER RESOLVED by the City Council of the City of Mountain Brook that the City Clerk be, and he hereby is, authorized and directed to publish in accordance with applicable state law, by posting in four (4) conspicuous places within the City of Mountain Brook, as follows: City Hall, 56 Church Street, Gilchrist Drug Company, 2805 Cahaba Road, Overton Park, 3020 Overton Road, and The Invitation Place, 3150 Overton Road, a notice in words and figures substantially as follows:

“ZONING NOTICE

Notice is hereby given that at a regular meeting of the City Council of the City of Mountain Brook to be held on Monday, February 9, 2015, at 7:00 p.m., in the Council Chamber of the Mountain Brook City Hall located at 56 Church Street, Mountain Brook, Alabama 35213, the City Council will hold a public hearing regarding a proposal that the City Council adopt an ordinance in words and figures substantially as follows:

‘ORDINANCE NO. _____

AN ORDINANCE REPEALING SECTIONS 109-31, 109-32, 109-195, 109-227, AND 18-20 OF THE CITY CODE AND ADOPTING 2015 VERSIONS OF SPECIFIED TECHNICAL CODES RELATING TO INSPECTION ACTIVITIES, ENFORCEMENT OF BUILDING PROVISIONS AS PROVIDED IN SAID CODES AND FIRE PREVENTION

WHEREAS, the City Council of the City of Mountain Brook, Alabama (the “City Council”) heretofore has adopted various technical codes promulgated by the International Code Council (the “ICC”) and the National Fire Protection Association relating to buildings, residences and other structures in the City of Mountain Brook (the “City”), and operations in the City concerning fuel gas, mechanical, plumbing, and fire protection and life safety (collectively, the “Technical Codes”);

WHEREAS, the City Council desires that, except to the extent specified herein, the City adopt, the 2015 versions of the Technical Codes (the “2015 Technical Codes”) that are specified herein for use and application for buildings and structures within its corporate limits;

WHEREAS, the adoption of the 2015 Technical Codes by reference is authorized by §11-45-8 Code of Alabama (1975); and

WHEREAS, the adoption of the 2015 Technical Codes will facilitate the performance of inspection activities by the City, and promote the public safety, health and general welfare of its citizens and owners, occupants and users of buildings and structures in the City.

NOW, THEREFORE, BE IT ORDAINED by the City Council of the City as follows:

Section 1. Section 109-31 of the City Code is hereby repealed and replaced with the following:

“Sec. 109-31. Building Codes—Adoption by reference.

(a) Except as provided herein, the International Building Code - 2015 Edition (“ICC Building Code”) and International Residential Code - 2015 Edition (the “IRC”), both published by the ICC and available for purchase at 900 Montclair Road, Birmingham, Alabama, are hereby adopted as the Building Code of the City by reference as though they were copied herein.

(b) With respect to the ICC Building Code and the IRC, the City modifies the forms proposed by the ICC as follows:

(i) Section [A]101.4. of ICC Building Code - Referenced codes: The following codes that are referenced in this Section of the ICC Building Code are not adopted: (a) the International Property Maintenance Code referenced in Section 101.4.4; and (b) the International Existing Building Code referenced in Section 101.4.7.

(ii) Section [A] 109.2 of ICC Building Code & Section R108.2 of IRC – Schedule of Permit Fees: These Sections are not adopted in the form proposed by the ICC, and are replaced in their entirety with the following:

Schedule of Permit Fees. On buildings, structures, electrical, gas, mechanical, and plumbing systems or alterations requiring a permit, a fee or fees as set forth in City Code Section 14-1 shall be paid at the time of filing application, in accordance with such fee schedule as shall be set from time to time by the city council.

A list of such fees shall be kept on file in the city clerk’s office.

(iii) Sections [A] 111.1 of ICC Building Code & R110.1 of IRC – Use and Occupancy. These Sections are not adopted in the form proposed by the ICC, and are replaced in their entirety with the following:

“Use and occupancy. No residential building or structure shall be used or occupied, and no change in the existing occupancy classification of a residential building or structure or portion thereof shall be made until the building official has issued a certificate of occupancy which has been signed by the building official and the City Manager. No commercial building or structure shall be used or occupied, and no change in the existing occupancy classification of a commercial building or structure or portion thereof shall be made until the building official has issued a certificate of occupancy which has been signed by the building official, the fire official, and the City Manager. A certificate of occupancy shall not be issued until after the City Manager shall have determined that the building conforms to all provisions and regulations of the city with respect thereto, including its use under the zoning ordinances of the city. A certificate of occupancy (whether a temporary certificate of the regular certificate) issued without the signature or the building

official, fire official (in the case of commercial buildings), and the City Manager shall not be deemed to be a certificate of occupancy issued under this code or under the city's zoning ordinance.

(iv) Sections [A] 113 of ICC Building Code & R112 of the IRC – Board of Appeals. These Sections are not adopted in the form proposed by the ICC, and are replaced in their entirety with the following:

“Appeals regarding the application of the adopted building codes may be presented to the City Manager for consideration. The City Manager may elect to render a decision on such appeal or remand the appeal to the board of zoning adjustment. In cases where the appeal is heard by the City Manager and a decision is rendered, the appellant, if not satisfied with the decision, may then appeal to the board of zoning adjustment.

The board of zoning adjustment of the City of Mountain Brook, Alabama, as said board is prescribed by Section 11-52-80 Code of Alabama (1975), as amended, shall constitute a board of adjustments and appeals under these codes.”

(v) Sections [A] 114.4 of ICC Building Code & R113.4 of IRC- Violation Penalties. These Sections are not adopted in the form proposed by the ICC, and are replaced in their entirety with the following:

R113.4 Violation Penalties. Any person who violates a provision of these codes or fails to comply with any of the requirements thereof or who erects, constructs, alters or repairs a building or structure in violation of the approved construction documents or directive of the building official, or of a permit or certificate issued under the provisions of these codes, shall be subject to penalties as prescribed by law.

In instances where a person commences work prior to making application for a required permit, all applicable permit fees shall be doubled. Once notified in writing by the building official of the City that a report or building permit application must be submitted, such person must submit such report within ten (10) days. Persons who fail to make such report within the time period required shall be subject to additional penalties as provided under Sec. 1-6.1 of the City Code and by §13A-10-4 of the Code of Alabama.

(vi) Chapter 11 of IRC- Energy Efficiency. This Chapter is adopted except as follows: (a) notwithstanding any provisions contained in Chapter 11 or elsewhere in the IRC, the Energy Efficiency requirements in the IRC shall not be applicable to the repair, renovation, alteration or reconstruction of *existing* buildings and structures; and (b) the minimum standards for insulation to be used in connection with the repair, renovation, alteration or

reconstruction of *existing* buildings and structures shall not be less than R-30 for ceiling spaces, R-13 for walls and R-19 for floors.

(vii) Section P2904 of the IRC- Dwelling Unit Fire Sprinkler Systems. This Section is adopted, but the following provision is added as P2904.8.9:

P2904.8.9 Residential Sprinkler Exemption. Notwithstanding any provision in this Section P2904 or elsewhere in the IRC, any homeowner, upon application to the City’s building official, may request an exemption to the sprinkler system requirements of P2904.1 for a dwelling and such exemption shall be granted upon satisfaction of each of the following:

- a. The applicant must either confer with the City Fire Marshal or his or her designee about the benefits of installing a residential fire sprinkler system or review presentation materials developed by the Fire Marshal concerning sprinkler systems;
- b. The applicant must certify that he or she has met the requirements in subsection (a) above, and fully understands and acknowledges the risks of opting not to install a residential fire sprinkler system;

Exceptions:

- i. No exemption shall be granted for any dwelling constructed less than 5 feet from the property line; and
- ii. No exemption shall be granted for 2-family dwelling units.”

Section 2. Section 109-32 of the City Code, which reflected amendments to the previously enacted Section 109-31, is hereby repealed and replaced by the following:

“Sec. 109-32. Same – Amendments - Reserved.”

Section 3. Section 109-195 of the City Code is repealed and replaced with the following:

“Sec. 109-195. Gas and Mechanical Codes—Adoption by reference.

(a) Except as provided herein, the International Fuel Gas Code - 2015 Edition (the “Gas Code”) and International Mechanical Code - 2015 Edition (the “Mechanical Code”), both published by International Code Council (“ICC”) and available for purchase at 900 Montclair Road, Birmingham, Alabama, are hereby adopted as the Gas and Mechanical Code of the City by reference as though they were copied herein.”

(b) With respect to the Gas Code and the Mechanical Code, the City amends the form proposed by the ICC as follows:

(i) Sections [A]106.6.2 of Gas Code & [A]106.5.2 of Mechanical Code – Fee Schedule. These Sections are not adopted in the form proposed by the ICC, and are replaced in their entirety with the following:

“Schedule of Permit Fees. On buildings, structures, electrical, gas, mechanical, and plumbing systems or alterations requiring a permit, a fee or fees as set forth in City Code Section 14-1 shall be paid at the time of filing application, in accordance with such fee schedule as shall be set from time to time by the city council. A list of such fees shall be kept on file in the city clerk’s office.”

(ii) Sections [A] 108.4 of Gas Code & Mechanical Codes- Violation Penalties. These Sections are not adopted in the form proposed by the ICC, and are replaced in their entirety with the following:

“[A] 108.4 Violation Penalties. Any person who violates a provision of these codes or fails to comply with any of the requirements thereof or who erects, constructs, alters or repairs a building or structure in violation of the approved construction documents or directive of the building official, or of a permit or certificate issued under the provisions of this code, shall be subject to penalties as prescribed by law.

In instances where a person commences work prior to making application for a required permit, all applicable permit fees shall be doubled. Once notified in writing by the building official of the City that a report or building permit application must be submitted, such person must submit such report within ten (10) days. Persons who fail to make such report within the time period required shall be subject to additional penalties as provided under Sec. 1-6.1 of the city code and by §13A-10-4 of the Code of Alabama.”

(iii) Sections 109 of Gas Code & Mechanical Code – Means of Appeals. These Sections in these codes are not adopted in the form proposed by the ICC, and are replaced in their entirety with the following:

“Appeals regarding the application of the adopted building codes may be presented to the City Manager for consideration. The City Manager may elect to render a decision on such appeal or remand the appeal to the board of zoning adjustment. In cases where the appeal is heard by the City Manager and a decision is rendered, the appellant, if not satisfied with the decision, may then appeal to the board of zoning adjustment.

The board of zoning adjustment of the City of Mountain Brook, Alabama, as said board is prescribed by Section 11-52-80 Code of Alabama (1975), as amended, shall constitute a board of adjustments and appeals under these codes.”

Section 4. Section 109-227 of the City Code is repealed and replaced with the following:

“Sec. 109-227. Plumbing Code—Adoption by reference.

(a) Except as provided herein, the International Plumbing Code - 2015 Edition published by International Code Council (“ICC”) (the “Plumbing Code) and available for purchase at 900 Montclair Road, Birmingham, Alabama, is hereby adopted as the Plumbing Code of the City by reference as though it were copied herein.

(b) With respect to the Plumbing Code, the City amends the form proposed by the ICC as follows:

(i) Section [A] 106.6.2 of Plumbing Code – Fee Schedule. This Section is not adopted in the form proposed by the ICC, and is replaced in its entirety with the following:

Schedule of Permit Fees. On buildings, structures, electrical, gas, mechanical, and plumbing systems or alterations requiring a permit, a fee or fees as set forth in City Code Section 14-1 shall be paid at the time of filing application, in accordance with such fee schedule as shall be set from time to time by the city council. A list of such fees shall be kept on file in the city clerk’s office.

(ii) Section [A] 108.4 of Plumbing Code - Violation Penalties. This Section is not adopted, and is replaced in its entirety with the following:

[A] 108.4 Violation Penalties. Any person who violates a provision of this code or fails to comply with any of the requirements thereof or who erects, constructs, alters or repairs a building or structure in violation of the approved construction documents or directive of the building official, or of a permit or certificate issued under the provisions of this code, shall be subject to penalties as prescribed by law.

In instances where a person commences work prior to making application for a required permit, all applicable permit fees shall be doubled. Once notified in writing by the building official of the City that a report or building permit application must be submitted, such person must submit such report within ten (10) days. Persons who fail to make such report within the time period required shall be subject to additional penalties as provided under Sec. 1-6.1 of the City Code and by §13A-10-4 of the Code of Alabama.”

(iii) Section 109 of Plumbing Code - Means of Appeals. This Section is not adopted and is replaced in its entirety with the following:

Appeals regarding the application of the adopted building code

may be presented to the city manager for consideration. The City Manager may elect to render a decision on such appeal or remand the appeal to the board of zoning adjustment. In cases where the appeal is heard by the City Manager and a decision is rendered, the appellant, if not satisfied with the decision, may then appeal to the board of zoning adjustment.

The board of zoning adjustment of the City of Mountain Brook, Alabama, as said board is prescribed by Section 11-52-80 Code of Alabama (1975), as amended, shall constitute a board of adjustments and appeals under this code.”

Section 5. Section 18-20 of the City Code is repealed and replaced with the following:

“Sec. 18-20. Fire Prevention Code - Adoption by reference

(a) Except as provided herein, the International Fire Code - 2015 Edition published by the International Code Council (“ICC”) and available for purchase at 900 Montclair Road, Birmingham, Alabama (the “Fire Code”), and the Life Safety Code (NFPA 101) - 2015 Edition, available for purchase from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA, or by calling (800) 344-3555 (the “Life Safety Code”), are hereby adopted as the Fire Prevention Code of the City by reference as though they were copied herein.

(b) With respect to the Fire Code, the City amends the form proposed by the ICC as follows:

(i) Section 108 – Board of Appeals. This Section of the Fire Code is not adopted and is replaced in its entirety with the following:

Appeals regarding the application of the adopted code may be presented to the city manager for consideration. The city manager may elect to render a decision on such appeal or remand the appeal to the board of zoning adjustment. In cases where the appeal is heard by the city manager and a decision is rendered, the appellant, if not satisfied with the decision, may then appeal to the board of zoning adjustment.

The board of zoning adjustment of the City of Mountain Brook, Alabama, as said board is prescribed by Section 11-52-80 Code of Alabama (1975), as amended, shall constitute a board of adjustments and appeals under this code.

(ii) Section [A] 109.4 - Violation Penalties. This Section of the Fire Code is not adopted and is replaced in its entirety with the following:

[A] 109.4 Violation Penalties. Any person who violates a provision of this code or fails to comply with any of the requirements thereof or who erects, constructs, alters or repairs a

building or structure in violation of the approved construction documents or directive of the fire code official, or of a permit or certificate issued under the provisions of this code, shall be subject to penalties as prescribed by law.

In instances where a person commences work prior to making application for a required permit, all applicable permit fees shall be doubled. Once notified in writing by the building or fire official of the City that a report or building permit application must be submitted, such person must submit such report within ten (10) days. Persons who fail to make such report within the time period required shall be subject to additional penalties as provided under Sec. 1-6.1 of the City Code and by §13A-10-4 of the Code of Alabama.”

(iii) Section [A] 113.2 – Schedule of permit fees. This Section of the Fire Code is not adopted, and is replaced in its entirety with the following:

Schedule of Permit Fees. On buildings, structures, and other matters under this code that require a permit, a fee or fees as set forth in City Code Section 14-1 shall be paid at the time of filing application, in accordance with such fee schedule as shall be set from time to time by the City Council. A list of such fees shall be kept on file in the City Clerk’s office.

(iv) Section 912.2 – Location (of Fire Department Connections). This Section of the Fire Code is not adopted, and is replaced in its entirety with the following:

9.1.2.2 Location. Fire department connections shall be located not more than 100 feet from the nearest fire hydrant. With respect to hydrants, driveways, buildings and landscaping, fire department connections shall be so located that the fire apparatus and hose connected to supply the system will not obstruct access to the buildings for other fire apparatus. The location of the department connections shall be *approved* by the fire chief or fire official.

(v) Adoption of Certain Appendices: The provisions of Appendix B - Fire-Flow Requirements for Buildings, Appendix C – Fire Hydrant Locations and Distribution, and Appendix D – Fire Apparatus Access Roads each are adopted in their entirety.

(c) With respect to the Life Safety Code, the City amends the form proposed by the National Fire Protection Association as follows:

(i) Chapter 24 – One-and Two Family Dwellings. This Chapter is not adopted.

(ii) Reserved.”

Section 6. This ordinance is cumulative in nature and is in addition to any power and authority which the City of Mountain Brook may have under any other ordinance or law.

Section 7. If any part, section or subdivision of this ordinance shall be held unconstitutional or invalid for any reason, such holding shall not be construed to invalidate or impair the remainder of this ordinance, which shall continue in full force and effect, notwithstanding such holding.

Section 8. Any provisions herein that the City has adopted that deviate from the Technical Codes that are adopted by reference shall prevail over any conflicting provision of those Technical Codes. All other ordinances or parts of ordinances heretofore adopted by the City Council of the City of Mountain Brook, Alabama, which are inconsistent with the provisions of this ordinance, are hereby expressly repealed.

In addition, when a provision in the adopted Technical Codes or this Ordinance refers to the duties of certain named officials, the official of the City of Mountain Brook, Alabama whose duties most closely correspond to those of such named official shall be deemed the official responsible for the enforcement of said provision.

Section 9. The effective date of this Ordinance shall be April 1, 2015.'

BE IT FURTHER RESOLVED that the City Clerk be, and he hereby is, further authorized and directed to give written notice of the hearing to the owners of the property located in whole or in part within 500 feet from the boundaries of the property described in this resolution in the form and manner and within the time required by Act No. 1123 of the 1973 Regular Session of the Legislature of Alabama.

BE IT FURTHER RESOLVED that the City Clerk be, and hereby is, further authorized and directed to post the Notice herein above set out, which includes the proposed ordinance, in four conspicuous places within the City in accordance with applicable state law.

ADOPTED: This 12th day of January, 2015.

Council President

APPROVED: This 12th day of January, 2015.

Mayor

CERTIFICATION

I, Steven Boone, City Clerk of the City of Mountain Brook, Alabama hereby certify the above to be a true and correct copy of a resolution adopted by the City Council of the City of Mountain Brook at its meeting held on January 12, 2015, as same appears in the minutes or record of said meeting.

I further certify that copies of the resolution above were posted on January ____, 2015 in four (4) conspicuous places within the City of Mountain Brook, as follows:

City Hall, 56 Church Street

Gilchrist Pharmacy, 2805 Cahaba Road

Overton Park, 3020 Overton Road

The Invitation Place, 3150 Overton Road

City Clerk

2015-003



Steve Boone <boones@mtnbrook.org>

Re: Revised 115 Trust Agreement

1 message

Steve Boone <boones@mtnbrook.org>

Wed, Dec 17, 2014 at 2:57 PM

To: Hardwick Walthall <HWalthall@maynardcooper.com>

I will put this on the Council agenda for Jan 12, 2015. I will insert the effective date (being the date the resolution is adopted).

I will insert the City Manager's e-mail address.

I will add exhibits as well.

Thanks.

On Fri, Dec 12, 2014 at 4:10 PM, Hardwick Walthall <HWalthall@maynardcooper.com> wrote:

Steve:

Attached is the Amended and Restated Trust 115 Agreement incorporating the changes you provided. Here are a couple of points to keep in mind. We can discuss at your convenience.

1. I think this document needs to reflect the effective date that the amended and restated trust agreement should go into effect (replacing the terms and conditions of the original trust agreement). Do you have a date in mind?
2. Please note there are a few blanks still in the document: the effective date described above as well as the e-mail address for the City Manager in the notice section (9.7).
3. In addition, the Exhibits will need to be completed.

I am generally in the office next week if you would like to discuss further.

Regards,

Hardwick

RESOLUTION NO. 2015-003

BE IT RESOLVED by the City Council of the City of Mountain Brook, Alabama, that the City Council hereby authorizes the execution of the “City of Mountain Brook Amended and Restated Section 115 Trust Agreement”, in the form as attached hereto as Exhibit A, with respect to the City’s post-employment benefits (medical insurance) trust.

ADOPTED: This ____ day of January, 2015.

Council President

APPROVED: This ____ day of January, 2015.

Lawrence T. Oden, Mayor

CERTIFICATION

I, Steven Boone, City Clerk of the City of Mountain Brook, Alabama hereby certify the above to be a true and correct copy of a resolution adopted by the City Council of the City of Mountain Brook at its meeting held on January ____, 2015, as same appears in the minutes of record of said meeting.

City Clerk

**CITY OF MOUNTAIN BROOK
AMENDED AND RESTATED
SECTION 115 TRUST AGREEMENT**

Effective as of January ____, 2015

**CITY OF MOUNTAIN BROOK
AMENDED AND RESTATED
SECTION 115 TRUST AGREEMENT**

TABLE OF CONTENTS

ARTICLE I	CONTRIBUTIONS.....	1
1.1	Receipt of Contributions	2
1.2	Compliance with Laws.....	2
1.3	Directions to Trustee by the Company or Company Agents	2
ARTICLE II	PAYMENTS FROM TRUST FUND.....	2
2.1	Payments Directed by Company or a Company Agent.....	2
2.2	Impossibility of Diversion Prior to Satisfaction of all Liabilities	3
2.3	Transfer of Assets	3
2.4	Tax-Exempt Status	3
ARTICLE III	INVESTMENTS.....	3
3.1	General	3
3.2	Trustee's Adherence to Investment Guidelines	4
3.3	Appointment of an Investment Manager.....	4
ARTICLE IV	POWERS OF TRUSTEE	4
4.1	Powers.....	4
4.2	Fees and Expenses	6
ARTICLE V	TRUSTEE'S DUTIES.....	6
5.1	General	6
5.2	Consultation	6
5.3	Accounts and Records.....	6
5.4	Limitation on Trustee's Liability and Indemnification.....	7
5.5	Finality of Decisions or Acts.....	7
ARTICLE VI	RESIGNATION, REMOVAL AND SUCCESSION OF TRUSTEE	7
6.1	Resignation.....	7
6.2	Removal	7
6.3	Successor Trustee.....	7
6.4	Report by Trustee.....	7
6.5	Waiver of Notice	8
ARTICLE VII	REPRESENTATIONS AND WARRANTIES OF THE COMPANY	8
7.1	Authority to Establish Trust Fund and Enter into Agreement	8
7.2	Authorized Person.....	8

ARTICLE VIII	AMENDMENT AND TERMINATION OF AGREEMENT	8
8.1	Amendment.....	8
8.2	Termination.....	8
ARTICLE IX	GENERAL.....	8
9.1	Limited Effect of Plan and Trust Fund	8
9.2	Protective Clause.....	8
9.3	Construction of Agreement	9
9.4	Trust Exemption.....	9
9.5	Gender and Number	9
9.6	Headings.....	9
9.7	Written Communications	9
9.8	Electronic Data Exchange	10
9.9	Severability	10
9.10	Assignment of Agreement.....	10
9.11	No Effect on Current or Future Benefits.....	10

**CITY OF MOUNTAIN BROOK
AMENDED AND RESTATED
SECTION 115 TRUST AGREEMENT**

THIS AMENDED AND RESTATED SECTION 115 TRUST AGREEMENT (this “Agreement”) is made, entered into, and effective as of January ____, 2015 by and between the City of Mountain Brook (the “City”) and Steven Boone (the “Trustee”).

WHEREAS, in furtherance of its essential governmental function, the City has heretofore or herewith adopted one or more retiree welfare benefit plans (which may be a multiple-employer plan), attached hereto as Exhibit A, which may be amended from time to time in the sole discretion of the City in accordance with Section 8.1, (collectively, the “Plan”), the purpose of which is to provide certain welfare benefits for those retirees of the City and their eligible spouses and dependents covered by the Plan;

WHEREAS, the City has contributed funds to a trust fund (the “Trust Fund”) for the benefit of the retirees and their eligible spouses and dependents under and in accordance with the Plan, and such Trust Fund has been established pursuant to that certain City of Mountain Brook Section 115 Trust Agreement dated effective as of July 27, 2009 (the “Trust Agreement”), entered into by and between the City and Regions Bank d/b/a Regions Morgan Keegan Trust (the “Original Trustee”);

WHEREAS, the Trust Fund constitutes a tax-exempt trust pursuant to Section 115 of the Internal Revenue Code of 1986, as amended (the “Code”) and/or Treasury Regulations § 301.7701-1(a)(3) as confirmed by the Internal Revenue Service by the issuance of Private Letter Ruling 200937023 dated June 15, 2009;

WHEREAS, The City has decided to remove the Original Trustee and appoint the Trustee named above as the successor trustee to administer the Trust Fund and has notified the Original Trustee of such removal;

WHEREAS, the Trustee named above has accepted the appointment by the City as successor trustee, as evidenced by the Trustee’s execution of this Agreement;

WHEREAS, the City and Trustee desire to make certain changes to the Trust Agreement in order to (i) confirm the replacement of the Original Trustee with the Trustee as successor trustee and (ii) make certain changes to Article IV and V of the Trust Agreement in order to clarify certain powers and duties of the Trustee;

WHEREAS, Section 8.1 of the Trust Agreement provides that the Trust Agreement may be amended at any time provided that the Trust Fund assets shall continue to be used exclusively for the purpose of providing health benefits for the Plan;

WHEREAS, in order to accomplish the amendment and restatement of the Trust Agreement to reflect the changes described above, the City and Trustee have prepared this Agreement.

NOW, THEREFORE, in consideration of the premises and of the mutual covenants contained herein, the City and the Trustee agree as follows:

ARTICLE I

CONTRIBUTIONS

1.1 Receipt of Contributions. The Trustee shall receive any contributions paid to it in cash or in the form of such other property as it may from time to time deem acceptable and which shall have been delivered to it. Any contribution of property will be made at its fair market value (unless otherwise required) and such value will be provided to the Trustee when contributed. All contributions so received, together with the income therefrom and any other increment thereon shall be held, invested, reinvested and administered by the Trustee pursuant to the terms of this Agreement without distinction between principal and income. The Trustee shall not be responsible for the calculation or collection of any contribution under the Plan, but shall be responsible only for property received by it pursuant to this Agreement. All contributions to the Trust Fund shall be made by the City.

1.2 Compliance with Laws. This Agreement (including Exhibits A and B) and the Trust Fund are intended to comply with all of the requirements of Statement No. 45 of the Government Accounting Standard Board ("GASB") in order to allow the use of a higher discount rate in determining the present value of Other Post-Employment Benefits ("OPEB") liabilities and also to constitute an essential governmental purpose under Section 115 of the Code. City hereby represents and warrants to the Trustee that the Investment Policies or other investment guidelines set forth in Exhibit B, as may be amended from time to time in the sole discretion of City, are compliant with any and all applicable laws, rules and ordinances, including but not necessarily limited to ALA. CODE § 11-104-1, et. seq. (2014) (collectively, "Laws") and represent all applicable Laws with which the Trustee must comply in performing its duties and obligations hereunder. The Trustee shall be bound to perform its duties and obligations in accordance with Exhibit B. It shall be the sole obligation of the City to update Exhibit B to conform with any changes in the Laws, and the Trustee shall not be bound by such changes until such time as Trustee has received written notice from the City of a modification to Exhibit B.

1.3 Directions to Trustee by the City or City's Agents. The City shall have sole responsibility for determining the existence, non-existence, nature and amount of the rights and interests of all persons in the Trust Fund. All directions by the City or a City Agent (as defined below) to the Trustee shall be in writing signed by or on behalf of the City. The City shall furnish to the Trustee the name(s) of any employee of the City who is designated and authorized to direct the Trustee in writing to take action on the City's behalf. The City also shall furnish to the Trustee the name of each other person who is designated and authorized to direct the Trustee in writing to take action on the City's behalf (a "City Agent"). The Trustee shall be entitled to rely fully on the written instructions of the City, a City Agent and/or a City Agent who is an investment manager (per Section 3.3) in the discharge of the Trustee's duties and shall not be liable for any loss or other liability resulting from such direction (or lack of direction). The City promptly shall notify the Trustee in writing of the removal, replacement of, or change in the scope of authority or responsibilities of any employee of the City, City Agent or City Agent who is an investment manager, and unless and until notified by the City in writing of such changes, the Trustee shall be fully protected in acting upon the assumption that the City employee, the City Agent or the City Agent who is an investment manager has not been removed and/or replaced and that the scope of authority and responsibilities of the City employee, City Agent or the City Agent who is an investment manager have not been altered by the City or its Council.

ARTICLE II PAYMENTS FROM TRUST FUND

2.1 Payments Directed by City or a City Agent. The Trustee shall from time to time, at either the City's or City Agent's direction, make payments out of the Trust Fund to the persons or entities to whom such monies are to be paid in such amounts and for such purposes as may be specified in the written directions. To the extent permitted by law, the Trustee shall be under no liability for any payment made

pursuant to the written direction of the City or a City Agent. Any direction of the City or a City Agent shall constitute a certification that the distribution or payment so directed is one which the City or City Agent is authorized to direct.

2.2 Impossibility of Diversion Prior to Satisfaction of all Liabilities. Except as set forth below in this Section 2.2, it shall be impossible at any time for any part of the Trust Fund to be used for, or diverted to, purposes other than to pay premiums toward the Plan and/or provide the benefits contemplated under the Plan for the exclusive benefit of covered retirees and their eligible spouses and dependents, except that any reasonable expenses of administering the Plan or Trust Fund may be made from the Trust Fund as provided for herein. Upon termination of the Trust Fund, any assets remaining in the Trust Fund will be used solely to meet its obligations to pay premiums toward the Plan and/or provide benefits under the Plan to the City's retirees, their eligible spouses and dependents who participate in the Plan and to satisfy any other remaining debts or liabilities of the Trust Fund. Any assets remaining in the Trust Fund after meeting its obligations for premiums or to participants and satisfying any liabilities of the Trust Fund shall revert solely to the City, or, as determined solely by the City, to any other entity that is a state, a political subdivision of the state or an entity the income of which is excluded from gross income under Section 115. However, in no event shall any assets of the Trust Fund be transferred for the benefit of any entity that is not a state, a political subdivision of the state or an entity the income of which is excluded from gross income under Section 115. Neither the legislature of Alabama, nor any other entity, person or organization shall have the power or authority to appropriate any assets of the Trust. The assets of the Trust shall not be subject to the claims of any creditors and will not be subject to execution, attachment, garnishment, the operation of bankruptcy, the insolvency laws, or other processes whatsoever, nor shall any assignment thereof be enforceable in court.

2.3 Transfer of Assets. To the extent allowed by law, the City, in its sole discretion, may direct the Trustee to transfer the assets of the Trust Fund to any other trust (including an agent multiple-employer trust) or account if such other trust or account complies with Section 115 and GASB 45 and such trust or account also will maintain a segregated accounting of assets to be used for the same purpose set forth in Section 2.2. However, if the transfer is to be made to a trust for which the Trustee is not the trustee, the notice provisions of Section 6.2 and the termination provisions of Section 8.2 herein shall apply.

2.4 Tax-Exempt Status. Notwithstanding any provision of this Agreement to the contrary, if the Trust Fund established hereunder shall for any reason fail to be granted, or otherwise lose, tax-exempt status under Section 115 of the Code, and the Internal Revenue Service notifies the City that the Plan and/or Trust Fund do not so qualify, the City shall provide the Trustee with a copy of such notification, and the Trust Fund shall continue to be operated in accordance with this Agreement, subject to being modified to comply with Section 115 of the Code and subject to termination pursuant to Section 8.2.

ARTICLE III INVESTMENTS

3.1 General. The Trustee shall invest and reinvest the principal and income of the Trust Fund and keep the Trust Fund invested, without distinction between principal and income, in such securities or in such property, real or personal, tangible or intangible, as the Trustee shall deem advisable, including but not limited to stocks, common or preferred, trust and participation certificates, interest in investment companies whether so-called "open-end mutual funds" or "closed-end mutual funds," leaseholds, fee titles, bonds, or notes and mortgages, and other evidences of indebtedness or ownership (which investments may include any investment vehicles maintained, managed or advised by the Trustee or any of its affiliates); however, investments shall be governed by and/or limited as set forth in Sections 3.2 and 3.3. Investments shall be so diversified as to minimize the risk of large losses unless under the circumstances it is clearly prudent not to do so in the sole judgment of the Trustee. In performance of its

duties under this Section 3.1, the Trustee may recommend the City engage one or more financial institutions as an investment manager pursuant to Section 3.3 in order to make investment transaction decisions and hold investments.

3.2 Trustee's Adherence to Investment Guidelines. The discretion of the Trustee or any investment manager appointed pursuant to Section 3.3 in investing and reinvesting the principal and income of the Trust Fund shall be subject to any investment guidelines or policy set forth in Exhibit B, and any written changes thereto from time to time, as the City may adopt and communicate in writing. The Trustee and any investment manager appointed pursuant to Section 3.3 shall have the duty to act strictly in accordance with Exhibit B, and any changes thereto, as so communicated by the City from time to time in writing.

3.3 Appointment of an Investment Manager. Upon the recommendation of Trustee, the City may appoint an investment manager or managers to manage all or any part of the Trust Fund. In the event of such appointment, the City shall obtain the investment manager's written acknowledgment that it is a fiduciary with respect to the Plan and Trust Fund. Any investment manager shall have all powers of the Trustee in the management of such part of the Trust Fund, including the power to acquire or dispose of assets of the Trust Fund. In the event an investment manager is so appointed, the Trustee shall not be liable for the acts or omissions of such investment manager or be under any obligation to invest or otherwise manage that part of the Trust Fund that is subject to the management of the investment manager. The Trustee shall not be responsible for any loss or investment performance caused by its acting upon any instructions from any investment manager which the Trustee reasonably believes to be genuine. At the direction of the City, the Trustee shall segregate such portion of the Trust Fund held by it as will be subject to the management of an investment manager into one or more separate accounts to be known as investment manager accounts. The Trustee shall follow the directions of the investment manager with respect to the account of such investment manager and shall not be obligated to invest or otherwise manage any such investment manager account other than to the extent that the investment manager may utilize the Trustee as a manager of reserves. Subject to procedures and conditions as may be established by the City, the Trustee and the investment manager, the investment manager may place direct orders for the purchase or sale of securities or other property for its investment manager account. The Trustee shall retain custody of the assets comprising said account, unless custodial arrangements satisfactory to the Trustee shall otherwise be made. The City may remove an investment manager and appoint a successor to manage any investment manager account. If no successor investment manager is appointed, the portion of the Trust Fund held in such investment manager's account shall return to the unsegregated portion of the Trust Fund and the Trustee shall have authority to manage such account. The Trustee shall be fully protected in relying upon the appointment/removal of an investment manager.

ARTICLE IV POWERS OF TRUSTEE

4.1 Powers. Subject to the provisions of Article III, the Trustee, in addition to all powers and authorities under common law, statutory authority, and other provisions of this Agreement including without limitation those set forth in Article III, shall have the following powers and authorities, to be exercised in the Trustee's sole discretion:

- (a) To purchase, or subscribe for, any securities or other property and to retain the same in trust;
- (b) To sell, exchange, convey, transfer, grant options to purchase, or otherwise dispose of any securities or other property held by the Trustee, by private contract or at public auction, and any sale may be made for cash or upon credit, or partly for cash and partly upon credit. No person

dealing with the Trustee shall be bound to see to the application of the purchase money or to inquire into the validity, expediency, or propriety of any such sale or other disposition;

(c) To vote upon any stocks, bonds, or other securities; to give general or special proxies or powers of attorney with or without power of substitution; to exercise any conversion privileges, subscription rights, or other options, and to make any payments incidental thereto; to oppose, or to consent to, or otherwise participate in, corporate reorganizations or other changes affecting corporate securities, and to delegate discretionary powers, and to pay any assessments or charges in connection therewith; and generally to exercise any of the powers of an owner with respect to stock, bonds, securities or other property held as part of the Trust Fund; however, the Trustee shall not vote proxies relating to securities for which it has not been assigned full investment management responsibilities. In the event another party has been assigned such investment management responsibilities, the Trustee shall deliver the proxies to said party who will then have full responsibility for voting those proxies;

(d) To cause any securities or other property held as part of the Trust Fund to be registered in the Trustee's own name or in the name of one or more of the Trustee's nominees, and to hold any investments in bearer form, but the books and records of the Trustee shall at all times show that all such investments are part of the Trust Fund;

(e) To borrow or raise money for the purposes of the Trust in such amount, and upon such terms and conditions, as the Trustee shall deem advisable; and for any sum so borrowed, to issue a promissory note as Trustee, and to secure the repayment thereof by pledging all, or any part, of the Trust Fund; and no person lending money to the Trustee shall be bound to see to the application of the money lent or to inquire into the validity, expediency, or propriety of any borrowing;

(f) To keep such portion of the Trust Fund in cash or cash balances as the Trustee may, from time to time, deem to be in the best interests of the trust created hereby, without liability for interest thereon;

(g) To accept and retain for such time as it may deem advisable any securities or other property received or acquired by it as Trustee hereunder, whether or not such securities or other property would normally be purchased as investments hereunder;

(h) To make, execute, acknowledge, and deliver any and all documents of transfer and conveyance and any and all other instruments that may be necessary or appropriate to carry out the powers herein granted;

(i) To settle, compromise, or submit to arbitration any claims, debts, or damages to or owing to or from the Trust Fund, to commence or defend suits or legal or administrative proceedings, and to represent the Trust Fund in all suits and legal and administrative proceedings;

(j) To invest funds of the Trust Fund in night deposits or savings accounts maintained by Regions Bank or its affiliates, which deposits or accounts bear a reasonable rate of interest;

(k) To invest in Treasury Bills and other forms of United States government obligations;

(l) To deposit monies in federally insured savings accounts or certificates of deposit in banks or savings and loan associations, including accounts and deposits maintained, managed or advised by Regions Bank or any of its affiliates;

(m) To do all such acts, take all such proceedings, and exercise all such rights and privileges, although not specifically mentioned herein, as the Trustee may deem necessary to administer the Trust Fund, and to carry out the purposes of this Agreement.

4.2 Fees and Expenses. The Trustee will not receive any compensation for the services performed by Trustee under this Agreement. The Trustee shall, however, be reimbursed for any reasonable expenses directly incurred by the Trustee in the administration of the Trust Fund. The Trustee may enter contracts or arrangements under which persons (including, without limitation, agents, auditors, certified public accountants, internal auditors, and/or counsel) will advise or assist the Trustee in the carrying out of the Trustee's duties under this Agreement. Such expenses shall be paid from the Trust Fund, unless otherwise paid by the City. The City may direct the Trustee to pay the fees and expenses of investment managers from the Trust Fund. The Trustee shall not be responsible for determining the reasonableness of any compensation paid or agreed to be paid to an investment manager.

ARTICLE V TRUSTEE'S DUTIES

5.1 General. The Trustee shall discharge its duties under this Agreement solely in the interests of the retirees and their eligible spouses and dependents covered under the Plan and for the exclusive purposes of paying premiums, providing benefits to such persons and defraying reasonable expenses of administering the Trust Fund, with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims, and by diversifying the investments of the Trust Fund so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so, all in accordance with the provisions of this Agreement insofar as they are consistent with applicable law, as this Agreement and applicable law may be from time to time amended; but the duties and obligations of the Trustee as such shall be limited to those expressly imposed upon it by this Agreement notwithstanding any reference herein to the Plan, or the provisions thereof, it being hereby expressly agreed that the Trustee is not a party to the Plan.

5.2 Consultation. The Trustee may consult with counsel, and the Trustee shall not be deemed imprudent by reason of its taking or refraining from taking any action in accordance with the opinion of counsel. The Trustee shall not be required to give any bond or any other security for the faithful performance of its duties under this Agreement, except such as may be required by a law which prohibits the waiver thereof.

5.3 Accounts and Records. The Trustee shall keep accurate and detailed accounts of all investments, receipts, disbursements, and other transactions hereunder and all such accounts and other records relating thereto shall be open to inspection and audit at all reasonable times by any person designated by the City. The Trustee shall furnish to the City a written statement of account upon request by the Mountain Brook City Council setting forth all receipts and disbursements for the requested accounting period (or such more frequent reporting basis as agreed to by the parties). Additionally, the Trustee shall furnish to the City an annual written statement of account within 120 days after the end of the Trust's year end setting forth all receipts and disbursements. Failure by the City or City Agent to disapprove any such statement of account within 120 days after its receipt thereof shall be deemed approval thereof. The approval by the City or a City Agent of the statement of account shall serve to release and discharge the Trustee from any liability or accountability to the City as respects the propriety of the Trustee's acts or transactions shown in the statement of account, except with respect to any acts or transactions as to which the City or a City Agent shall file written objections with the Trustee within the 120-day time period prescribed. The

Trustee shall not be required by the terms of this Agreement or by the sole capacity of acting as trustee to file an accounting with any court.

5.4 Limitation on Trustee's Liability and Indemnification. The City, or its designated third party administrator, shall administer the Plan as provided therein, and the Trustee shall not be responsible in any respect for administering the Plan nor shall the Trustee be responsible for the adequacy of contributions to the Trust Fund to meet or discharge any payments or liabilities under the Plan. Further, the Trustee shall not be responsible in any respect for any act or omission of any prior trustee or custodian of any assets of the Trust Fund or the Plan, and the City agrees, to the extent permitted law, to indemnify and hold the Trustee harmless from and against any liabilities that the Trustee may incur, which are the direct or indirect result of a prior trustee's or custodian's acts or omissions. The City further agrees to indemnify and hold harmless the Trustee against any and all claims, damages, liabilities, costs and expenses (including without limitation attorneys' fees) assessed against, incurred by or imposed upon the Trustee and/or its successor in connection with or arising out of any claim, demand, proceeding, action, suit, settlement or compromise in which the Trustee may be involved or to which it may be a party by reason of its acting and serving as Trustee hereunder, except in the case of willful negligence or willful misconduct on the part of the Trustee. The right to be defended, indemnified and held harmless hereunder shall extend to the Trustee and its successor and shall continue to apply after the Trustee ceases to serve as Trustee with respect to acts or omissions committed prior to such cessation. Therefore, the provision of this section shall survive the removal or resignation of the Trustee as to acts or omissions committed prior to such removal or resignation. Such right to indemnification shall not be exclusive of other rights to which the Trustee may be entitled as a matter of law.

5.5 Finality of Decisions or Acts. Except for the right of a participant to appeal the denial of a claim, any decision or action of the Trustee made or done in good faith upon any matter within the scope of authority and discretion of the Trustee shall be final and binding upon all persons. In the event of judicial review of actions taken by any fiduciary within the scope of its duties in accordance with the terms of the Plan and this Agreement, such actions shall be upheld unless determined to have been arbitrary and capricious.

ARTICLE VI RESIGNATION, REMOVAL AND SUCCESSION OF TRUSTEE

6.1 Resignation. The Trustee may resign at any time by giving 30 days' notice in writing to the City.

6.2 Removal. The City may remove the Trustee at any time upon 30 days' notice in writing to the Trustee.

6.3 Successor Trustee. Upon the resignation or removal of the Trustee, the City shall appoint a successor trustee who shall have the same powers and duties as those conferred upon the Trustee hereunder. Upon acceptance of such appointment by the successor trustee, the Trustee shall assign, transfer, and pay over to such successor trustee the funds and properties then constituting the Trust Fund. The Trustee is authorized, however, to reserve such reasonable sum of money, as it may deem advisable, for payment of its fees and expenses in connection with the settlement of its account or otherwise, and any balance of such reserve remaining after the payment of such fees and expenses shall be paid over to the successor trustee. Until such a successor is appointed, the current Trustee shall have full authority to act hereunder; provided, however, that if no successor is appointed on or before the effective date of a resignation or removal, the Trustee may file a civil action to seek the appointment of a successor.

6.4 Report by Trustee. Within 120 days after the resignation or removal of the Trustee, the Trustee shall furnish to the City a written statement of account with respect to the portion of the year for which

the Trustee served. Failure by the City or a City Agent to disapprove any such statement of account within 60 days after its receipt thereof shall be deemed approval thereof. The approval by the City or a City Agent of the statement of account shall serve to release and discharge the Trustee from any liability or accountability to the City as respects the propriety of the Trustee's acts or transactions shown in the statement of account, except with respect to any acts or transactions as to which the City or a City Agent shall file written objections with the Trustee within the 60-day time period prescribed.

6.5 Waiver of Notice. In the event of any resignation or removal of the Trustee, the Trustee and the City may in writing waive any notice of resignation or removal as may be provided hereunder.

ARTICLE VII REPRESENTATIONS AND WARRANTIES OF THE CITY

7.1 Authority to Establish Trust Fund and Enter into Agreement. The City hereby represents and warrants that it has consulted with legal counsel regarding the City's authority to establish the Trust Fund and to enter into this Agreement and that it has been conclusively determined that the City has the authority to establish the Trust Fund and to enter into this Agreement.

7.2 Authorized Person. The City represents and warrants that the person executing this Agreement below is authorized by the City to enter into this Agreement.

ARTICLE VIII AMENDMENT AND TERMINATION OF AGREEMENT

8.1 Amendment. Any or all of the provisions of this Agreement may be amended at any time and from time to time, in whole or in part, by an instrument in writing, signed by the Trustee and the City. No such amendment shall authorize or permit any part of the Trust Fund (other than such part as is required to pay administration expenses) to be used for or diverted to purposes other than for the exclusive benefit of the retirees and their eligible spouses and dependents; except as provided in Section 2.2, no such amendment shall cause or permit any portion of the Trust Fund to revert to or become the property of the City. Exhibit A may be amended from time to time in the sole discretion of the City to add or remove plans that are covered by the Trust; however, a plan may not be removed from coverage under the Trust unless and until all liabilities associated with such plan have first been satisfied.

8.2 Termination. This Agreement may be terminated at any time by the City, and upon such termination, or upon the dissolution or liquidation of the City, the Trust Fund shall be paid out by the Trustee as and when directed by the City or a City Agent, in accordance with the provisions of Article II hereof and the terms of the Plan.

ARTICLE IX GENERAL

9.1 Limited Effect of Plan and Trust Fund. Neither the establishment of the Plan nor the Trust Fund nor any modification thereof, nor the creation of any fund or account, nor the payment of any welfare benefits, shall be construed as giving to any person covered under the Plan or other person any legal or equitable right against the Trustee, the City, or any officer or employee thereof, except as may otherwise be provided in the Plan or in this Agreement.

9.2 Protective Clause. Neither the City nor the Trustee shall be responsible for the validity of any contract of insurance issued in connection with the Plan or Trust Fund or for the failure on the part of the

insurer to make payments provided by such contract, or for the action of any person which may delay payment or render a contract null and void or unenforceable in whole or in part.

9.3 Construction of Agreement. This Agreement shall be construed and enforced according to the laws of the State of Alabama.

9.4 Trust Exemption. The City has previously submitted this Agreement to the Internal Revenue Service for a private letter ruling on its status as a tax-exempt trust under Section 115 of the Code.

9.5 Gender and Number. Wherever any words are used herein in the masculine, feminine or neuter, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

9.6 Headings. The headings and sub-headings of this Agreement have been inserted for convenience of reference and are to be ignored in any construction of the provisions hereof.

9.7 Written Communications. All notices, demands, directions, designations, specifications, consents, instructions, approvals, requirements, information, statements or communications between the City and the Trustee required or permitted to be given, made, disclosed, furnished or transmitted under this Agreement shall be in writing and/or an electronic medium or format agreed upon by the City and Trustee and directed by first-class (postage prepaid) U.S. mail, electronic facsimile transmission, or electronic mail to the recipient at its physical address, facsimile number, or electronic mail address set forth below in this Section 9.7 or at any other physical address, facsimile number, or electronic mail address of which a party shall have notified the other party in accordance with the procedures of this Section 9.7. All notices, demands, directions, designations, specifications, consents, instructions, approvals, requirements, information, statements or communications between a City Agent (including a City Agent who is an investment manager) and the Trustee required or permitted to be given, made, disclosed, furnished or transmitted under this Agreement shall be in writing and/or an electronic medium or format agreed upon by the City (or if applicable, a City Agent) and the Trustee and directed by first-class (postage prepaid) U.S. mail, electronic facsimile transmission, or electronic mail (1) to the Trustee at its physical address, or facsimile number set forth below in this Section 9.7 or at any other physical address, facsimile number, or electronic mail address of which the Trustee shall have notified the City Agent in accordance with this Section 9.7 and (2) to the City Agent at a physical address, facsimile number, or electronic mail address of which the City or City Agent shall have notified the Trustee. Notice of a change in a City Agent's physical address, facsimile number or electronic email address shall be given in accordance with the procedures of this Section 9.7.

(a) If to the City:

City Manager
City of Mountain Brook
56 Church Street
Birmingham, AL 35213-3700
Fax: 205.879.6913

Electronic Mail Address: gastons@mtnbrook.org

(b) If to the Trustee:

Finance Director

City of Mountain Brook
56 Church Street
Birmingham, AL 35213-3700
Fax: 205.879.6913
Electronic Mail Address: boones@mtnbrook.org

9.8 Electronic Data Exchange. Notwithstanding the foregoing Section 9.7, the City (or a City Agent, if applicable) and the Trustee may establish procedures to facilitate the secure electronic transmission and exchange of data (such as computer files) between the City (or a City Agent, if applicable) and the Trustee. All communications pertaining to any such procedures shall be subject to Section 9.7.

9.9 Severability. If any provisions of this Agreement shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof, and this Agreement shall be construed and enforced as if such provision, to the extent invalid or unenforceable had not been included.

9.10 Assignment of Agreement. The Trustee may not assign this Agreement to any other trustee, corporation, person or entity unless the City consents to such assignment in writing in advance of the effective date thereof.

9.11 No Effect on Current or Future Benefits. Nothing in this Agreement shall be construed to define or otherwise grant any right or privilege to any benefits to any person. Benefits, if any, shall be governed by the terms of the applicable plan document. Further, this Agreement is not intended to assure or deny any existing or future employee, retired employee, any of their dependents, or any other person of any right of employment or entitlement to any benefit or otherwise restrict the ability of the City to modify or eliminate any existing or future benefit.

IN WITNESS WHEREOF, this Agreement has been executed the day and year first above written.

“CITY”

City of Mountain Brook

By: _____

Its: _____

“TRUSTEE”

Steven Boone

EXHIBIT A

Copies of Retiree Welfare Benefit Plan(s) Covered under the Section 115 Trust Agreement

(attached)

Local Government Health Benefit Plan



Local Government Plan Effective January 1, 2014



SUMMARY OF BENEFITS LOCAL GOVERNMENT HEALTH INSURANCE PLAN JANUARY 1, 2014

This table is a summary of benefits and is subject to all other terms and conditions of the Plan.

To maximize your benefits, seek medical services from a Preferred Provider who participates in the BlueCard Preferred Provider Organization (PPO) Program. To find out if your provider is a PPO member, call 1-800-810-BLUE(2563) or access the Blue Cross website at www.bcbs.com/healthtravel/index.html. Please be aware that not all providers participating in the BlueCard PPO Program will be recognized by Blue Cross as approved providers for the type of service being furnished as explained more fully in "Benefit Conditions."

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
INPATIENT HOSPITAL BENEFITS		
Inpatient Facility Coverage (including maternity)	Covered at 100% of the allowance, subject to a \$200 per admission deductible if pre-certification obtained within 72 hours. If pre-certification received late, covered at 100% of the allowance, subject to a \$600 per admission deductible. No benefits if pre-certification is not obtained. \$50 co-pay per day for days 2-5	Covered at 80% of the allowance, subject to a \$200 per admission deductible if pre-certification obtained within 72 hours. If pre-certification received late, covered at 80% of the allowance, subject to a \$600 per admission deductible. No benefits if pre-certification is not obtained. \$50 co-pay per day for days 2-5
Preadmission Certification	All hospital admissions, including emergency admissions, require preadmission certification within 72 hours, except maternity. For preadmission certification, call 1-800-551-2294. If preadmission certification is not obtained, no benefits are available.	All hospital admissions, including emergency admissions, require preadmission certification within 72 hours, except maternity. For preadmission certification, call 1-800-551-2294. If preadmission certification is not obtained, no benefits are available.
OUTPATIENT HOSPITAL BENEFITS		
Surgery	Covered at 100% of the allowance, subject to the \$100 facility co-pay. Certain outpatient surgeries require pre-certification, call 1-800-551-2294.	Covered at 80% of the allowance, subject to the calendar year deductible. Certain outpatient surgeries require pre-certification, call 1-800-551-2294.
Medical Emergency	Covered at 100% of the allowance, subject to the \$200 facility co-pay.	Covered at 100% of the allowance, subject to the \$200 facility co-pay.
Accidental Injury	Covered at 100% of the allowance with no deductible or co-pay required if services are provided within 72 hours of the accident.	Covered at 100% of the allowance with no deductible or co-pay required if services are provided within 72 hours of the accident.
Diagnostic X-rays & Tests	Covered at 100% of the allowance, subject to the \$100 facility co-pay per visit or cost of service, whichever is less.	Covered at 80% of the allowance, subject to the calendar year deductible.
Diagnostic Lab & Pathology	Covered at 100% of the allowance, subject to a \$3 co-pay per test.	Covered at 80% of the allowance, subject to the calendar year deductible.
Note: In Alabama, inpatient and outpatient benefits for non-member hospitals are available only in cases of accidental injury and covered as an out-of-network hospital.		
PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT BENEFITS		
Physician Office Visits, Office Surgery & Outpatient Consultations	Covered at 100% of the allowance, subject to the \$35 office visit co-pay.	Covered at 80% of the allowance, subject to the calendar year deductible.
Nurse Practitioners / Nurse Midwives, Physician Assistant Office Visits, Office Surgery & Outpatient Consultations	Covered at 100% of the allowance, subject to the \$20 office visit co-pay.	Covered at 80% of the allowance, subject to the calendar year deductible.
Emergency Room	Covered at 100% of the allowance, subject to the office visit co-pay.	Covered at 100% of the allowance, subject to the office visit co-pay.
Inpatient Visits	Covered at 100% of the allowance.	Covered at 80% of the allowance, subject to the calendar year deductible.
Maternity	Covered at 100% of the allowance.	Covered at 80% of the allowance, subject to the calendar year deductible.
Lab & Pathology Exams	Covered at 100% of the allowance, subject to a \$3 co-pay per test.	Covered at 80% of the allowance, subject to the calendar year deductible.
Diagnostic X-rays & Tests	Covered at 100% of the allowance.	Covered at 80% of the allowance, subject to the calendar year deductible.

INTRODUCTION

This summary of health care benefits of the Local Government Health Insurance Plan (LGHIP) is designed to help you understand your coverage. This booklet replaces any previously issued information. All terms, conditions and limitations are not covered here. All benefits are subject to the terms, conditions and limitations of the contract or contracts between the State Employees Insurance Board (SEIB) and Blue Cross Blue Shield (BCBS) of Alabama or other third party administrators that the SEIB may contract with that it deems it necessary to carry out its statutory obligations. Copies of all contracts are kept on file at the SEIB office and are available for review.

The SEIB shall have absolute discretion and authority to interpret the terms and conditions of the LGHIP and reserves the right to change the terms and conditions and/or end the LGHIP at any time and for any reason.

The following provisions of this booklet contain a summary, in English, of your rights and benefits under the LGHIP. If you have questions about your benefits, please contact Customer Service at 1-800-321-4391. If needed, simply request a Spanish translator and one will be provided to assist you in understanding your benefits.

Atención por favor Este folleto contiene un resumen en inglés de sus beneficios y derechos del plan. Si tiene alguna pregunta acerca de sus beneficios, por favor póngase en contacto con el departamento de Servicio al Cliente llamando al 1-877-255-7250. Solicite simplemente un intérprete de español y se proporcionará uno para que le ayude a entender sus beneficios.

Local Government Health Insurance Program Benefit Plan

Administered By:
State Employees' Insurance Board
Post Office Box 304900
Montgomery, Alabama 36130-4900
Phone: 334.263.8326
Toll-Free: 1.866.836.9137
Website: www.alseib.org

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
ROUTINE PREVENTIVE CARE		
Routine Immunizations and Preventive Services	Covered at 100% of the allowance with no deductible or co-pay. See www.bcbsal.com/preventiveservices for a listing of the specific immunizations and preventive services.	Covered at 80% of the allowance subject to the calendar year deductible. See www.bcbsal.com/preventiveservices for a listing of the specific immunizations and preventive services.
Additional Routine Preventive Services	Covered at 100% of the allowance with no deductible or co-pay. In addition to the standard, the following will apply: <ul style="list-style-type: none"> Urinalysis (once by age 5, then once between ages 12-17) CBC (once every 2 calendar years ages 6-17, then once every calendar year age 18 and over) Glucose testing (once every calendar year age 18 and over) Cholesterol testing (once every calendar year age 18 and over) TB skin testing (once before age 1, once between ages 1-4, and once between ages 14-18) 	Covered at 80% of the allowance subject to the calendar year deductible. In addition to the standard, the following will apply: <ul style="list-style-type: none"> Urinalysis (once by age 5, then once between ages 12-17) CBC (once every 2 calendar years ages 6-17, then once every calendar year age 18 and over) Glucose testing (once every calendar year age 18 and over) Cholesterol testing (once every calendar year age 18 and over) TB skin testing (once before age 1, once between ages 1-4, and once between ages 14-18)
MENTAL HEALTH SERVICES		
Inpatient Facility Services	Covered at 80% of the participating allowance, subject to a \$200 inpatient per admission deductible.	Covered at 80% of the allowance, subject to a \$200 inpatient per admission deductible.
Inpatient Physician Services	Covered at 80% of the allowance.	Covered at 80% of the allowance, subject to the calendar year deductible.
SEIB Approved Outpatient Provider Services	Covered at 100% of the allowance, subject to a \$14 co-pay per visit; limited to 20 visits per person per calendar year.	Covered at 80% of the allowance, subject to the calendar year deductible; limited to 20 visits per person per calendar year.
SUBSTANCE ABUSE SERVICES		
Inpatient Facility Services	Covered at 80% of the allowance, subject to a \$200 inpatient per admission deductible.	Covered at 80% of the allowance, subject to a \$200 inpatient per admission deductible.
Inpatient Physician Services	Covered at 80% of the allowance.	Covered at 80% of the allowance, subject to the calendar year deductible.
SEIB Approved Outpatient Provider Services	Covered at 100% of the allowance, subject to a \$14 co-pay per visit; limited to 20 visits per person per calendar year. (Other co-pays may apply based on services rendered.)	Covered at 80% of the allowance, subject to the calendar year deductible; limited to 20 visits per person each calendar year.
ANNUAL PROVISIONS		
Calendar Year Deductible	\$200 per person each calendar year; maximum of three deductibles per family.	\$200 per person each calendar year; maximum of three deductibles per family.
Annual Out-of-Pocket Maximum	\$8,250 Individual annual out-of-pocket maximum; \$12,500 aggregate family maximum.	\$8,250 Individual annual out-of-pocket maximum; \$12,500 aggregate family maximum.
In-Network Services: Deductibles, copays and coinsurance apply to the out-of-pocket maximum, including prescription drugs (excludes Medicare Blue Rx plan). For members up to age 18, deductibles and coinsurance for in-network dental services under the group dental benefits apply to the out-of-pocket maximum.		
Out-of-Network Services: Do not apply to the out-of-pocket maximum.		
MAJOR MEDICAL SERVICES		
Participating Chiropractor Services	Covered at 80% of the allowance with no deductible. Precertification is required after the 18th visit. If more than one provider is being utilized (even if the provider is under the same tax identification number) precertification is required again after the 25th visit.	Non-Participating: Covered at 80% of the allowance, subject to the calendar year deductible. Member is responsible for the 20% coinsurance and any amount billed over the fee schedule. Precertification is required after the 18th visit. If more than one provider is being utilized (even if the provider is under the same tax identification number) precertification is required again after the 25th visit.
Physical Therapy, Speech Therapy and Occupational Therapy	Covered at 80% of the allowance, subject to the calendar year deductible and limited to 15 visits each calendar year. <i>Preauthorization</i> is required after the 15 th visit to determine the medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.	Covered at 80% of the allowance, subject to the calendar year deductible and limited to 15 visits each calendar year. <i>Preauthorization</i> is required after the 15 th visit to determine the medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWRK (NON-PPO)
MAJOR MEDICAL SERVICES (CONTINUED)		
Durable Medical Equipment	Covered at 80% of the allowance, subject to the calendar year deductible.	
Ambulance Services	Covered at 80% of the allowance, subject to the calendar year deductible.	
Allergy Testing & Treatment	Covered at 80% of the allowance, subject to the calendar year deductible.	
Participating Home Health Services	Covered at 80% of the allowance, subject to the calendar year deductible, when services are rendered by a participating Home Health agency. Precertification is required; call 1-800-551-2294. NOTE: No coverage for services rendered by a non-participating Home Health agency.	
Diabetic Education	Covered at 100% of the allowance with no deductible; limited to five diabetic classes (in an approved diabetic education facility) per person within a six-month period for any diabetic diagnosis (not held to insulin dependent diabetics); services in excess of this maximum must be certified through case management; call 1-800-551-2294.	
PRESCRIPTION DRUGS – ACTIVE AND NON-MEDICARE RETIREES		
Prescription Drug Card Program for Generic Drugs	Participating Pharmacy: Generic drugs covered at 100% of the allowance subject to a \$5 co-pay per prescription; 60-day supply on maintenance drugs for one co-pay.	Non-Participating Pharmacy: No benefits are available for prescriptions purchased at a non-Participating Pharmacy.
Point-of-Sale Drug Program for Brand Drugs	Participating Pharmacy: Brand name drugs covered at 80% of the allowance, subject to the calendar year deductible. Claims Authorization Number required.	Non-Participating Pharmacy: No benefits are available for prescriptions purchased at a non-Participating Pharmacy.
PRESCRIPTION DRUGS – MEDICARE RETIREES AND MEDICARE DEPENDENTS OF RETIREES–LGHP's EMPLOYER GROUP WAIVER PLAN (EGWP)		
Prescription Drug Card Program for Generic Drugs	Preferred/Extended Supply Network Pharmacies \$5 co-pay for 30-day supply \$10 co-pay for 60-day supply \$10 co-pay for 90-day supply Non-Preferred Pharmacies \$5 co-pay for 30-day supply \$10 co-pay for 60-day supply \$15 co-pay for 90-day supply	Non-Participating Pharmacy: No benefits are available for prescriptions purchased at a non-Participating Pharmacy.
Point-of-Sale Drug Program for Brand Drugs	Retail & Extended Supply Network Pharmacies 20% coinsurance after the \$100 drug deductible is met. Deductible applies only to Medicare covered Part D Drugs.	Non-Participating Pharmacy: No benefits are available for prescriptions purchased at a non-Participating Pharmacy.
VISION CARE (Note: This is an SEIB administered benefit. No claims should be filed to Blue Cross and Blue Shield of Alabama.)		
Routine Eye Exam	Routine examinations are limited to one per year for a \$40 fee when a participating provider is used. Please see benefit booklet for additional program provisions. SEIB's vision network is on our website at www.alseib.org	Not covered.

For prescription call 1-800-551-2294. Call Blue Cross and Blue Shield of Alabama at 1-800-337-4391. Visit SEIB's website at www.alseib.org.

TABLE OF CONTENTS

OVERVIEW OF THE PLAN	3
Purpose of the Plan	3
Using myBlueCross to Get More Information over the Internet	3
Definitions	3
Receipt of Medical Care	3
Beginning of Coverage	3
Limitations and Exclusions	3
Medical Necessity and Precertification	3
In-Network Benefits	3
Relationship between Blue Cross and/or Blue Shield Plans and the Blue Cross and Blue Shield Association	3
Claims and Appeals	4
Termination of Coverage	5
ELIGIBILITY AND ENROLLMENT	6
Eligible Participants	6
Eligible Dependent	6
Qualified Medical Child Support Orders	7
Initial Group Enrollment	8
Initial Employee Enrollment	8
Family Coverage Enrollment	8
Open Enrollment	9
Special Open Enrollment	9
When Coverage Commences	10
Cancellation of Family Coverage	10
Transfers	10
Notice	10
Supersession	10
Declination of Coverage	10
Premium	10
PROVISION FOR MEDICARE ELIGIBLES	11
Active Employees	11
Retired Employees	11
TERMINATION OF COVERAGE	13
When Coverage Terminates	13
Family and Medical Leave Act	13
CONTINUATION OF GROUP HEALTH COVERAGE (COBRA)	14
Introduction	14
What is COBRA Continuation Coverage?	14
Qualified Beneficiaries	14
COBRA Rights for Covered Employees	14
COBRA Rights for a Covered Spouse and Dependent Children	14
Coverage Available	15
When Your Employer Should Notify the SEIB	15
When You Should Notify the SEIB	15
Election Period	15
Length of Coverage	16
Adding New Dependents to COBRA	16
Family and Medical Leave Act	17
Premium Payment	17
Termination of Continuation Coverage	17
Keep the SEIB Informed of Address Changes	18
If You Have Any Questions	18
SEIB Contact Information	18

BENEFIT CONDITIONS	19
COST SHARING	20
Calendar Year Out-of-Pocket Maximum	20
Other Cost sharing Provisions	20
Out-of-Area Services	21
INPATIENT HOSPITAL BENEFITS	23
Precertification Certification and Post Admission Review	23
Inpatient Hospital Benefits for Maternity	23
Deductible	23
Inpatient Hospital Benefits in a Non-Participating Hospital in Alabama	24
Women's Health and Cancer Rights Act	24
Organ and Tissue Transplant Benefits	24
OUTPATIENT FACILITY BENEFITS	25
Outpatient Hospital Benefits in a Non-Participating in Alabama	26
Pre-certification	26
UTILIZATION MANAGEMENT	27
Case Management	27
Disease Management	28
Appeal of Utilization Management Decision	28
"Peer to Peer" Review	29
Appeal	29
Independent Review	29
ROUTINE PREVENTIVE CARE	30
PPO (PREFERRED PROVIDER ORGANIZATION) BENEFITS	31
Preferred Provider (PPO) Benefits for Physicians, Nurse Practitioners and Physicians Assistants	31
MENTAL HEALTH AND SUBSTANCE ABUSE PREFERRED PROVIDER ORGANIZATIONS (PPO)	32
PARTICIPATING CHIROPRACTOR BENEFITS	34
TOBACCO CESSATION PROGRAM	35
PHYSICIAN SUPERVISED WEIGHT MANAGEMENT AND NUTRITIONAL COUNSELING PROGRAM	38
SEIB DISCOUNTED VISION CARE PROGRAM	37
MAJOR MEDICAL BENEFITS	38
Covered Major Medical Expenses	38
PRESCRIPTION DRUGS	40
Active Employees and Non-Medicare Retirees Prescription Drug Card Program	40
Point-of-Sale Drug Program	40
Medicare Retirees and Medicare Dependents of Retirees Covered under LGHP's Employer Group Waiver Plan (EGWP)	40
Prescription Drug Card Program for Generic Drugs	40
Point-of-Sale Drug Program for Brand Drugs	40
MEDICAL EXCLUSIONS	41
GENERAL PROVISIONS	46
Privacy of Your Protected Health Information	46
Incorrect Benefit Payments	48
Responsibility for Actions of Providers of Services	48
Misrepresentation	48
Obtaining, Use and Release of Information	48
Responsibility of Members and Providers to Furnish Information	48
Providers of Services Subject to Contract Provision	48

GENERAL PROVISIONS (CONTINUED)	49
Benefit Decisions	49
Changes for More Than The Allowed Amounts	49
Applicable State Law	49
Plan Changes	49
Rescission	49
No Assignment	49
COORDINATION OF MEDICAL BENEFITS (COB)	51
Order of Benefit Determination	51
Active Employee or Retired or Laid-Off Employee	52
COBRA or State Continuation Coverage	52
Determination of Amount of Payment	52
COB Terms	53
Right to Receive and Release Needed Information	53
Facility of Payment	54
Right of Recovery	54
Special Rules for Coordination with Medicare	54
SUBROGATION	55
Right of Subrogation	55
Right of Reimbursement	55
Right to Recovery	55
FILING A CLAIM, CLAIM DECISIONS, AND APPEAL OF BENEFIT DENIAL	56
Filing of Claims Required	56
Who Files Claims	56
Who Receives Payment	56
How to File Claims	56
Hospital Benefits	56
Provider Services and Other Covered Expenses	57
Blue Cross Preferred Care Benefits	57
When Claims Must Be Submitted	57
Receipt and Processing Claims	57
Post-Service Claims	57
Pre-Service Claims	58
Concurrent Care Determinations	59
Member Satisfaction	60
Customer Service	60
Blue Cross Blue Shield Appeals	60
How to Appeal Post-Service Adverse Benefit Determinations	61
How to Appeal Pre-Service Adverse Benefit Determinations	61
External Reviews	63
Expedited External Reviews for Urgent Pre-Service Claims	63
SEIB APPEALS PROCESS	64
General Information	64
Informal Review	64
Administrative Review	64
Formal Appeal	64
Items That Will Not Be Reviewed Under the Administrative Review or Formal Appeal Process	64
DEFINITIONS	65



OVERVIEW OF THE PLAN

Purpose of the Plan

The LGHIP is intended to help you and your covered dependents pay for the costs of medical care. The LGHIP does not pay for all of your medical care. For example, you may be required to pay deductibles, copayments, and coinsurance.

Using myBlueCross to Get More Information over the Internet

Blue Cross Blue Shield of Alabama (BCBS) is the Claims Administrator for the LGHIP. BCBS's home page on the internet is www.bcbsal.com. If you go there, you will see a section of BCBS's home page called myBlueCross. Registering for myBlueCross is easy and secure. Once you have registered, you will have access to information and forms that will help you take maximum advantage of your benefits under the LGHIP.

Definitions

Near the end of this booklet you will find a section called "Definitions," which identifies words and phrases that have specialized or particular meanings. In order to make this booklet more readable, we generally do not use initial capitalized letters to denote defined terms. Please take the time to familiarize yourself with these definitions so that you will understand your benefits.

Receipt of Medical Care

Even if the LGHIP does not cover benefits, you and your provider may decide that care and treatment are necessary. You and your provider are responsible for making this decision.

Beginning of Coverage

The section of this booklet called "Eligibility" will tell you what is required for you to be covered under the LGHIP and when your coverage begins.

Limitations and Exclusions

In order to maintain the cost of the LGHIP at an overall level that is reasonable to all plan members, the LGHIP contains a number of provisions that limit benefits. There are also exclusions that you need to pay particular attention to as well. These provisions are found through the remainder of this booklet. You need to be aware of these limits and exclusions in order to take maximum advantage of the LGHIP.

Medical Necessity and Precertification

The LGHIP will only pay for care that is medically necessary and not investigational, as determined by BCBS. BCBS developed medical necessity standards to aid BCBS when BCBS makes medical necessity determinations. BCBS publishes these standards on the internet at www.bcbsal.com/providers/policies. The definition of medical necessity is found in the "Definitions," section of this booklet.

In some cases, the LGHIP requires that you or your treating provider precertify the medical necessity of your care. The provisions later in this booklet will tell you when precertification is required. Look on the back of your ID card for the phone number that you or your provider should call. In some cases, BCBS's contracts with providers require the provider to initiate the precertification process for you. Your provider should tell you when these requirements apply. You are responsible for making sure that your provider initiates and complies with any precertification requirements under the LGHIP. Please note that precertification relates only to the medical necessity of care; it does not mean that your care will be covered under the LGHIP. Precertification also does not mean that we have been paid all monies necessary for our administration of the LGHIP to be in force on the date that services or supplies are rendered.

In-Network Benefits

One way in which the LGHIP tries to manage healthcare costs is through negotiated discounts with in-network providers. As you read the remainder of this booklet, you should pay attention to the type of in-network provider that is treating you. If you receive covered services from an in-network provider, you will

normally only be responsible for out-of-pocket costs such as deductibles, copayments, and coinsurance. If you receive services from an out-of-network provider, these services may not be covered at all under the plan. In that case, you will be responsible for all charges billed to you by the out-of-network provider. If the out-of-network services are covered, in most cases, you will have to pay significantly more than what you would pay an in-network provider because of lower benefit levels and higher cost-sharing. As one example, out-of-network facility claims will often include very expensive ancillary charges (such as implantable devices) for which no extra reimbursement is available as these charges are not separately considered under the LGHIP. Additionally, out-of-network providers have not contracted with BCBS or any Blue Cross and/or Blue Shield plan for negotiated discounts and can bill you for amounts in excess of the allowed amounts under the LGHIP.

In-network providers are hospitals, physicians, pharmacies, and other healthcare providers or suppliers that contract with BCBS or any Blue Cross and/or Blue Shield plans (directly or indirectly through, for example, a pharmacy benefit manager) for furnishing healthcare services or supplies at a reduced price. Examples of in-network providers include PMO, Preferred Care, and BlueCard PPO. To locate in-network providers in Alabama, go to www.bcbsal.com.

- First, click "Find a Doctor."
- Second, select a healthcare provider type: doctor, hospital, pharmacy, other healthcare provider, or other facility or supplier.
- Third, enter a search location by using the zip code for the area you would like to search, or by selecting a state.

A special feature of your plan gives you access to the national network of providers called BlueCard PPO. Each local Blue Cross and/or Blue Shield plan designates which of its providers are PPO providers. In order to locate a PPO provider in your area, you should call the BlueCard PPO toll-free access line at 1-800-810-BLUE (2583) or visit the BlueCard PPO Provider Finder website at <http://provider.bcbs.com>. To receive in-network PPO benefits for lab services, the laboratory must contract with the Blue Cross and/or Blue Shield plan located in the same state as your physician. When you or your physician orders durable medical equipment (DME) or supplies, the service provider must participate with the Blue Cross and/or Blue Shield plan where the supplies are shipped. If you purchase DME supplies directly from a retail store, they must contract with the Blue Cross and/or Blue Shield plan in the state or service area where the store is located. PPO providers will file claims on your behalf with the local Blue Cross plan where services are rendered. The local Blue Cross plan will then forward the claims to BCBS for verification of eligibility and determination of benefits.

Sometimes a network provider may furnish a service to you that is either not covered under the LGHIP or is not covered under the contract between the provider and the local Blue Cross plan where services are rendered. When this happens, benefits may be denied or may be covered under some other portion of the LGHIP, such as "Other Covered Services."

Relationship between Blue Cross and/or Blue Shield Plans and the Blue Cross and Blue Shield Association

BCBS is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of Independent Blue Cross and Blue Shield plans. The Blue Cross and Blue Shield Association permits BCBS to use the Blue Cross and Blue Shield service marks in the state of Alabama. BCBS is not acting as an agent of the Blue Cross and Blue Shield Association. No representation is made that any organization other than BCBS and the State Employees' Insurance Board will be responsible for honoring this contract. The purpose of this paragraph is for legal clarification; it does not add additional obligations on the part of BCBS not created under the original agreement.

Claims and Appeals

When you receive services from an in-network provider, your provider will generally file claims for you. In other cases, you may be required to pay the provider and then file a claim with BCBS for reimbursement.

under the terms of the LGHIP. If BCBS denies a claim in whole or in part, you may file an appeal with BCBS. BCBS will give you a full and fair review. Thereafter, you may have the right to an independent external review. The provisions of the plan dealing with claims or appeals are found further on in this booklet.

Termination of Coverage

The section below called "Eligibility" tells you when coverage will terminate under the LGHIP. If coverage terminates, no benefits will be provided thereafter, even if for a condition that began before the LGHIP or your coverage termination. In some cases you will have the opportunity to buy COBRA coverage after your LGHIP coverage terminates. COBRA coverage is explained in detail later in this booklet.



ELIGIBILITY AND ENROLLMENT

Eligible Participants

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

Elected officers of a local government unit are also eligible while in office. Elected officers will be classified for insurance purposes as active employees upon proper notification to the SEIB and compliance with the LGHIP's enrollment rules.

All eligible employees must be enrolled at all times during their employment with the unit except for any time(s) that the employee is covered by other group coverage. If an eligible employee is covered by other group coverage, that employee must provide a "Declaration of Coverage" form to the SEIB with proof of other group coverage. If an employee has declined coverage in the LGHIP and later loses their other group coverage, that eligible employee must immediately notify the SEIB and enroll in the LGHIP.

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

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

- Have been enrolled in the LGHIP for 10 years prior to the date of retirement, or
- If unit has been enrolled less than 10 years, the employee must have been enrolled continuously from the unit's inception date.

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

Each government unit is responsible for determining whether eligible retirees may continue their LGHIP coverage and, if so, whether it may be maintained upon entitlement to Medicare. Once a governmental unit makes this determination it must be applied uniformly to all retirees.

An active employee, who retires from a local government unit that does not allow retirees to continue on the coverage, will be offered COBRA upon written notification of retirement from the local government unit. (See "Termination of Services".)

An active employee who retires from a local government unit that allows retirees to continue coverage has the option of electing retiree coverage or COBRA. If COBRA coverage is elected, the retiree will forfeit his or her right to elect retiree coverage at a later date.

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

Eligible Dependent

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

1. Your spouse (excludes divorced or common-law spouse).

2. A child under age 26, only if the child is:
 - a. your son or daughter (A court decree establishing paternity will be temporarily effective for 60 days, at which time an amended birth certificate stating the father's name will be due.)
 - b. a child legally adopted by you or your spouse (including any probationary period during which the child is required to live with you)
 - c. your stepchild
 - d. your grandchild, niece or nephew for whom the court has granted custody to you or your spouse.
3. An incapacitated dependent over age 25 will be considered for coverage provided dependent:
 - a. is unmarried,
 - b. is permanently mentally or physically disabled or incapacitated,
 - c. is so incapacitated as to be incapable of self-sustaining employment,
 - d. is dependent upon the subscriber for 50% or more support,
 - e. is otherwise eligible for coverage as a dependent except for age,
 - f. the condition must have occurred prior to the dependent's 26th birthday, and
 - g. is not eligible for any other group insurance benefits.

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

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

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

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

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

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

Qualified Medical Child Support Orders

If the SEIB receives an order from a court or administrative agency directing the LGHIP to cover a child, the SEIB will determine whether the order is a Qualified Medical Child Support Order (QMCSO). A QMCSO is a qualified order from a court or administrative agency directing the plan to cover the employee's child regardless of whether the employee has enrolled the child for coverage. The SEIB has adopted procedures for determining whether such an order is a QMCSO. You have a right to obtain a copy of those procedures free of charge by contacting the SEIB.

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

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

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

Initial Group Enrollment

Eligible employees, elected officers, retirees and dependents who make application on or before the effective date of the Group Contract will be enrolled for coverage as of the effective date of the Group Contract.

Initial Employee Enrollment

All full-time employees of the local government unit (and elected officials if covered by the government unit) must enroll in the LGHIP or submit a declination form with proof of other employer group health insurance coverage.

Family Coverage Enrollment

Family Coverage Enrollment

A participating employee, elected officer or retiree in the Program may apply for family coverage under the following circumstances:

- upon initial enrollment (enrollment form LG01), or
- upon acquiring a new dependent (dependent change form LG02B), or
- at annual open enrollment (dependent change form LG02B) or
- if a dependent qualifies for dependent special enrollment (dependent change form LG02B).

Dependents

Appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.) must be submitted to the SEIB. Note: to ensure that enrollment deadlines are met, change forms should be submitted to the SEIB even if all the required documentation is not available. If the required documentation is not received with an enrollment form or change form, the SEIB will send a notice to you that the required documentation must be submitted within 60 days of the letter. If the required documentation is not received by the SEIB within those 60 days, the request to add dependent coverage will be denied.

Initial Enrollment/New Employees

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

Acquiring New Dependent

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

The effective date of coverage will be:

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

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

Annual Open Enrollment

A participating employee, elected official or retiree may apply to add a dependent or apply for family coverage during the month of November for a January 1 effective date. The effective date indicated on the form should be January 1.

Dependent Special Enrollment

If a dependent loses their other group coverage, the subscriber may apply for Dependent Special Open Enrollment. The effective date of coverage will be the date the other group coverage ceased. See "Special Enrollment Period, Dependents." The only dependents eligible are those who experienced a "qualifying event."

Open Enrollment

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

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

Eligible participants are permitted to change insurance carriers/plans.

Special Enrollment Period

Employees

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

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

To be eligible for special enrollment an employee must have a declination of coverage form with proof of other employer group coverage on file. Employees requesting special enrollment must notify the SEIB in writing within the 30 days of a qualifying event. Notification must include:

1. a letter requesting participation in the special enrollment; and
2. a completed enrollment form; and
3. Thereafter, the proof of the qualifying event listing the reason and date of loss for all individuals affected by loss of coverage (e.g. employment termination on company letterhead); must be submitted within 60 days of the qualifying event.

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

Dependents

To be eligible for dependent special enrollment an employee must submit a dependent change form with proof of loss of other employer group coverage. Employees requesting dependent special enrollment must notify the SEIB in writing within 30 days of the qualifying event. Notification must include:

1. a letter requesting participation in the special enrollment; and
2. a completed dependent change form; and
3. Thereafter, the proof of the qualifying event listing the reason and date of loss for all individuals affected by loss of coverage (e.g., employment termination on company letterhead) must be submitted within 60 days of the qualifying event.

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

When Coverage Commences

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

Cancellation of Family Coverage

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

Transfers

1. New hires meeting the following criteria will be considered as transfers under the LGHIP:
 - New hire, previously covered by the LGHIP or by the State Employees' Health Insurance Plan (SEHIP), and
2. New hire, terminated employment with another local government unit covered by the LGHIP, or State employee covered by the SEHIP, who became employed with a local government unit during the same calendar month of termination.

Notice

Notice of any enrollment changes is the responsibility of the employee (for example, additions or deletions of dependents or address changes).

In addition, it is the responsibility of the subscriber to notify the SEIB immediately when the eligibility of a covered dependent changes. If it is determined that an act (such as adding an ineligible person to coverage) or omission (such as failing to remove a person no longer eligible from coverage) of the subscriber results in or contributes to the payment of claims by the LGHIP for persons ineligible for coverage, the subscriber will be personally responsible for all such overpayments and shall be subject to disciplinary action including termination of coverage. (Note: an ex-spouse is ineligible for coverage and cannot be maintained as a dependent under family coverage regardless of a judgment or divorce decree requiring the subscriber to provide health care for an ex-spouse. However, an ex-spouse may be eligible for COBRA continuation coverage.)

Supernumeraries

Supernumeraries will be classified for insurance purposes as retired employees.

Declination of Coverage

Employees may decline coverage at any time. The earliest effective date of cancellation will be the first day of the month following receipt of both the Declination of Coverage and acceptable proof of group coverage with another employer. Acceptable proof is a current letter from employer/insurance carrier verifying current coverage.

Premium

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



PROVISION FOR MEDICARE ELIGIBLES

Active Employees

The State Employees' Insurance Board provides active employees, over age 65, coverage under the LGHIP under the same conditions as any employee under age 65. Medicare is secondary to benefits payable under the LGHIP for employees over age 65 and their spouses over age 65. If the service is also covered by Medicare, the claim can be submitted to Medicare who may pay all or a portion of the unpaid balance of the claim subject to Medicare limitations.

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

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

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

Retired Employees

Health benefits will be modified when you or your dependent becomes entitled to Medicare. Coverage under this plan will be reduced by those benefits payable under Medicare, Parts A and B. If a retiree or dependent becomes entitled to Medicare because of a disability before age 65, the retiree must notify the SEIB to be eligible for the reduced premiums and to ensure that claims are paid properly.

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

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

Medicare Part D Prescription Drug Coverage

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

It is your responsibility to inform LGHIP of any prescription drug coverage that you have or may get in the future. You can only be enrolled in one Medicare prescription drug plan at a time. You are not required to be enrolled in the LGHIP EGWP but if you want to opt out, you must complete an EGWP Opt-Out Form and return it to the SEIB. Opt-out forms are available on SEIB's website at www.seib.org.

If you opt out of this plan, you will have no prescription drug coverage from the LGHIP. You will, however, still have the LGHIP secondary Medicare Part A and B coverage if you opt-out of the LGHIP EGWP. You can also decide to join a different Medicare Part D prescription drug plan. You can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week for help in learning how to enroll in another Medicare Part D prescription drug plan. (TTY users should call 1-877-486-2048.)

Keep in mind that if you leave the LGHIP plan and do not have or do not enroll in another prescription drug plan, you may have to pay a late enrollment penalty in addition to your premium for Medicare prescription drug coverage in the future.

Medicare limits when you can make changes to your coverage. You may leave this plan only at certain times of the year or under certain special circumstances. Generally, there is an open enrollment period at the end of each year when you can change Medicare Part D prescription drug plans for coverage that will be effective January 1 of the following year. To request to leave the LGHIP EGWP, please submit the EGWP Opt-Out Form to:

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

Once you are a member of the LGHIP EGWP, you have the right to appeal plan decisions about payment of services if you disagree. Read EGWP plan documents to know the rules you must follow to receive coverage with this Medicare prescription drug plan.



TERMINATION OF COVERAGE

When Coverage Terminates

The member's coverage will terminate:

1. On the last day of the month in which the member's employment terminates.
2. When this plan is discontinued.
3. When premium payments cease.
4. In addition to the above, the coverage terminates for a dependent:
 - a. on the last day of the month in which such person ceases to be an eligible dependent, or
 - b. if the dependent becomes eligible to be insured as an employee in the Program.

In many cases you will have the option to choose continuation of group benefits as provided by the Public Health Service Act. (See COBRA Section.)

Family and Medical Leave Act

The State Employees' Insurance Board will adhere to the provisions of the Family and Medical Leave Act.



CONTINUATION OF GROUP HEALTH COVERAGE (COBRA)

Introduction

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

This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of this law. You and your spouse should take the time to read this carefully.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of coverage under the LGHIP when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed under the section entitled "Qualified Beneficiaries" below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. You, your spouse and your dependent children could become qualified beneficiaries if coverage under the LGHIP is lost because of a qualifying event. Under the LGHIP, qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage.

Qualified Beneficiaries

Individuals entitled to COBRA continuation coverage are called qualified beneficiaries. Individuals who may be qualified beneficiaries are the spouse and dependent children of a covered employee and, in certain circumstances, the covered employee. Under current law, in order to be a qualified beneficiary, an individual must generally be covered under the LGHIP on the day before the event that caused a loss of coverage such as termination of employment, or a divorce from, or death of, the covered employee. (An increase in the cost of retiree coverage relative to active employee coverage is also considered a loss of coverage for COBRA purposes.) In addition, a child born to the covered employee, or who is placed for adoption with the covered employee, during the period of COBRA continuation coverage, is also a qualified beneficiary.

COBRA Rights for Covered Employees

If you are a covered employee, you will become a qualified beneficiary if you lose your coverage under the LGHIP because either one of the following qualifying events happens:

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

COBRA coverage will continue for up to a total of 18 months from the date of your termination of employment or reduction in hours, assuming you pay your premiums on time.

If you are on a leave of absence covered by the Family and Medical Leave Act of 1993 (FMLA), and you do not return to work, you will be given the opportunity to buy COBRA coverage. The period of your COBRA coverage will begin when you fall to return to work following the expiration of your FMLA leave or you inform the SEIB that you do not intend to return to work, whichever occurs first.

COBRA Rights for a Covered Spouse and Dependent Children

If you are the spouse of a covered employee, you will become a qualified beneficiary if you lose your coverage under the LGHIP because either one of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
- You become divorced or legally separated from your spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the LGHIP as a "dependent child."

Coverage Available

If you choose continuation coverage, the SEIB is required to offer you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the LGHIP to similarly situated employees or family members.

When Your Employer Should Notify the SEIB

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

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

When You Should Notify the SEIB

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

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

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

Election Period

When the SEIB is notified that a qualifying event has happened, COBRA continuation coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. In addition, a covered employee may elect COBRA continuation coverage on behalf of his or her spouse and either covered parent may elect COBRA continuation coverage on behalf of their children.

If you do not choose continuation coverage, your group health insurance will end.

After the SEIB receives timely notice that a qualifying event has occurred, the SEIB will (1) notify you that you have the option to buy COBRA, and (2), send you a COBRA election notice.

You have 60 days within which to elect to buy COBRA coverage. The 60-day period begins to run from the later of (1) the date you would lose coverage under the LGHIP, or (2), the date on which the SEIB notifies you that you have the option to buy COBRA coverage. Each qualified beneficiary has an independent right to elect COBRA coverage. You may elect COBRA coverage on behalf of your spouse, and parents may elect COBRA coverage on behalf of their children. An election to buy COBRA coverage will be considered made on the date the election notice is sent back to the SEIB.

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

Because there may be a lag between the time your coverage under the plan ends and the time we learn of your loss of coverage, it is possible that the LGHIP may pay claims incurred during the 60-day election period. If this happens, you should not assume that you have coverage under the LGHIP. The only way your coverage will continue is if you elect to buy COBRA and pay your premiums on time.

Length of Coverage

COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage will last for up to a total of 36 months when one of the following qualifying events occurs:

- Death of the employee,
- Divorce or legal separation, or
- Dependent child loses eligibility as a "dependent child" under LGHIP.

COBRA continuation coverage will last for up to a total of 18 months when one of the following qualifying events occurs:

- End of employment or
- Reduction in the hours of employment.

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

- **Disability** – If you or a covered member of your family is or becomes disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act and you timely notify the SEIB, the 18-month period of COBRA coverage for the disabled person may be extended to up to 11 additional months (for a total of up to 29 months) or the date the disabled person becomes covered by Medicare, whichever occurs sooner. This 29-month period also applies to any non-disabled family members who are receiving COBRA coverage, regardless of whether the disabled individual elects the 29-month period for him or herself. The 29-month period will run from the date of the termination of employment or reduction in hours. For this disability extension to apply, the disability must have started at some time before the 60th day of COBRA coverage and must last at least until the end of the 18-month period of COBRA coverage.

The cost for COBRA coverage after the 18th month will be 150% of the full cost of coverage under the plan, assuming that the disabled person elects to be covered under the disability extension. If the only persons who elect the disability extension are non-disabled family members, the cost of coverage will remain at 102% of the full cost of coverage.

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

For this disability extension of COBRA coverage to apply, you must give the SEIB timely notice of Social Security's disability determination before the end of the 18-month period of COBRA coverage and within 60 days after the later of (1) the date of the initial qualifying event, (2) the date on which coverage would be lost because of the initial qualifying event, or (3) the date of Social Security's determination. You must also notify the SEIB within 30 days of any revocation of Social Security disability benefits.

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

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

spouse or dependent children to lose coverage under the plan if the covered employee had not been terminated from employment.

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

Adding New Dependents to COBRA

You may add new dependents to your COBRA coverage under the circumstances permitted under the LGHIP. Except as explained below, any new dependents that you add to your COBRA coverage will not have independent COBRA rights. This means, for example, that if you die, they will not be able to continue coverage.

If you are the covered employee and you acquire a child by birth or placement for adoption while you are receiving COBRA coverage, then your new child will have independent COBRA rights. This means that if you die, for example, your child may elect to continue receiving COBRA benefits for up to 36 months from the date on which your COBRA benefits began.

If your new child is disabled within the 60-day period beginning on the date of birth or placement of adoption, the child may elect coverage under the disability extension if you timely notify the SEIB of Social Security's disability determination as explained above.

Family and Medical Leave Act

If you are on a leave of absence covered by the Family and Medical Leave Act of 1993 (FMLA), and you do not return to work, you will be given the opportunity to elect COBRA continuation coverage. The period of your COBRA continuation coverage will begin when you fail to return to work following the expiration of your FMLA leave or you inform your employer that you do not intend to return to work, whichever occurs first.

Premium Payment

If you qualify for Continuation Coverage, you will be required to pay the group's premium plus 2% administrative fee directly to the State Employees' Insurance Board. Members who are disabled under Title II or Title XVI of the Social Security Act when a qualifying event occurs, will be required to pay 150% of the group's premium for the 15th through the 29th month of coverage or the month that begins more than 30 days after the date is determined that you are no longer disabled under Title II or Title XVI of the Social Security Act, whichever comes first. (If the only persons who elect the disability extension are non-disabled family members, the cost of coverage will remain at 102% of the full cost of coverage.) Your coverage will be canceled if you fail to pay the entire amount in a timely manner.

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

Termination of Continuation Coverage

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

1. SEIB no longer provides group health coverage;
2. The premium for your continuation coverage is not paid on time;
3. You become covered, after electing continuation coverage, under another group plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary. (Note: there are limitations on plans imposing a preexisting condition of exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act.);
4. You become entitled to Medicare;

5. You extend coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled.

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

Note: If you are entitled to Medicare before you become a qualified beneficiary, you may elect COBRA continuation coverage; however, your Medicare coverage will be primary and your COBRA continuation coverage will be secondary. You must have Medicare Parts A and B in order to have full coverage.

Keep the SEIB Informed of Address Changes

In order to protect your family's rights, you must keep the SEIB informed of any changes in the address of family members. You should also keep a copy for your records of any notices you send to the SEIB.

If You Have Any Questions

Questions concerning your COBRA continuation coverage rights may be addressed by calling the SEIB at 1.866.836.9137 or 334.263.8326 or by mail at the contact listed below. For more information about your COBRA rights, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

SEIB Contact Information

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

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



BENEFIT CONDITIONS

To qualify as plan benefits, medical services and supplies must meet the following:

- They must be furnished after your coverage becomes effective;
- Blue Cross must determine before, during, or after services and supplies are furnished that they are medically necessary. (Note: all inpatient hospital stays and some outpatient procedures must be reviewed by Blue Cross. See Utilization Management section for details).
- PPO benefits must be furnished while you are covered by the LGHIP and the provider must be a PPO provider when the services are furnished to you.
- Separate and apart from the requirement in the previous paragraph, services and supplies must be furnished by a provider (whether Preferred Provider or not) who is recognized by Blue Cross as an approved provider for the type of service or supply being furnished. For example, Blue Cross reserves the right not to pay for some or all services or supplies furnished by certain persons who are not Medical Doctors (MD's), even if the services or supplies are within the scope of the provider's license. Call Blue Cross Customer Services if you have any question whether your provider is recognized by Blue Cross as an approved provider for the services or supplies you plan on receiving.
- Services and supplies must be furnished when the LGHIP and your coverage are both in effect and fully paid for. No benefits will be provided for services you receive after the plan or your coverage ends, even if they are for a condition which began before the LGHIP or your coverage ends.



COST SHARING

	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Out-of-Pocket Maximum	\$6,250 per member, \$12,500 per family Certain benefits pay at 100% of the allowed amount thereafter	Out-of-network services do not apply to the out-of-pocket

Calendar Year Out-of-Pocket Maximum

The calendar year out-of-pocket maximum is specified in the table above. All cost-sharing amounts (calendar year deductible, copayment and coinsurance) for in-network covered services that you or your family is required to pay under the LGHIP apply to the calendar year out-of-pocket maximum. Once the maximum has been reached, covered expenses of the type that count towards the maximum will be paid at 100% of the allowed amount for the remainder of the calendar year.

There may be many expenses you are required to pay under the LGHIP that do not count toward the calendar year out-of-pocket maximum, and that you must continue to pay even after you have met the calendar year out-of-pocket maximum. The following are some examples:

- Out-of-network cost-sharing amounts (deductibles, copayments, coinsurance);
- Amounts paid for non-covered services or supplies;
- Amounts paid for services or supplies in excess of the allowed amount (for example, an out-of-network provider requires you to pay the difference between the allowed amount and the provider's total charges);
- Amounts paid for services or supplies in excess of any plan limits (for example, a limit on the number of covered visits for a particular type of provider); and,
- Amounts paid as a penalty (for example, failure to pre-certify).

The calendar year out-of-pocket maximum applies on a per person per calendar year basis, subject to the family maximum.

The calendar year family out-of-pocket maximum is an aggregate dollar amount. This means that all amounts that count toward the individual calendar year out-of-pocket maximum will count toward the family aggregate amount. Once the family calendar year out-of-pocket maximum is met, affected benefits for all covered family members will pay at 100% of the allowed amount for the remainder of the calendar year.

Example: If one member in the family reaches the maximum of \$6,250, that one member's covered benefits would be covered at 100%. Out of pocket expenses for all other family members will continue to count toward the family maximum of \$12,500.

Other Cost Sharing Provisions

The LGHIP may impose other types of cost sharing requirements such as the following:

- **Per admission deductibles:** These apply upon admission to a hospital. Only one per admission deductible is required when two or more family members have expenses resulting from injuries received in one accident.
- **Copayments:** A copayment is a fixed dollar amount you must pay on receipt of care. The most common example is the office visit copayment that must be satisfied when you go to a doctor's office.
- **Coinsurance:** Coinsurance is the amount that you must pay as a percent of the allowed amount. A common example is the percentage of the allowed amount that you must pay when you receive other covered services.

- **Amounts in excess of the allowed amount:** As a general rule, and as explained in more detail in "Definitions," the allowed amount may often be significantly less than the provider's actual charges. You should be aware that when using out-of-network providers you can incur significant out-of-pocket expenses as the provider has not contracted with BCBS or their local Blue Cross and/or Blue Shield plan for a negotiated rate and they can bill you for amounts in excess of the allowed amount. For example: Out-of-network provider claims may include expensive ancillary charges (billed by the facility or a physician) such as implantable devices for which no extra reimbursement is available as these charges are not separately considered under the LGHIP. This means you will be responsible for these charges if you use an out-of-network provider.

Out-of-Area Services

BCBS has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of BCBS's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program and may include negotiated National Account arrangements available between BCBS and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside the BCBS service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating healthcare providers. BCBS in both instances are described below.

A. BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, BCBS will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside the BCBS service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to BCBS.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over or under estimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price BCBS uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, BCBS would then calculate your liability for any covered healthcare services according to applicable law.

B. Negotiated (non-BlueCard Program) National Account Arrangements

As an alternative to the BlueCard Program, your claims for covered healthcare services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount you pay for covered healthcare services under this arrangement will be calculated based on the negotiated price (lower of either billed covered charges or negotiated price) (Refer to the description of negotiated price under Section A., BlueCard Program) made available to BCBS by the Host Blue.

C. Non-Participating Healthcare Providers Outside the Blue Cross and Blue Shield of Alabama Service Area

1. Member Liability Calculation

When covered healthcare services are provided outside of BCBS service area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in this paragraph.

2. Exceptions

In some exception cases, BCBS may pay such claims based on the payment BCBS would make if we were paying a non-participating provider inside of the BCBS service area, as described elsewhere in this benefit booklet, where the Host Blue's corresponding payment would be more than the BCBS in-service area non-participating provider payment, or in BCBS's sole and absolute discretion, BCBS may negotiate a payment with such a provider on an exception basis. In other exception cases, BCBS may use other payment bases, such as billed covered charges, to determine the amount BCBS will pay for services rendered by non-participating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment BCBS will make for the covered services as set forth in this paragraph.



INPATIENT HOSPITAL BENEFITS

Preadmission Certification and Post Admission Review

To be eligible for inpatient hospital benefits, all inpatient hospital admissions and stays (except medical emergency must have Post-admission Review) must be reviewed, approved, and certified by BCBS as medically necessary before you are admitted to the hospital. SEIB contracts with BCBS for health management programs.

BCBS will only certify the medical necessity of the requested benefit, not whether you are eligible to receive the requested benefits. You are responsible for being aware of the limitations of your benefits.

To obtain preadmission certification:

- You or your provider must telephone BCBS at least seven days before the proposed elective hospital admission at 1.800.551.2294. It is your responsibility to make sure this is done. Failure to comply may result in reduced benefits.
- BCBS will determine whether the proposed inpatient hospital admission and stay are medically necessary.

To obtain post-admission review:

- You, your provider or a person acting for you must telephone BCBS at 1.800.551.2294 with details of an elective admission prior to the admission. Admissions due to emergency diagnosis should be reported to BCBS no later than 72 hours after the admission. It is your responsibility to make sure this is done. After your admission, you or your physician may be asked to supply written information regarding your condition and treatment plan. Failure to comply may result in reduced benefits.
- Your provider and the hospital must provide BCBS with all medical records about your admission upon request.
- BCBS will determine whether the inpatient hospital admission and stay were medically necessary and whether the admission was for a medical emergency.

Subject to your rights of appeal, if you do not obtain preadmission certification or post-admission approval of an inpatient hospital admission and stay, BCBS will pay no benefits for your hospital stay or for any related charges. If you obtain admission certification but not within the specified time limits, you will be responsible for a \$600 deductible for the admission instead of the normal \$200. It is your responsibility to make sure all procedures are correctly followed.

Inpatient Hospital Benefits for Maternity

The SEIB may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the LGHIP or insurance issuer for prescribing a length of stay not in excess of the above periods. However, if the inpatient hospital stay is greater than 48 hours for vaginal delivery and 96 hours for Cesarean Section, post admission review must be obtained from BCBS.

NOTE: Newborns who remain hospitalized after the mother is discharged will require certification of medical necessity from BCBS.

Deductible

The deductible for each certified inpatient hospital admission is \$200 (with a \$50 per day copay for the second through the fifth day). You are responsible for payment of the deductible and copayment to the hospital. There is a separate deductible for each admission or readmission of each member to a hospital except when:

- There is more than one admission to treat the same pregnancy.
- Two or more family members with family coverage are admitted for accidental injuries received in the same accident, or
- You are transferred directly from one hospital to another.

Inpatient Hospital Benefits in a Non-Participating Hospital in Alabama

If you receive inpatient hospital services in a Non-Participating Hospital in the Alabama service area, no benefits are payable under the plan unless the services are to treat an accidental injury.

Women's Health and Cancer Rights Act

A member who is receiving benefits in connection with a mastectomy will also receive coverage for reconstruction of the breast on which a mastectomy was performed and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications at all stages of the mastectomy, including lymphedema.

Treatment decisions are made by the attending physician and patient. Benefits for this treatment will be subject to the same calendar year deductibles and coinsurance provisions that apply for other medical and surgical benefits.

Organ and Tissue Transplant Benefits

Inpatient and/or outpatient benefits are available for eligible transplantation services and expenses for the following organs and tissues:

• heart	• liver	• pancreas	• skin
• bone marrow*	• lungs	• cornea	• kidney
• heart valve	• small bowel		

*As used for the LGHIP, the term "bone marrow transplant" includes the harvesting, the transplantation and the chemotherapy components.

Benefits shall be payable only if the pre-transplant services, the transplant procedure and post-discharge services are performed in a hospital or facility with which Blue Cross has a written contract. You may call Customer Service for the name of the facility nearest you. The approval of a hospital or facility for transplantation services is limited to the specific types of organs and tissues stated in the approval.

For transplantation services to be considered eligible for coverage, prior benefit determination from BCBS shall be required in advance of the procedure. BCBS shall obtain the necessary medical information and make a determination as to whether the services are in accordance with generally accepted professional medical standards and not "investigational." (See "Glossary.")

Transportation includes pre-transplant, transplant and post-discharge services, and treatment of complications after transplantation. The initial transplantation evaluation at the transplant facility does not require a prior benefit determination through BCBS.

If the member is the recipient of a human organ or tissue transplant previously stated, donor organ procurement costs are covered, limited to search, removal of the organ, storage, transportation of the surgical harvesting team and the organ, and other medically necessary procurement costs.

Organ and Tissue Transplant Benefits are excluded:

- For services or expenses for replacements of natural organs with artificial or mechanical devices, in all hospitals and facilities for all organs without exception;
- When donor benefits are available through other group coverage;
- When government funding of any kind is provided;
- When the recipient is not covered under the LGHIP;
- For recipient or donor lodging, food or transportation costs;
- For donor and procurement services and costs incurred outside the United States.



OUTPATIENT FACILITY BENEFITS

The benefits below are available for charges by a facility for the types of services and supplies listed (except bed, board, and nursing care) when ordered by a provider and furnished in its outpatient department while you are not an inpatient:

- Services to treat an accidental injury within 72 hours after the injury.
- Facility charges for treatment of a medical emergency (treatment of sudden and severe symptoms that require immediate medical attention) after a \$200 copayment. Claims with emergency room charges that do not meet medical emergency guidelines will be considered under Major Medical.
- Payment of the hospital's charges for sleep disorder services rendered in an approved sleep disorder clinic. Please contact the BCBS Customer Service Department for a list of the approved facilities.
- Chemotherapy and radiation therapy services after a \$25 copayment per visit.
- Hemodialysis services after a \$25 copayment per visit.
- IV therapy after a \$25 copayment per visit
- Laboratory and pathology services after a \$3 copayment per test.
- X-ray services after a \$100 copayment per visit.
- Surgery after a \$100 copayment or cost per visit.

It is your responsibility to make sure that your provider obtains prior authorization from CareCore National, BCBS's radiology review organization, for certain outpatient diagnostic procedures. Failure to comply may result in reduced benefits. If you do not obtain prior authorization of an outpatient diagnostic procedure listed below, BCBS will pay no benefits for your outpatient procedure or for any related charges. If you obtain prior authorization, but not within the specified time limits, you will be responsible for a \$25 penalty for the outpatient procedure. You are also responsible for being aware of the limitations of your benefits.

- CAT Scan
- MRI
- PET Scan
- MUGA-gated Cardiac Scan
- Angiography/ Arteriography
- Cardiac Cath/Arteriography
- Bariatric Surgical procedures are limited to one per lifetime, subject to prior authorization by BCBS. Benefits for these services are provided only when the services are performed by a PPO provider. All physician and anesthesia services related to Bariatric Surgical procedures are limited to 50% of the allowable rate.

However, if you are admitted as an inpatient in any hospital immediately after receiving any of the above outpatient services (or within seven days after receiving tests) no outpatient hospital benefits will be available to you for those services, and those services instead will be covered as inpatient hospital benefits. Also, if you are admitted as a hospital inpatient more than seven days after the pre-operative tests, no benefits will be paid for them under any part of this contract.

Outpatient Hospital Benefits in a Non-Participating Hospital in Alabama

If you receive outpatient hospital services in a Non-Participating Hospital in the Alabama service area, no benefits are payable under the plan unless the services are to treat an accidental injury.

Pre-certification

Certain outpatient surgical/diagnostic procedures require prior authorization. Contact BCBS at 800.551.2294 before receiving the following services:

- Blepharoplasty
- Reduction Mammoplasty
- Septo/Rhinoplasty
- Uvula Procedure
- Bariatric Surgery

BCBS will only certify the medical necessity of the requested benefit, not whether you are eligible to receive the requested benefit.

It is your responsibility to make sure pre-certification is obtained for certain outpatient/surgical diagnostic procedures. Failure to comply may result in reduced benefits. If you do not obtain pre-certification of an outpatient/surgical diagnostic procedure, Blue Cross will pay no benefits for your outpatient procedure or for any related charges. If you obtain certification, but not within the specified time limits, you will be responsible for a \$25 penalty for the outpatient procedure. You are also responsible for being aware of the limitations of your benefits.



UTILIZATION MANAGEMENT

Inpatient Hospitalization

It is your responsibility to notify BCBS about all admissions. Failure to notify BCBS may result in a \$600 deductible on the hospital admission. NOTE: BCBS will only certify the medical necessity of the requested benefit, not whether you are eligible to receive the requested benefit. You are responsible for being aware of the limitations of your benefits.

Continued Stay Review

If your hospital stay must be extended beyond the days initially authorized, BCBS will contact your provider 24 hours before your scheduled discharge to obtain clinical data and process a request for extension-of-stay authorization. At the completion of the review, BCBS will confirm discharge or authorize additional days for your stay.

Determinations by BCBS to Limit or Reduce Previously Approved Care

If BCBS has previously approved a course of treatment to be provided over a period of time or number of treatments, and later decides to limit or reduce the previously approved course of treatment, BCBS will give you enough advance written notice to permit you to initiate an appeal and obtain a decision before the date on which care or treatments are no longer approved. You must follow any reasonable rules established for filing of your appeal, such as time limits within which the appeal must be filed.

Retrospective Review

If you fail to notify BCBS about a hospitalization you may request a Retrospective Review for medical necessity. Requests for retrospective review must be submitted to BCBS either in writing or by telephone. All information required to process the retrospective review must be submitted to Blue Cross within two years from the date the claims report is issued by BCBS.

In order to expedite the retrospective review process you may mail a copy of your medical records to BCBS. The records can be obtained from the hospital or treating provider. You will be responsible for any and all charges associated with retrieval and copying of medical records for medical review. Upon determination of medical necessity the claim will be processed according to the plan benefits and will include any applicable penalty for failure to pre-certify.

Maternity Management

"Baby Yourself", SEIB's Maternity Management Program offers a mechanism for identifying high-risk pregnancies and managing them to prevent complications at the time of delivery. As soon as a pregnancy is confirmed, the patient or the doctor should call BCBS at 1.800.551.2294. By participating in "Baby Yourself" and notifying BCBS before the end of the second trimester, your inpatient deductible and applicable daily copay(s) will be waived. After asking some questions regarding the pregnancy and medical history, BCBS's nurse contacts the doctor to obtain additional clinical information.

Following BCBS's evaluation, the expectant mother and the provider are sent information further explaining the program. Additionally, the expectant mother is sent a special Baby Yourself kit that includes educational materials related to pregnancy and childcare.

Case Management

You may be eligible to receive certain alternative benefits through individual case management when your condition is catastrophic or requires long term care. The program is administered by BCBS. To contact them call 1.800.551.2294.

If BCBS determines that you are a suitable candidate for individual case management, they will notify you. The letter will tell you that you are eligible to receive Alternative Benefits if you, your provider and BCBS can agree to an Alternative Benefit plan. Except for exceptions stated in your Alternative Benefits plan, all terms and conditions of the contract apply to you while you receive Alternative Benefits.

Alternative Benefits are available to you only when they replace services, care, treatment or supplies covered by another section of this contract. For example, alternative benefits may not be made available as an alternative to any benefit excluded (such as radial keratotomy).

Because individual case management is designed to provide the most appropriate benefits for each individual case, the Alternative Benefits plan for any member may differ from another member's plan even if they have the same medical condition. Providing Alternative Benefits to you or any other member is not to be construed as a waiver of the right to administer and enforce the contract exactly as it is written.

If you believe that you should receive Alternative Benefits, you may write BCBS explaining the reasons for your belief. If BCBS determines that you are a candidate for individual case management, they will contact you and begin the process. If BCBS determines that your medical condition does not make you a suitable candidate for Alternative Benefits or it is determined that you are not eligible for Alternative Benefits, they will write you of that decision. After receiving the decision you may write for reconsideration stating all the reasons why you believe that you are still entitled to Alternative Benefits. You may also submit any additional written information that you think is related to your request for reconsideration. If you fail to submit a request for reconsideration within sixty days of the decision you waive any right to challenge that decision later.

You must follow the procedures in this section before you can bring legal action against BCBS for Alternative Benefits. This does not change your right to have individual claims reviewed under the section titled "Filing a Claim, Reviewing Claim Decision and Appeal of Benefit Denial."

BCBS will terminate your Alternative Benefits when any of the following happens:

- The time limit (if any) of the written Alternative Benefits plan expires.
- BCBS determines that the Alternative Benefits being provided to you are no longer Medically Necessary or are no longer cost effective.
- You receive care, treatment, services, or supplies that are not set forth in the Alternative Benefits plan. This does not apply if care, treatment, services or supplies were for a separate medical condition.
- Your coverage ends.
- You tell BCBS, in writing, that you wish to stop Alternative Benefits. This will terminate your Alternative Benefits no more than five days after receipt of your notice by BCBS.

Disease Management

Disease Management is a program for members diagnosed with Diabetes, Coronary Artery Disease, or Chronic Obstructive Pulmonary Disease (COPD). This program is available to eligible members at no cost as a part of your benefits.

Blue Cross translates your doctor's treatment plan into daily actions to improve your health. They educate you in the disease process in hopes of avoiding relapses that can lead to hospital and emergency room visits.

First, Blue Cross identifies members who would benefit from the program by analyzing medical and pharmaceutical claims. Once identified, an invitation and welcome kit is mailed.

Working with you and your doctor, a health care professional specializing in your condition develops your personal health goals such as losing weight or lowering your blood pressure or blood sugar. You get support to help you reach your goals.

Everything about the program is confidential. Only you, your doctor and Blue Cross know you are in the program. Call Blue Cross at 1.800.551.2294

Appeal of Utilization Management Decision

BCBS provides a three-step appeals process that either the patient or the attending provider can initiate. All information required to process the appeal must be submitted to BCBS within one year from the date the claims report is issued by Blue Cross Blue Shield.

"Peer to Peer" Review

The attending provider can initiate a peer to peer review by contacting BCBS at 1.800.551.2294 or 1.866.578.7395 to discuss any case for which requested services were reduced or non-authorized. Based on the telephone discussion, the BCBS physician will determine whether the original decision was appropriate or should be amended. Proper documentation is provided to the patient and the attending provider after the review.

Appeal

When a disagreement between the attending provider and a BCBS physician is not resolved by a peer to peer review, review of the case can be initiated by the attending provider and/or patient via a telephonic or written request to:

Blue Cross Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35298
1.800.551.2294

Medical records are obtained and reviewed once a written release has been received from the patient. If the Committee finds additional medical information to justify the authorization, the services are certified. If not, the non-authorization is upheld. If an original adverse decision is reversed by the Committee, the attending provider, patient and claims office are notified in writing.

Independent Review

For claims involving medical judgment and/or rescissions of coverage, you may also file a request with BCBS for an independent, external review of the decision. You must request this external review within 4 months of the date of your receipt of adverse benefit determination or final adverse appeal determination. Your request for an external review must be in writing, must state you are filing a request for external review, and must be submitted to the following address:

Blue Cross and Blue Shield of Alabama
Attention: Customer Service Appeals
P.O. Box 10744
Birmingham, AL 35202-0744

If you request an external review, an independent organization will review BCBS's decision. You may submit additional written comments to the review organization. Once your external review is initiated, you will receive instructions about how to do this. If you give the review organization additional information, the review organization will provide BCBS with copies of this additional information to allow BCBS an opportunity to reconsider the denial. Both will be notified in writing of the review organization's decision. The decision of the review organization will be final and binding, subject to arbitration.



ROUTINE PREVENTIVE CARE

Routine immunizations and preventive care services when provided by an in-network PPO provider are covered at 100% of the BCBS allowable rate with no deductible or copayment.

Visit www.bcbsal.com/preventiveservices for a listing of specific immunizations and preventive care service. Please note that this list is subject to change. In addition to the services listed on the website, the following preventive services are also provided at 100% of the allowable rate with no deductible or copayment:

- Urinalysis (once by age 5, then once between ages 12-17)
- CBC (once every 2 calendar years ages 8-17, then once every calendar year age 18 and older)
- Glucose testing (once every calendar year age 18 and older)
- Cholesterol testing (once every calendar year age 18 and older)
- TB skin testing (once before age 1, once between ages 14-18)

Routine immunizations and preventive care services when provided by an out-of-network or non-PPO provider are covered at 80% of the allowable rate, subject to the calendar year deductible.



PREFERRED PROVIDER ORGANIZATION (PPO)

When you use a PPO Provider for services or treatment other than routine preventive services, you will receive enhanced benefits. When you DO NOT use a PPO Provider for services covered under the PPO program, covered services are paid at 80% of the PPO fee schedule under Major Medical subject to the deductible.

To maximize your benefits, seek medical services from a Preferred Provider who participates in the BlueCard Preferred Provider Organization (PPO) Program. Please call 1.800.810.BLUE (2583) or access the Blue Cross website at www.bcbs.com/healthtravel/finder.html to find out if your provider is a PPO member.

Preferred Provider (PPO) Benefits for Physicians, Nurse Practitioners, and Physicians Assistants

To take advantage of PPO benefits, simply choose a PPO Provider from the BlueCard PPO directory. Your provider will file all claims for PPO benefits. When your PPO provider requests the services of another provider for you, that provider must also be a PPO Provider in order for you to receive PPO benefits for his or her services, i.e., an anesthesiologist when surgery is performed or an independent laboratory or radiologist for diagnostic services.

- **Office Care Services** - the examination, diagnosis, and treatment for an illness or injury in a PPO Provider's office. The term treatment is inclusive of in-office minor surgery. You must pay a \$35 Physician copay or a \$20 Nurse Practitioner or Physician Assistant copay for each visit.
- **Surgical Care Services** - services for operations and cutting procedures and the usual care before and after operations, for reducing fractures and dislocations, for the endoscopic procedures recognized and accepted by Blue Cross, and of an assisting provider who assists in performance of surgical procedures when medically necessary. Surgeries performed in the office are subject to a \$35 copay.
- **Inpatient Medical Care Services** - visits by a PPO Provider for your care or treatment while you are an inpatient and entitled to inpatient hospital benefits under this contract. However, you will not receive benefits for inpatient medical care services if you receive benefits for surgical care, obstetrical care, or radiation therapy services during the same hospital stay because medical care services are included in the surgical, obstetrical or radiation therapy fee. However, if Blue Cross decides inpatient medical care was medically necessary and unrelated to the condition for which you were hospitalized you will receive medical care services benefits.

You will not be responsible for non-covered medical services when you use a PPO Provider, except when there is a signed agreement on file in the PPO Provider's office, taking patient responsibility for non-covered services. In which case, you will be responsible for the total charges for the non-covered medical services.

- **Consultation Services** - limited to one consultation each for medicine, surgery, and maternity by a PPO Provider while an inpatient during each period of continual hospitalization. The consultation must be for an illness or injury requiring the special skill or knowledge of the PPO Provider.
- **Diagnostic X-ray** - services are covered in full.
- **Outpatient Diagnostic Lab and Pathology** - coverage is provided for outpatient diagnostic lab and pathology services when performed by a PPO Provider. The member pays \$3 copay per test.
- **Emergency Room Physician Services** - care and treatment by a PPO Provider in hospital emergency rooms in an emergency other than for surgery or childbirth. You must pay a \$35 Physician copay or a \$20 Nurse Practitioner or Physician Assistant copay for each visit.

Note: The term "fee schedule" refers to the SEIB's negotiated fee that the approved facilities and providers have agreed to accept for providing psychiatric or substance abuse services. The fee schedule applied to non-approved facilities is consistent with the fee paid to the approved facilities.

NOTE: A comprehensive listing of all approved mental health providers is available on the BCBS website at www.bcbsai.org



MENTAL HEALTH AND SUBSTANCE ABUSE PREFERRED PROVIDER ORGANIZATIONS (PPO)

The LGHIP is designed to provide the following mental health and substance abuse benefits:

- Outpatient Care
 - Individual Therapy/Counseling
 - Family Therapy/Counseling
- Emergency Services
- Inpatient and Outpatient Services in a SEIB Approved Facility
- Alcohol and Drug Abuse Counseling

Your benefit coverage will vary depending on whether you choose an approved or non-approved provider. Your coverage with an approved provider is as follows:

Approved Outpatient Providers - When you visit a Certified Regional Mental Health Center or other approved provider (list available at www.bcbsai.org), outpatient treatment for mental and nervous disorders will be covered up to a maximum of 20 visits each calendar year at \$14 copay per visit. (Other copayments may apply based on the services received.) Mental illness day hospitalization, intensive day treatment and supportive day treatment are covered up to a maximum of 60 days each calendar year at 80% of fee schedule with no deductible. You can receive up to 40 outpatient substance abuse sessions covered at 100% of fee schedule with no deductible at an approved day/evening or weekend treatment program.

Approved inpatient Providers - inpatient psychiatric care and substance abuse treatment received at an approved hospital will be covered at 80% of fee schedule after a \$200 facility deductible per admission.

To be eligible for inpatient facility benefits, all inpatient admissions and stays (except medical emergencies that must have Post-admission Review) must be reviewed, approved, and certified by BCBS as medically necessary before you are admitted. The SEIB has employed BCBS as the Utilization Review Administrator. BCBS can be reached at 1.800.551.2294.

BCBS will only certify the medical necessity of the requested benefit, not whether you are eligible to receive the requested benefit. You are responsible for being aware of the limitations of your benefits.

To take advantage of benefits provided by the approved providers under the SEIB's Preferred Provider Organization (PPO), contact SEIB, BCBS Customer Service, or visit www.bcbsai.org. When you make an appointment identify yourself as having the SEIB's Mental Health and Substance Abuse PPO.

Nonapproved Outpatient Providers - When you visit a nonapproved psychologist or psychiatrist, outpatient treatment for mental and nervous disorders will be covered for up to a maximum of 20 visits per calendar year at 80% of fee schedule after a \$200 annual deductible. You will be responsible for 20% of fee schedule, plus any difference between the fee schedule amount and the amount the provider charges. There is no coverage for services provided by a nonapproved Licensed Professional Counselor or Licensed Social Worker or facility that is solely classified as a substance abuse outpatient or residential facility.

Nonapproved inpatient Providers - inpatient psychiatric care and substance abuse treatment received at a nonapproved hospital will be covered at 80% of fee schedule after a \$200 deductible per admission. You are responsible for 20% of fee schedule, plus any difference between the fee schedule amount and the amount that the Facility charges. This amount can be substantial, as much as 40% of your bill, and is not eligible for coverage under any other part of your contract. Admission Precertification is the same as in an Approved Facility.



PARTICIPATING CHIROPRACTOR BENEFITS

The Participating Chiropractor Program offers members several advantages when they visit a Participating Chiropractor. Services are covered at 80% of the Chiropractic Fee Schedule with no deductible. Participating Chiropractors have agreed to file all claims and accept Blue Cross' payment (along with the 20% coinsurance due from the patient) as payment in full; the patient will not be balance-billed for any "over-range" charges. All benefit payments will go to the Participating Chiropractor.

Precertification is required after the 18th visit. If more than one provider is being utilized (even if the provider is under the same tax identification number) precertification is required again after the 25th visit.

Participating Chiropractors may be required to precertify services during the course of your treatment. If so, the Participating Chiropractor will initiate the precertification process for you. If precertification is denied, you will have the right to appeal the denial.



TOBACCO CESSATION PROGRAM

A Tobacco Cessation Program is now provided by the SEIB for its covered members. Program literature can be obtained through our Wellness Program and on our website. For more information about available programs, please call *Alabama's Tobacco Quitline at 1.800.QUIT.NOW (1.800.784.8669)*. Online resources and support are also available through the following organizations:

American Cancer Society	www.cancer.org
Agency for Healthcare Research and Quality (AHRQ)	www.everypsychoses.org
National Cancer Institute	www.ahrq.gov
American Lung Association	www.cancer.gov
Mayo Clinic	www.lungusa.org/tobacco
	www.mayoclinic.org

The SEIB will reimburse each member 80% of the cost of the program, with no deductible. There is a lifetime maximum benefit of \$150. Tobacco cessation seminars and all forms of nicotine replacement are covered services. Forward your name, address, contact number and a copy of tobacco cessation program receipts to:

State Employees' Insurance Board
Wellness Division
PO Box 304900
Montgomery, AL 36130-4900

Prescription medications for tobacco cessation are covered through the Prescription Drug Program and are not subject to the \$150 lifetime maximum benefit.

All claims must be filed with the SEIB, not BCBS.



PHYSICIAN SUPERVISED WEIGHT MANAGEMENT AND NUTRITIONAL COUNSELING PROGRAMS

The SEIB will cover approved physician supervised weight management and nutritional counseling programs. The SEIB will reimburse up to 80% of the cost of a physician supervised weight management program and/or nutritional counseling, with no deductible, not to exceed \$150 per calendar year. You can apply for reimbursement by forwarding your name, address, contact number, daytime phone number, copy of the program receipt(s), and program contact information to:

State Employees' Insurance Board
Wellness Division
PO Box 304900
Montgomery, AL 36130-4900
866.838.3059

Medications, either by prescription or over the counter, are excluded from the program. Food and Dietary Supplements, except for those distributed by the Physician Supervised Weight Management Plan, are excluded from the program.

You must file your claims for this benefit with the SEIB, not BCBS.



SEIB DISCOUNTED VISION CARE PROGRAM

The SEIB has contracted independently with eye care providers across the state to form the Routine Vision Care Network. This is not a Blue Cross provider network. Check with your provider or visit our web page at www.alseib.org prior to receiving services to determine whether the provider is a participating provider.

Under the Routine Vision Care Network, participating providers will offer the following discounted services:

Routine vision examination (one per year)	\$40 Member payment
Routine vision examination-with dilation (one per year)	\$45 Member payment
Initial contact lens fitting	\$25 Member payment*
Follow-up contact lens visit	\$25 Member payment

* Initial contact lens fitting fee of \$25 is in addition to the routine vision examination fee.

Routine vision care examinations, initial contact lens fitting and follow-up contact lens visits are subject to the member payments stated above and will be accepted by the participating provider as full and complete. Be sure you identify yourself as a local government employee before receiving services.

Laser vision corrective surgery is available at a discounted rate through Participating Vision Care Providers. You may obtain a list of Participating Providers at: www.alseib.org or contact SEIB at 1.866.836.9137.



MAJOR MEDICAL BENEFITS

Services not covered under the BlueCard PPO program are paid at 80% of the allowed amount as Major Medical benefits after a \$200 calendar year deductible, maximum of 3 deductibles per family. Major Medical deductibles and coinsurance apply to annual out-of-pocket maximums of \$6,250 for individuals and \$12,500 aggregate for families.

Only one deductible is applicable to covered Major Medical expenses incurred for treatment of accidental injuries received in the same accident by two or more family members with family coverage.

You are responsible for payment of your covered Major Medical expenses to which the deductible applies.

Covered Major Medical Expenses

Some of the most frequently utilized major medical services are listed below. Contact BCBS Customer Service at 1.800.321.4391 for specific coverage questions prior to services being provided.

- Semi-private room and board, general nursing care and all normal and necessary hospital services and supplies when hospital benefits have expired. Major Medical Benefits for services and supplies provided to inpatients are subject to the requirements and limitations of preadmission certification and post-admission review.
- Allergy testing and treatment. This coverage is offered only under the Major Medical benefit regardless of whether a PPO Provider is used.
- Physical therapy is covered at 80% of the allowance, subject to the calendar year deductible and limited to 15 visits each calendar year. *Preauthorization* is required after the 15th visit to determine the medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied. It is your responsibility to make sure that precertification has been obtained. Please call 1.800.551.2294.
- Speech therapy is covered at 80% of the allowance, subject to the calendar year deductible and limited to 15 visits each calendar year. *Preauthorization* is required after the 15th visit to determine the medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied. It is your responsibility to make sure that preauthorization has been obtained. Please call 1.800.551.2294.
- Occupational therapy is covered at 80% of the allowance, subject to the calendar year deductible and limited to 15 visits each calendar year. *Preauthorization* is required after the 15th visit to determine the medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied. It is your responsibility to make sure that precertification has been obtained. Please call 1.800.551.2294.
- Diabetic education is covered at 100% of the allowance, with no deductible, limited to five diabetic classes (in an approved diabetic education facility) per person within a six-month period for any diabetic diagnosis (not held to insulin dependent diabetics); services in excess of this maximum must be certified through case management; call 1.800.551.2294.
- Prosthetic devices such as an artificial arm and orthopedic devices such as a leg brace.
- Medical supplies such as oxygen, crutches, splints, casts, trusses and braces, syringes and needles (other than insulin supplies), catheters, colostomy bags and supplies and surgical dressings.
- Professional ambulance service approved by Blue Cross to the closest hospital that could furnish the treatment needed for your condition. A provider must certify that the ambulance service was necessary. If Blue Cross requests it.
- Rental of durable medical equipment prescribed by a Provider for therapeutic use in a member's home, limited to the amount of its reasonable and customary purchase price. If you can buy it for less than you can rent it, or if it is not available for rent, Blue Cross will pay its allowed purchase price. Some examples of durable medical equipment are wheelchairs and hospital beds.

PRESCRIPTION DRUGS

- Hemodialysis services provided by a Participating Renal Dialysis Facility.
- Private duty nursing services of a licensed registered nurse (R.N.) or a licensed practical nurse (L.P.N.) if the services actually require the professional skills of a R.N. or L.P.N., are provided outside of a hospital or other facility, and are provided by a person not related to you by blood or marriage or a member of your household. No benefits are provided for any custodial care. In order to be covered, private duty nursing services must be pre-certified by BCBS.
- Home health care is covered at 80% of the allowance, subject to the calendar year deductible, when services are rendered by a participating Home Health agency. It is your responsibility to make sure that precertification has been obtained. Call 1.800.551.2294.
- Point-of-sale drug benefits. (See Prescription Drug section.)



Active Employees and Non-Medicare Retirees
Prescription Drug Card Program
 Generic drugs covered at 100% of the allowance, subject to \$5 copay per prescription when you use a Participating Pharmacy.

Point-of-Sale Drug Program
 Brand-name drugs covered at 80% of the allowance, subject to the calendar year Major Medical deductible when you use a Participating Pharmacy.

- You are responsible for paying the pharmacy for your prescription.
- Claims authorization number required.
- File your prescription claim with Blue Cross Blue Shield of Alabama, using the Major Medical Point-of-Sale Prescription Drug Claim form (CL-94) or you can file your claim online at www.bcbsal.org.

NOTE: No benefits are available for prescriptions purchased at a Non-Participating Pharmacy.

Medicare retirees and Medicare Dependents of retirees covered under LGHIP's Employer Group Waiver Plan (EGWP)

Prescription Drug Card Program for Generic Drugs
Preferred/Extended Supply Network Pharmacies
 \$ 5 copay for 30-day supply
 \$10 copay for 60-day supply
 \$10 copay for 90-day supply

Non-Preferred Pharmacies
 \$ 5 copay for 30-day supply
 \$10 copay for 60-day supply
 \$15 copay for 90-day supply

\$ 0 copay for Zostavax (shingles), Flu and Pneumonia Vaccine

Point-of-Sale Drug Program for Brand Drugs
Retail & Extended Supply Network Pharmacies
 20% coinsurance after the \$100 drug deductible is met. Deductible applies only to Medicare covered Part D Drugs.

NOTE: All Medicare Part B-eligible prescription drugs, to include Hepatitis Vaccines and all diabetic supplies are excluded from EGWP coverage since they are covered by Part B.

Drugs purchased at an out-of-network pharmacy may be covered under certain circumstances, such as for an illness while traveling outside the plan's service area where a network pharmacy is unavailable. Drugs purchased at an out-of-network pharmacy may require higher cost-sharing. Additionally, you may have to pay the full charge for the drug and submit documentation to receive reimbursement.

If you are not enrolled in EGWP, you have no prescription drug coverage through the Local Government Health Insurance Plan. Please see the EGWP plan documents to know the rules you must follow to receive coverage with this Medicare prescription drug plan.

MEDICAL EXCLUSIONS



In addition to other exclusions set forth in this handbook, the LGHIP will not provide benefits for the following, whether or not a Provider performs or prescribes them:

- A**
- Services or expenses for elective abortions.
 - Services or expenses for acupuncture, biofeedback, and other forms of self-care or self-help training.
 - Anesthesia services or supplies or both by local infiltration.
 - Services, care, treatment, or supplies furnished by a provider that is not recognized by BCBS as an approved provider for the type of service or supply being furnished. For example, the LGHIP reserves the right not to pay for some or all services or supplies furnished by certain persons who are not medical doctors (M.D.s), even if the services or supplies are within the scope of the provider's license. Call BCBS Customer Service if you have any question as to whether your provider is recognized as an approved provider for the services or supplies that you intend to receive.
 - Services or expenses for or related to Assisted Reproductive Technology (ART). ART is any process of taking human eggs or sperm or both and putting them into a medium or the body to try to cause reproduction. Examples of ART are in vitro fertilization and gamete intrafallopian transfer.
- C**
- Services or expenses of a hospital stay, except one for an emergency, unless BCBS has approved and pre-certified it before your admission. Services or expenses of a hospital stay for an emergency if we are not notified within 72 hours, or on our next business day after your admission, or if we determine that the admission was not medically necessary.
 - Services or expenses for which a claim is not properly submitted to Blue Cross.
 - Services or expenses for a claim we have not received within 12 months after services were rendered or expenses incurred.
 - Services or expenses for personal hygiene, comfort or convenience items such as: air-conditioners, humidifiers, whirlpool baths, and physical fitness or exercise apparel. Exercise equipment is also excluded. Some examples of exercise equipment are shoes, weights, exercise bicycles or tracks, weights or variable resistance machinery, and equipment producing isolated muscle evaluations and strengthening. Treatment programs, the use of equipment to strengthen muscles according to preset rules, and related services performed during the same therapy session are also excluded.
 - Services or expenses for sanitarium care, convalescent care, or rest care, including care in a nursing home.
 - Services or expenses for cosmetic surgery. Cosmetic surgery is any surgery done primarily to improve or change the way one appears. "Reconstructive surgery" is any surgery done primarily to restore or improve the way the body works or correct deformities that result from disease, trauma or birth defects. Reconstructive surgery is a covered benefit, cosmetic surgery is not. (See "Women's Health and Cancer Rights Act" for exceptions.) Complications or later surgery related in any way to cosmetic surgery is not covered, even if medically necessary, if caused by an accident, or if done for mental or emotional relief.

- You may contact BCBS prior to surgery to find out whether a procedure will be reconstructive or cosmetic. You and your physician must prove to our satisfaction that surgery is reconstructive and not cosmetic. You must show us history and physical exams, visual field measures, photographs and medical records before and after surgery. We may not be able to determine prior to your surgery whether or not the proposed procedure will be considered cosmetic.
 - Some surgery is always cosmetic such as ear piercing, neck tucks, face lifts, buttock and thigh lifts, implants to smelt but normal breasts (except as provided by the Women's Health and Cancer Rights Act), hair implants for male-pattern baldness and correction of frown lines on the forehead. In other surgery, such as blepharoplasty (eyelids), rhinoplasty (nose), chemical peel and chin implants, it depends on why that procedure was done. For example, a person with a deviated septum may have trouble breathing and may have many sinus infections. To correct this they have septoplasty. During surgery the physician may remove a hump or shorten the nose (rhinoplasty). The septoplasty would be reconstructive surgery while the rhinoplasty would be denied as cosmetic surgery. Surgery to remove excess skin from the eyelids (blepharoplasty) would be cosmetic if done to improve your appearance, but reconstructive if done because your eyelids kept you from seeing very well.
 - Services or expenses for treatment of injury sustained in the commission of a crime (except for treatment of injury as a result of a medical condition or as a result of domestic violence) or for treatment while confined in a prison, jail, or other penal institution.
 - Services or expenses for custodial care. Care is "custodial" when its primary purpose is to provide room and board, routine nursing care, training in personal hygiene, and other forms of self-care or supervisory care by a physician for a person who is mentally or physically disabled.
- D**
- Dental implants into, across, or just above the bone and related appliances. Services or expenses to prepare the mouth for dental implants such as those to increase the upper and lower jaws or their borders, sinus lift process, guided tissue regrowth or any other surgery, bone grafts, hydroxyapatite and similar materials. These services, supplies or expenses are not covered even if they are needed to treat conditions existing at birth, while growing, or resulting from an accident. These services, supplies or expenses are excluded even if they are medically or dentally necessary.
 - Services for or related to a dependent pregnancy, including the six-week period after delivery. A dependent pregnancy means the pregnancy of any dependent other than the contract holder's wife.
- E**
- Services, care, or treatment you receive after the ending date of your coverage. This means, for example, that if you are in the hospital when your coverage ends, we will not pay for any more hospital days. We do not insure against any condition such as pregnancy or injury. We provide benefits only for services and expenses furnished while this plan is in effect.
 - Prescription drugs for erectile dysfunction.
 - Eyeglasses or contact lenses or related examinations or fittings.
 - Services or expenses for eye exercises, eye refractions, visual training orthoptics, shaping the cornea with contact lenses, or any surgery on the eye to improve vision including radial keratotomy.
- F**
- Services or expenses in any federal hospital or facility except as required by federal law.
 - Services or expenses for routine foot care such as removal of corns or calluses or the trimming of nails (except mycotic nails).

G

- Unless otherwise required by applicable law, services or expenses covered in whole or in part under the laws of the United States, any state, county, city, town or other governmental agency that provides or pays for care, through insurance or any other means.

H

- Hearing aids or examinations or fittings for them.

I

- Investigational treatment, procedures, facilities, drugs, drug usage, equipment or supplies, including investigational services that are part of a clinical trial. Under federal law, the plan cannot deny a member participation in an approved clinical trial, is prohibited from dropping coverage because member chooses to participate in an approved clinical trial, and from denying coverage for routine care that the plan would otherwise provide just because a member is enrolled in an approved clinical trial. This applies to all approved clinical trials that treat cancer or other life-threatening diseases.

L

- Services or expenses that you are not legally obligated to pay, or for which no charge would be made if you had no health coverage.
- Services or expenses for treatment which does not require a licensed provider, given the level of simplicity and the patient's condition, will not further restore or improve the patient's bodily functions, or is not reasonable as to number, frequency, or duration.

M

- Services or expenses we determine are not medically necessary.
- Services or supplies to the extent that a member is, or would be, entitled to reimbursement under Medicare, regardless of whether the member properly and timely applied for, or submitted claims to Medicare, except as otherwise required by federal law.
- Care and treatment for mental health disorders or disease (including substance abuse).

N

- Services or expenses of any kind for nicotine addiction such as smoking cessation treatment. The only exception to this exclusion is expenses for nicotine withdrawal drugs prescribed by a physician and dispensed by a licensed pharmacist from an in-network pharmacy.
- Services or expenses of any kind provided by a Non-Participating Hospital located in Alabama for Major Medical benefits or any other benefits under this contract except inpatient and outpatient hospital benefits in case of accidental injury.
- Services, care or treatment you receive during any period of time with respect to which payment for your coverage has not been made and that nonpayment results in termination of coverage.

O

- Services or expenses for treatment of any condition including, but not limited to, obesity, diabetes, or heart disease, that is based upon weight reduction or dietary control. This exclusion does not apply to Bariatric

benefits. For example, braces on the teeth are excluded for any purpose, even to prepare a person with a cleft palate for surgery on the bones of the jaw or because of injury of natural teeth. This exclusion does not apply, except as indicated above for braces or other orthodontic appliances, to those services by a physician to treat or replace natural teeth which are harmed by accidental injury covered under major medical.

- Services provided through teleconsultation.
- Dental treatment for or related to temporomandibular joint (TMJ) disorders. This includes Phase II according to the guidelines approved by the Academy of Craniomandibular Disorders. These treatments permanently alter the teeth or the way they meet and include such services as balancing the teeth, shaping the teeth, reshaping the teeth, restorative treatment, treatment involving artificial dental structures such as crowns, bridges or dentures, full mouth rehabilitation, dental implants, treatment for irregularities in the position of the teeth (such as braces or other orthodontic appliances) or a combination of these treatments.
- Services, supplies, implantable devices, equipment and accessories billed by any out-of-network third party vendor that are used in surgery or any operative setting. This exclusion does not apply to services and supplies provided to a member for use in their home pursuant to a physician's prescription.
- Services or expenses for or related to organ, tissue or cell transplants except specifically as allowed by this plan.
- Travel, even if prescribed by your physician (not including ambulance services otherwise covered under the plan).

W

- Services or expenses for an accident or illness resulting from active participation in war, or any act of war, declared or undeclared, or from active participation in riot or civil commotion.
- Services or expenses rendered for any disease, injury or condition arising out of and in the course of employment for which benefits and/or compensation is available in whole or in part under the provisions of any workers' compensation or employers' liability laws, state or federal. This applies whether you fail to file a claim under that law. It applies whether the law is enforced against or assumed by the group. It applies whether the law provides for hospital or medical services as such. It applies whether the provider of those services was authorized as required by the law. Finally, it applies whether your group has insurance coverage for benefits under the law.

Surgical procedures if medically necessary and in compliance with BCBS's guidelines. Bariatric Surgical procedures are limited to one per lifetime, subject to prior authorization. Benefits are those services are provided only when the services are performed by a PPD Provider. All physician and anesthesia services related to Bariatric Surgical procedures are limited to 50% of the allowable rate.

- Services or expenses provided by an out-of-network provider for any benefits under this plan, unless otherwise specifically stated in the plan.

P

- Physical, Speech, and/or Occupational therapy for the 16th and subsequent visits that were not preauthorized.
- Private duty nursing.

R

- Services or expenses for recreational or educational therapy.
- Hospital admissions in whole or in part when the patient primarily receives services to rehabilitate such as physical therapy, speech therapy, or occupational therapy.
- Services or expenses any provider rendered to a member who is related to the provider by blood or marriage or who regularly resides in the provider's household. Examples of a provider include a physician, a licensed registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed physical therapist.
- Room and board for hospital admissions in whole or in part when the patient primarily receives services that could have been provided on an outpatient basis based upon the patient's condition and the services provided.
- Routine well child care and routine immunizations except for the services described in "Routine Preventive Benefits."
- Routine physical examinations except for the services described in "Routine Preventive Benefits."

S

- Services or expenses for, or related to, sexual dysfunctions or inadequacies not related to organic disease (unless the injury results from an act of domestic violence or a medical condition) or which are related to surgical sex transformations.
- Sleep studies performed outside of a healthcare facility, such as home sleep studies, whether or not supervised or attended.
- Services or expenses of any kind for or related to reverse sterilizations.
- Services or supplies for substance abuse including any service furnished by a substance abuse residential facility.

T

- Services or expenses to care for, treat, fill, extract, remove or replace teeth or to increase the periodontium. The periodontium includes the gums, the membrane surrounding the root of a tooth, the layer of bone covering the root of a tooth and the upper and lower jaws and their borders, which contain the sockets for the teeth. Care to treat the periodontium, dental pulp or "dead" teeth, irregularities in the position of the teeth, artificial dental structures such as crowns, bridges or dentures, or any other type of dental procedure is excluded. Hydroxyapatite or any other material to make the gums rigid is excluded. It does not matter whether their purpose is to improve conditions inside or outside the mouth (oral cavity). These services, supplies or expenses are not covered even if they are used to prepare a patient for services or procedures that are plan



GENERAL PROVISIONS

Privacy of Your Protected Health Information

The confidentiality of your personal health information is important to the SEIB. Under a new federal law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), plans such as this one are generally required to limit the use and disclosure of your protected health information to treatment, payment, and health care operations. This section of this booklet explains some of HIPAA's requirements. Additional information is contained in the LGHIP's notice of privacy practices. You may request a copy of this notice by contacting the SEIB.

Disclosures of Protected Health Information to the Plan Sponsor:

In order for your benefits to be properly administered, the LGHIP needs to share your protected health information with the plan sponsor (the State of Alabama). Following are circumstances under which the LGHIP may disclose your protected health information to the plan sponsor:

- The LGHIP may inform the plan sponsor whether you are enrolled in the LGHIP.
- The LGHIP may disclose summary health information to the plan sponsor. The plan sponsor must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying you.
- The LGHIP may disclose your protected health information to the plan sponsor for plan administrative purposes. This is because employees of the plan sponsor perform some of the administrative functions necessary for the management and operation of the LGHIP.

Following are the restrictions that apply to the plan sponsor's use and disclosure of your protected health information:

- The plan sponsor will only use or disclose your protected health information for plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. See the LGHIP's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.
- If the plan sponsor discloses any of your protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to keep your protected health information as required by the HIPAA regulations.
- The plan sponsor will not use or disclose your protected health information for employment-related actions or decisions or in connection with any other benefit or benefit plan of the plan sponsor.
- The plan sponsor will promptly report to the plan any use or disclosure of your protected health information that is inconsistent with the uses or disclosures allowed in this section of this booklet.
- The plan sponsor will allow you or the LGHIP to inspect and copy any protected health information about you that is in the plan sponsor's custody and control. The HIPAA regulations set forth the rules that you and the LGHIP must follow in this regard. There are some exceptions.
- The plan sponsor will amend, or allow the LGHIP to amend, any portion of your protected health information to the extent permitted or required under the HIPAA regulations.
- With respect to some types of disclosures, the plan sponsor will keep a disclosure log. The disclosure log will go back for six years (but not before April 14, 2003). You have a right to see the disclosure log. The plan sponsor does not have to maintain the log if disclosures are for certain plan related purposes, such as payment of benefits or healthcare operations.
- The plan sponsor will make its internal practices, books, and records, relating to its use and disclosure of your protected health information available to the LGHIP and to the U.S. Department of Health and Human Services, or its designee.

- The plan sponsor will, if feasible, return or destroy all of your protected health information in the plan sponsor's custody or control that the plan sponsor has received from the LGHIP or from any business associate when the plan sponsor no longer needs your protected health information to administer the plan. If it is not feasible for the plan sponsor to return or destroy your protected health information, the plan sponsor will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

The following classes of employees or other workforce members under the control of the plan sponsor may use or disclose your protected health information in accordance with the HIPAA regulations that have just been explained:

- Benefits Administration and Operations
- Legal
- Finance

If any of the foregoing employees or workforce members of the plan sponsor use or disclose your protected health information in violation of the rules that are explained above, the employees or workforce members will be subject to disciplinary action and sanctions – which may include termination of employment. If the plan sponsor becomes aware of any such violation, the plan sponsor will promptly report the violation to the SEIB and will cooperate with the plan to correct the violation, to impose appropriate sanctions, and to relieve any harmful effects to you.

Security of Your Personal Health Information:

Following are restrictions that will apply to the plan sponsor's storage and transmission of your electronic protected health information:

- The plan sponsor will have in place appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of your electronic protected health information, as well as to ensure that only those classes of employees or other workforce members of the plan sponsor described above have access to use or disclose your electronic protected health information in accordance with the HIPAA regulations.
- If the plan sponsor discloses any of your electronic protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to have in place the appropriate safeguards as required by the HIPAA regulations.

The plan sponsor will report to the SEIB any security incident of which it becomes aware in accordance with the HIPAA regulations.

Our Use and Disclosure of Your Personal Health Information:

As a business associate of the SEIB, BCBS has an agreement with the SEIB that allows BCBS to use your personal health information for treatment, payment, healthcare operations, and other purposes permitted or required by HIPAA. In addition, by applying for coverage and participating in the LGHIP, you agree that BCBS may obtain, use and release all records about you and your minor dependents that BCBS needs to administer the plan or to perform any function authorized or permitted by law. You further direct all persons to release all records to BCBS about you and your minor dependents that BCBS needs in order to administer the plan.

HIPAA Exemption: As a non-federal governmental health plan, the State of Alabama can elect to exempt the LGHIP from certain provisions of HIPAA. The State of Alabama has elected to exempt the LGHIP from the following HIPAA requirement:

Parity in the application of certain limits to mental health benefits: Group health plans that provide both medical and surgical benefits and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.

The privacy provisions of the Health Insurance Portability and Accountability Act require that you be notified at least once every three years about the availability of the State Employees' Insurance Board's privacy practices [45 CFR 164.520(c)(1)(ii)]. Accordingly, you may obtain a copy for our privacy practices by going to our website at www.alseib.org or you can request a copy by writing to us at:

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

Delegation of Discretionary Authority to Blue Cross

The SEIB has delegated to BCBS the discretionary responsibility and authority to determine claims under the LGHIP, to construe, interpret, and administer claims, and to perform every other act necessary or appropriate in connection with claims administration services under the LGHIP.

Whenever BCBS makes reasonable determinations that are neither arbitrary nor capricious in the administration of claims of the LGHIP, those determinations will be final and binding on you, subject only to your right of review under the LGHIP.

Incorrect Benefit Payments

Every effort is made to process claims promptly and correctly. If payments are made to you or to a provider who furnished services or supplies to you, and BCBS finds at a later date that the payments were incorrect, you or the provider will be required to repay any overpayment or BCBS may deduct the amount of the overpayment from any future payment to you or the provider. If BCBS does this, they will notify you.

Responsibility for Actions of Providers of Services

BCBS and the State Employees' Insurance Board (SEIB) will not be responsible for any acts or omissions, whether negligent, intentional, or otherwise, by any institution, facility, or individual provider in furnishing or not furnishing any services, care, treatment, or supplies to you. BCBS and SEIB will not be responsible if any provider of service fails or refuses to admit you to a facility, or treat you, or provide services to you. BCBS and SEIB are not required to do anything to enable providers to furnish services, supplies, or facilities to you.

Misrepresentation

Any misrepresentation by you in application for or in connection with coverage under the contract will make your coverage invalid as of your effective date, and in that case BCBS and SEIB will not be obligated to return any portion of any fees paid by or for you. Any misrepresentation by SEIB in application for or in connection with the contract will make the entire contract invalid as of the contract effective date, and in that case BCBS will not be obligated to return any fees paid by the group for you or any other member.

Any employee or retiree knowingly and willfully submitting materially false information to the SEIB or engaging in fraudulent activity that causes financial harm to the LGHIP, may be required, upon a determination by the SEIB, (1) to repay all claims and other expenses, including interest, incurred by the plan related to the intentional submission of false or misleading information or fraudulent activity and (2) be subject to disqualification from coverage under the LGHIP.

Obtaining, Use, and Release of Information

By submitting your application for coverage or any claims for benefits you authorize BCBS to obtain from all providers, hospitals, facilities, other providers of service, and all other persons or institutions having information concerning you, all records that in its judgment are necessary or desirable for processing your claim, performing our contractual duties or complying with any law. You also authorize providers of health services, and any other person or organization, to furnish to BCBS any such records or information it requests.

Your authorization allows BCBS to use and release to other persons or organization any such records and information as considered necessary or desirable in its judgment. Neither BCBS or any provider or other person or organization will be liable for obtaining, furnishing, using, or releasing any such records or information.

Responsibility of Members and Providers to Furnish Information

By submitting an application for coverage or a claim for benefits you agree that in order to be eligible for benefits:

- A claim for benefits must be properly submitted to and received by BCBS.
- A provider, hospital, or other provider that has furnished or prescribed any services or supplies to a member must provide the records, information, and evidence BCBS requests in connection with benefits claimed or paid for the services or supplies.
- A member who receives services or supplies for which benefits are claimed must provide the records, information and evidence BCBS requests.

Refusal by any member or provider of services to provide BCBS records, information, or evidence reasonably requested will be grounds for denial of any further payments of benefits to or for this member or provider.

Providers of Services Subject to Contract Provision

Any hospital, provider, or other provider of services or supplies for which benefits are claimed or paid will be considered, through acceptance of the benefits or payment, to be bound by this contract's provisions.

Benefit Decisions

By submitting a claim for benefits you agree that any determination BCBS makes in deciding claims or administering the contract that is reasonable and not arbitrary or capricious will be final.

Charges for More than the Allowed Amounts

When benefits for provider's services are based on allowed amounts, the benefit payments are determined and made by BCBS upon consideration of the factors described previously in the definition of Allowed Amount. If a provider charges you more than the allowed amount paid by BCBS as benefits, you are responsible for the charges in excess of the allowed amount.

Applicable State Law

This contract is issued and delivered in the State of Alabama and will be governed by the law of Alabama to the extent that state law is applicable.

Plan Changes

- Any or all of the provisions of the LGHIP may be amended by the State Employees' Insurance Board at any time by an instrument in writing.
- No representative or employee of BCBS is authorized to amend or vary the terms and conditions of the LGHIP, make any agreement or promise, not specifically contained in the LGHIP, or waive any provision of the LGHIP.

Rescission

Under the Patient Protection and Affordable Care Act (the ACA), the SEIB cannot rescind your coverage once you are covered under the LGHIP unless you perform an act, practice, or omission that constitutes fraud, or unless you make an intentional misrepresentation of material fact as prohibited by the terms of the LGHIP. The SEIB must provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded.

A rescission is a retroactive cancellation or discontinuance of coverage. A cancellation of coverage is not a rescission if (a) the cancellation or discontinuance of coverage has only a prospective effect, or (b) the cancellation or discontinuance of coverage is effective retroactively due to a failure to timely pay required premiums or contributions towards the cost of coverage.

No Assignment

The LGHIP will not honor an assignment of your claim to anyone. Some of the contracts BCBS has with providers of services, such as hospitals, require BCBS to pay benefits directly to the providers. With other claims BCBS may choose whether to pay you or the provider. If you or the provider owes the LGHIP money BCBS may deduct

the amount owed from the benefit paid. When BCBS pays or deducts the amount owed from you or the provider, this completes our obligation to you under the LGHIP. Upon your death or incompetence, or if you are a minor, the LGHIP may pay your estate, your guardian or any relative the LGHIP believes is due to be paid. This, too, completes LGHIP's plan obligation to you.



COORDINATION OF MEDICAL BENEFITS

Coordination of Medical Benefits (COB) is a provision designed to help manage the cost of health care by avoiding duplication of benefits when a person is covered by two or more benefit plans. COB provisions determine which plan is primary and which is secondary.

A primary plan is one whose benefits for a person's health care coverage must be determined first without taking the existence of any other plan into consideration.

A secondary plan is one which takes into consideration the benefits of the primary plan before determining benefits available under its plan.

Some COB terms have defined meanings. These terms are set forth at the end of this COB section.

Order of Benefit Determination

Which plan is primary is decided by the first rule below that applies:

Noncompliant Plan: If the other plan is a noncompliant plan, then the other plan shall be primary and this plan shall be secondary unless the COB terms of both plans provide that this plan is primary.

Employee/Dependent: The plan covering a patient as an employee, member, subscriber, or contract holder (that is, other than as a dependent) is primary over the plan covering the patient as a dependent. In some cases, depending upon the size of the employer, Medicare secondary payer rules may require us to reverse this order of payment. This can occur when the patient is covered as an inactive or retired employee. Is also covered as a dependent of an active employee, and is also covered by Medicare. In this case, the order of benefit determination will be as follows: first, the plan covering the patient as a dependent; second, Medicare; and third, the plan covering the patient as an inactive or retired employee.

Dependent Child – Parents Not Separated or Divorced: If both plans cover the patient as a dependent child of parents who are married or living together (regardless of whether they have ever been married), the plan of the parent whose birthday falls earlier in the year will be primary. If the parents have the same birthday, the plan covering the patient longer is primary.

Dependent Child – Separated or Divorced Parents: If two or more plans cover the patient as a dependent child of parents who are divorced, separated, or no longer living together (regardless of whether they have ever been married), benefits are determined in this order:

1. If there is no court decree allocating responsibility for the child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
 - a. first, the plan of the custodial parent;
 - b. second, the plan covering the non-custodial parent's spouse;
 - c. third, the plan covering the non-custodial parent; and,
 - d. last, the plan covering the non-custodial parent's spouse.
2. If a court decree states that a parent is responsible for the dependent child's healthcare expenses or healthcare coverage and the plan of that parent has actual knowledge of those terms, the plan of the court-ordered parent is primary.

If the court-ordered parent has no healthcare coverage for the dependent child, benefits will be determined in the following order:

- a. first, the plan of the spouse of the court-ordered parent;
- b. second, the plan of the non-court-ordered parent; and,
- c. third, the plan of the spouse of the non-court-ordered parent.

If a court decree states that both parents are responsible for the dependent child's healthcare expenses or healthcare coverage, the provisions of "Dependent Child – Parents Not Separated or Divorced" (the "birthday rule") above shall determine the order of benefits.

If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the dependent child, the provisions of the "birthday rule" shall determine the order of benefits.

3. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under the "birthday rule" as if those individuals were parents of the child.

Active Employee or Retired or Laid-Off Employee:

1. The plan that covers a person as an active employee (that is, an employee who is neither laid off nor retired) or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.
2. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.
3. This rule does not apply if the rule in the paragraph "Employee/Dependent" above can determine the order of benefits. For example, if a retired employee is covered under his or her own plan as a retiree and is also covered as a dependent under an active spouse's plan, the retiree plan will be primary and the spouse's active plan will be secondary.

COBRA or State Continuation Coverage:

1. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.
2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
3. This rule does not apply if the rule in the paragraph "Employee/Dependent" above can determine the order of benefits. For example, if a former employee is receiving COBRA benefits under his former employer's plan (the "COBRA plan") and is also covered as a dependent under an active spouse's plan, the COBRA plan will be primary and the spouse's active plan will be secondary. Similarly, if a divorced spouse is receiving COBRA benefits under his or her former spouse's plan (the "COBRA plan") and is also covered as a dependent under a new spouse's plan, the COBRA plan will be primary and the new spouse's plan will be secondary.

Longer/Shorter Length of Coverage: If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

Equal Division: If the plans cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been the primary plan.

Determination of Amount of Payment

1. If this plan is primary, it shall pay benefits as if the secondary plan did not exist.
2. If our records indicate this plan is secondary, we will not process your claims until you have filed them with the primary plan and the primary plan has made its benefit determination.

If this plan is required to make a secondary payment according to the above rules, it will subtract the amount paid by the primary plan from the amount it would have paid in the absence of the primary plan, and pay the difference, if any. In many cases, this will result in no payment by this plan.

COB Terms

Allowable Expense: Except as set forth below or where a statute requires a different definition, the term "allowable expense" means any healthcare expense, including coinsurance, copayments, and any applicable deductible that is covered in full or in part by any of the plans covering the person.

The term "allowable expense" does not include the following:

- An expense or a portion of an expense that is not covered by any of the plans.
- Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person.
- Any type of coverage or benefit not provided under this plan. For example, if this plan does not provide benefits for mental health disorders and substance abuse, dental services and supplies, vision care, prescriptions drugs, or hearing aids, or other similar type of coverage or benefit, then it will have no secondary liability with respect to such coverage or benefit. In addition, the term "allowable expense" does not include the amount of any reduction in benefits under a primary plan because (a) the covered person failed to comply with the primary plan's provisions concerning second surgical opinions or precertification of admissions or services, or (b), the covered person had a lower benefit because he or she did not use a preferred provider.

Birthday: The term "birthday" refers only to month and day in a calendar year and does not include the year in which the individual is born.

Custodial Parent: The term "custodial parent" means:

- A parent awarded custody of a child by a court decree; or,
- In the absence of a court decree, the parent with whom the child resides for more than one half of the calendar year without regard to any temporary visitation.

Group-Type Contract: The term "group-type contract" means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. The term does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

Hospital Indemnity Benefits: The term "hospital indemnity benefits" means benefits not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

Noncompliant Plan: The term "noncompliant plan" means a plan with COB rules that are inconsistent in substance with the order of benefit determination rules of this plan. Examples of noncompliant plans are those that state their benefits are "excess" or "always secondary."

Plan: The term "plan" includes group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

The term "plan" does not include non-group or individual health or medical reimbursement insurance contracts. The term "plan" also does not include hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Primary Plan: The term "primary plan" means a plan whose benefits for a person's healthcare coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if:

- The plan either has no order of benefit determination rules, or its rules differ from those permitted by this regulation; or,
- All plans that cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

Secondary Plan: The term "secondary plan" means a plan that is not a primary plan.

Right to Receive and Release Needed Information

Certain facts about healthcare coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. BCBS may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. BCBS is not required to tell or get the consent of any person to do this. Each person claiming benefits under this plan must give BCBS any facts it needs to apply these COB rules and to determine benefits payable as a result of these rules.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, BCBS may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. BCBS will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by BCBS is more than BCBS should have paid under this COB provision, BCBS may recover the excess from one or more of the persons it has paid to or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Special Rules for Coordination with Medicare

Except where otherwise required by federal law, the plan will pay benefits on a secondary basis to Medicare or will pay no benefits at all for services or supplies that are included within the scope of Medicare's coverage, depending upon, among other things, the size of your group, whether your group is a member of an association, and the type of coordination method used by your group. For example, if this plan is secondary to Medicare under federal law, this plan will pay no benefits for services or supplies that are included within the scope of Medicare's coverage if you fail to enroll in Medicare when eligible.



SUBROGATION

Right of Subrogation

If BCBS pays or provides any benefits for you under the LGHIP is subrogated to all rights of recovery that you have in contract, tort, or otherwise against any person or organization for the amount of benefits the LGHIP has paid or provided. The LGHIP may use your right to recover money from that other person or organization.

Right of Reimbursement

Besides the right of subrogation, the LGHIP has a separate right to be reimbursed or repaid from any money you, including your family members, recover for an injury or condition for which the LGHIP has paid plan benefits. This means that you promise to repay the LGHIP from any money you recover the amount the LGHIP has paid or provided in plan benefits. It also means that if you recover money as a result of a claim or a lawsuit, whether by settlement or otherwise, you must repay the LGHIP. And, if you are paid by any person or company besides the LGHIP, including the person who injured you, that person's insurer, or your own insurer, you must repay the LGHIP. In these and all other cases, you must repay the LGHIP.

The LGHIP has the right to be reimbursed or repaid first from any money you recover, even if you are not paid for all of your claim for damages and you are not made whole for your loss. This means that you promise to repay the LGHIP first even if the money you recover is for (or said to be for) a loss besides plan benefits, such as pain and suffering. It also means that you promise to repay the LGHIP first even if another person or company has paid for part of your loss. And it means that you promise to repay the LGHIP first even if the person who recovers the money is a minor. In these and all other cases, the LGHIP still has the right to first reimbursement or repayment out of any recovery you receive from any source.

Right to Recovery

You agree to promptly furnish BCBS all information that you have concerning your rights of recovery or recoveries from other persons or organizations and to fully assist and cooperate with BCBS in protecting and obtaining the LGHIP's reimbursement and subrogation rights in accordance with this Section. You may receive questionnaires requesting more information. Any member who has not responded within 30 days of receiving three questionnaires will have their claims suspended until they have complied with the questionnaire.

You or your attorney will notify BCBS before filing any suit or settling any claim so as to enable the LGHIP to participate in the suit or settlement to protect and enforce the LGHIP's rights under this section. If you do notify BCBS so that the LGHIP is able to and does recover the amount of LGHIP benefit payments for you, the LGHIP will share proportionately with you in any attorneys' fees charged you by your attorney for obtaining the recovery. If you do not give BCBS such notice, the LGHIP's reimbursement or subrogation recovery under this section will not be decreased by any attorney's fee for your attorney.

You further agree not to allow the reimbursement and subrogation rights of the LGHIP under this section to be limited or harmed by any other acts or failures to act on your part. It is understood and agreed that if you do, the SEIB may suspend or terminate payment or provision of any further benefits for you under the LGHIP.

Provider Services and Other Covered Expenses

To file a claim for provider services and other covered Major Medical expenses, present your identification card to the provider of service. Benefit payments are normally made directly to the provider.

However, if the provider does not file for benefits, claims should be filed directly by you. When it is necessary for you to file claims, complete a Medical Expense Claim Form (CL-438) or Major Medical Point-of-Sale Prescription Drug Claim Form (CL-94) and obtain itemized bills from the provider to attach. It is to your advantage to file your claims as they are incurred or at least every three months. The itemized bills must contain:

• Patient's full name	• Contract number	• Name and address of provider
• Type of service	• Date of service	• Diagnosis
• Charge for each service	• Date of accident (if any)	

Send the claim to: Blue Cross Blue Shield of Alabama, 450 Riverchase Parkway East, Birmingham, Alabama 35298. You should always make copies for your personal records before filing. For your convenience, Medical Expense Claim Forms (CL-438) or Major Medical Point-of-Sale Prescription Drug Claim Forms (CL-94) are available from any Blue Cross Blue Shield of Alabama office.

Blue Cross Preferred Care Benefits

One of the greatest advantages of visiting a PPO Provider or PPO Facility is that you are relieved of any claim filing. Provider and PPO Facilities agree to handle all claim filing procedures for you.

When Claims Must Be Submitted

All claims for benefits must be submitted properly by you or your provider of services within 365 days of the date you receive the services or supplies. Claims not submitted and received by BCBS within this 365-day period will not be considered for payment of benefits.

Receipt and Processing Claims

Claims for medical benefits under the LGHIP can be post-service, pre-service, or concurrent. The following explains how BCBS processes these different types of claims and how you can appeal a partial or complete denial by BCBS of a claim.

You must act on your own behalf or through an authorized representative if you wish to exercise your rights under this section of your booklet. An authorized representative is someone you designate in writing to act on your behalf. BCBS has developed a form that you must use if you wish to designate an authorized representative. You can get the form by calling the BCBS Customer Service Department. You can also go to the BCBS internet website at www.bcbsal.com and request a copy of the form. You can also go to the BCBS web site at www.bcbsal.com and ask BCBS to mail you a copy of the form. If a person is not properly designated as your authorized representative, BCBS will not be able to deal with him or her in connection with the exercise of your rights under this section of your booklet.

For urgent pre-service claims, your provider is deemed to be your authorized representative unless you advise BCBS otherwise in writing.

Post-Service Claims

What Constitutes a Post-Service Claim?

For you to obtain benefits after medical services have been rendered or supplies purchased (a post-service claim), BCBS must receive a properly completed and filed claim from you or your provider. If BCBS receives a submission that does not qualify as a claim, it will notify you or your provider of the additional information needed. Once BCBS receives that information, it will process the submission as a claim.

In order for BCBS to treat a submission by you or your provider as a post-service claim, it must be submitted on a properly completed standardized claim form or, in the case of electronically filed claims, must provide BCBS with the data elements that BCBS specifies in advance. Most providers are aware of BCBS's claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call the BCBS customer



FILING A CLAIM, CLAIM DECISIONS, AND APPEAL OF BENEFIT DENIAL

The following explains the rules under LGHIP for filing claims and appeals with BCBS and for filing voluntary appeals with the SEIB. The procedures relating to pre-certification, pre-approval or review of certain benefits, including inpatient hospital benefits, private duty nursing, and certain surgical/diagnostic procedures, case management and certain predeterminations are explained in other sections of this booklet.

Filing of Claims Required

A claim prepared and submitted to BCBS must be received by BCBS before it can consider any claim for payment of benefits for services or supplies. In addition, there are certain services (such as Preadmission Certification and precertification of nursing services) that must be approved in advance before they will be recognized as benefits. No communications with BCBS by you, your provider, or anyone else about the existence or extent of coverage can be relied on by you or your provider or will be binding in any way on BCBS when the communications are made before the services or supplies are provided and a claim for them is submitted and received.

Who Files Claims

Providers of services who have agreements with BCBS generally prepare and submit claims directly to BCBS. Claims for services or supplies furnished to you by providers without agreements with BCBS must be prepared and submitted by either you or the provider. For services requiring preadmission or precertification requests and approvals, the responsibility and manner for submitting requests are mentioned previously.

Who Receives Payment

• BCBS agreements with some providers require it to pay benefits directly to them. On all other claims it may choose to pay either you or the provider. If you or the provider owes BCBS any sums, it may deduct from its benefit payment the amount that it is owed. Its payment to you or the provider (or deduction from payments to either) of amounts owed will be considered to satisfy its obligation to you. BCBS does not have to honor any assignment of your claim to anyone, including a provider. Nothing in the contract gives a provider the right to sue for recovery from BCBS for benefits payable under the contract.

• If you die or become incompetent or are a minor, BCBS pays your estate, your guardian or any relative that in its judgment is entitled to the payment. Payment of benefits to one of these people will satisfy its obligation to you.

How to File Claims

When you use your benefits, a claim must be filed before payment can be made. The LGHIP will pay for covered services you receive after the effective date of your coverage.

Hospital Benefits

In most cases, presenting your identification card is all you will need to establish credit for you and your dependents for admission to any hospital in Alabama and across the nation. Benefit payments are normally made to the hospital.

If care is received in a hospital outside of Alabama, reimbursement will be made through the Blue Cross Blue Card Program. If a hospital outside of Alabama does not file claims with BCBS, you should file the claim yourself directly to: Blue Cross Blue Shield, 450 Riverchase Parkway East, Birmingham, Alabama 35298.

Note: Preadmission Certification and Post Admission Review is required for all hospital admissions and for many outpatient diagnostic tests and surgeries. Ask your provider to contact BCBS at 1.800.551.2294.

service department and ask for a claim form. Tell BCBS the type of service or supply for which you wish to file a claim (for example, hospital, physician, or pharmacy), and BCBS will send you the proper type of claim form. When you receive the form, complete it, attach an itemized bill, and send it to BCBS at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858. Claims must be submitted and received by BCBS within 24 months after the service takes place to be eligible for benefits.

Processing of Claims

Even if BCBS has received all of the information needed to treat a submission as a claim, from time to time it might need additional information in order to determine whether the claim is payable. The most common example of this is medical records needed to determine whether services or supplies were medically necessary. If additional information is needed, BCBS will ask you to furnish it and will suspend further processing of your claim until the information is received. You will have 90 days to provide the information to BCBS. To expedite receipt of the information, BCBS may request it directly from your provider. BCBS will send you a copy of its request. However, you will remain responsible for seeing that BCBS gets the information on time.

Ordinarily, BCBS will notify you of the decision within 30 days of the date on which your claim is filed. If it is necessary to ask you for additional information, BCBS will notify you of its decision within 15 days if it receives the requested information. If BCBS does not receive the information, your claim will be considered denied at the expiration of the 90-day period BCBS gave you for furnishing the information.

In some cases, BCBS may ask for additional time to process your claim. If you do not wish to give BCBS additional time, it will go ahead and process your claim based on the information it has. This may result in a denial of your claim.

Pre-Service Claims

What is a Pre-Service Claim?

A pre-service claim is one in which you or your provider are required to obtain approval before services or supplies are rendered. For example, you may be required to obtain preadmission certification of inpatient hospital benefits. Or you may be required to obtain a pre-procedure review of other medical services or supplies in order to obtain coverage under the plan. Pre-service claims pertain only to the medical necessity of a service or supply. If BCBS grants a pre-service claim, BCBS is not telling you that the service or supply is, or will be, covered; BCBS is only telling you that the service or supply meets BCBS's medical necessity guidelines.

In order to file a pre-service claim with BCBS, you or your provider must call the BCBS Health Management Department at 205.988.2245 (in Birmingham) or 1.800.551.2294 (toll-free). You must give your contract number, the name of the facility in which you are being admitted (if applicable), the name of a person BCBS can call back, and a phone number to reach that person. You may also, if you wish, submit pre-service claims in writing. Written pre-service claims should be sent to Blue Cross at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858.

Non-urgent pre-service claims (for example, those relating to elective services and supplies) must be submitted to BCBS during its regular business hours. Urgent pre-service claims can be submitted at any time. Emergency admissions to a hospital do not require you to file a pre-service claim so long as you provide notice to BCBS within 48 hours of the admission and BCBS certifies the admission as both medically necessary and as an emergency admission. You are not required to pre-certify an inpatient hospital admission if you are admitted to a Concurrent Utilization Review Program (CURP) hospital by a Preferred Medical Doctor (PMD Physician). If your plan provides chiropractic, physical therapy, or occupational therapy benefits and you receive covered treatment from an in-network chiropractor, in-network physical therapist, or in-network occupational therapist, your provider is responsible for initiating the precertification process for you.

If you attempt to file a pre-service claim but fail to follow BCBS's procedures for doing so, BCBS will notify you of the failure within 24 hours (for urgent pre-service claims) or five days (for non-urgent pre-service claims). BCBS's notification may be oral, unless you ask for it in writing. BCBS will provide this notification to you only if (1) your attempt to submit a pre-service claim was received by a person or organizational unit of BCBS that is customarily responsible for handling benefit matters, and (2) your submission contains the name of a member, a specific medical condition or symptom, and a specific treatment or service for which approval is being requested.

Urgent Pre-Service Claims

BCBS will treat your claim as urgent if a delay in processing your claim could seriously jeopardize your life, health, or ability to regain maximum function or, in the opinion of your treating physician, a delay would subject you to severe pain that cannot be managed without the care or treatment that is the subject of your claim. If your treating physician indicates that your claim is urgent, BCBS will treat it as such.

If your claim is urgent, BCBS will notify you of the decision within 72 hours. If more information is needed, BCBS will let you know within 24 hours of your claim. BCBS will tell you what further information is needed. You will then have 48 hours to provide this information to BCBS. You will receive notice of the decision within 48 hours after BCBS receives the requested information. BCBS's response may be oral; if it is, BCBS will follow it up in writing. If the requested information is not received, your claim will be considered denied at the expiration of the 48-hour period you were given for furnishing the information.

Non-Urgent Pre-Service Claims

If your claim is not urgent, you will receive a decision within 15 days. If more information is needed, BCBS will let you know before the 15-day period expires. You will then have 90 days to provide needed information to BCBS. To expedite receipt of this information, BCBS may request it directly from your provider. However, you will remain responsible for seeing that the information is provided on time. You will be notified of the decision within 15 days after BCBS receives the requested information. If the requested information is not received, your claim will be considered denied at the expiration of the 90-day period you were given for furnishing the information.

Courtesy Pre-Determinations: For some procedures BCBS encourages, but does not require, you to contact BCBS before you have the procedure. For example, if you or your physician thinks a procedure might be excluded as cosmetic, you can ask BCBS to determine beforehand whether the procedure is cosmetic or reconstructive. BCBS calls this type of review a courtesy pre-determination. If you ask for a courtesy pre-determination, BCBS will do its best to provide you with a timely response. If BCBS decides that it cannot provide you with a courtesy pre-determination (for example, BCBS cannot get the information it needs to make an informed decision), BCBS will let you know. In either case, courtesy pre-determinations are not pre-service claims under the plan. When BCBS processes requests for courtesy pre-determinations, BCBS is not bound by the time frames and standards that apply to pre-service claims. In order to request a courtesy pre-determination, you or your provider should call the BCBS customer service department.

Concurrent Care Determinations

Determinations by BCBS to Limit or Reduce Previously Approved Care
If BCBS has previously approved a course of treatment to be provided over a period of time or number of treatments, and later decides to limit or reduce the previously approved course of treatment, BCBS will give you enough advance written notice to permit you to initiate an appeal and obtain a decision before the date on which care or treatments are no longer approved. You must follow any reasonable rules established for the filing of your appeal, such as time limits within which the appeal must be filed.

Requests by You to Extend Previously Approved Care

If a previously approved course of treatment is about to expire, you may submit a request to extend your approved care. You may make this request in writing or orally either directly to BCBS or through your treating physician. The phone numbers to call in order to request an extension of care are as follows:

- For inpatient hospital care, call 205-988-2245 or 1-800-248-2342 (toll-free).
- For in-network physical therapy or occupational therapy (if covered by your plan) call 205-220-7202.
- For care from an in-network chiropractor (if covered by your plan) call 205-220-7202.

If your request for additional care is urgent, and if you submit it no later than 24 hours before the end of your pre-approved stay or course of treatment, BCBS will give you its decision within 24 hours of when your request is submitted. If your request is not made before this 24 hour time frame, and your request is urgent, BCBS will give you its determination within 72 hours. If your request is not urgent, BCBS will treat it as a new claim for benefits.

- Any determination by BCBS with respect to a post-service claim that results in your owing any money to your provider other than co-payments you make, or are required to make, when you see your provider;
- The denial by BCBS of a pre-service claim; or,
- An adverse concurrent care determination (for example, BCBS denies your request to extend previously approved services).

In all cases other than determinations by BCBS to limit or reduce previously approved care, you have 180 days following an adverse benefit determination by BCBS within which to submit an appeal.

How to Appeal Post-Service Adverse Benefit Determinations

If you wish to file an appeal of an adverse benefit determination relating to a post-service claim, BCBS recommends that you use a form that it has developed for this purpose. The form will help you provide Blue Cross with the information that it needs to consider your appeal. To get the form, you should call the BCBS Customer Service Department. You may also go to the internet website at www.bcbsal.com. Once there, you may ask BCBS to send you a copy of the form.

If you choose not to use the BCBS appeal form, you may send BCBS a letter. Your letter must contain at least the following information:

- The patient's name;
- The patient's contract number;
- Sufficient information to reasonably identify the claim or claims being appealed, such as date of service, provider name, procedure (if known), and claim number (if available) (the best way to satisfy this requirement is to include a copy of your Claims Report with your appeal); and,
- A statement that you are filing an appeal.

You must send your appeal to the following address:

Blue Cross Blue Shield of Alabama
Attention: Customer Service Appeals
P.O. Box 12185
Birmingham, Alabama 35202-2185

Please note that if you call or write BCBS without following the rules just described for filing an appeal, BCBS will not treat your inquiry as an appeal. BCBS will, of course, use best efforts to resolve your questions or concerns.

How to Appeal Pre-Service Adverse Benefit Determinations

You may appeal an adverse benefit determination by BCBS relating to a pre-service claim in writing or over the phone. If over the phone, you should call the appropriate phone number listed below:

- For inpatient hospital care and admissions, call 205.988.2245 (in Birmingham) or 1.800.551.2294 (toll-free).
- For Preferred Physical Therapy or Occupational Therapy call 205.220.7202.
- For care from a Participating Chiropractor call 205.220.6128.

If in writing, you should send your letter to:

- For inpatient hospital care and admissions:
Blue Cross and Blue Shield of Alabama
Attention: Health Management – Appeals
P.O. Box 2504
Birmingham, Alabama 35201-2504

or

and will make a determination on your claim within the pre-service or post-service time frames discussed above, as appropriate.

Your Right to Information

You have the right, upon request, to receive copies of any documents that BCBS relied on in reaching its decision and any documents that were submitted, considered, or generated by BCBS in the course of reaching a decision. You also have the right to receive copies of any internal rules, guidelines, or protocols that BCBS may have relied upon in reaching the decision. If the decision was based on a medical or scientific determination (such as medical necessity), you may also request that BCBS provide you with a statement explaining its application of those medical and scientific principles to you. If BCBS obtained advice from a health care professional (regardless of whether it relied on that advice), you may request that BCBS give you the name of that person. Any request that you make for information under this paragraph must be in writing. BCBS will not charge you for any information that you request under this paragraph.

Member Satisfaction

If you are dissatisfied with the adverse benefit determination of a claim, you may file an appeal with BCBS. You cannot file a claim for benefits under the plan in federal or state court unless you exhaust these administrative remedies.

Customer Service

If you have questions about your coverage, or need additional information about how to file claims, you should contact BCBS. BCBS Customer Service (located in Birmingham) is open for phone inquiries from 8:00 a.m. to 5:00 p.m. Monday through Friday. The phone number is:

1.800.321.4391

When you call about a claim, be sure to have the following information available:

- Your contract number
- Name of your employer
- Date of service
- Name of the provider

BCBS also has a special 24 hours a day, 7 days a week, Customer Service request line, called Rapid Response, for you to use when you need claim forms and other printed materials relevant to your benefits.

Rapid Response is quick and easy to use, so we encourage you to use it when you need materials such as:

- Claim Forms
- Replacement ID Cards
- Brochures
- Benefit Booklets

A voice activated system will ask for your name, complete mailing address, daytime phone number, what materials you are requesting, how many you need, and the contract number from your ID card. If you know the BCBS form number, you can request the item by that number.

The numbers for Rapid Response are:

205.988.5401 in Birmingham or 1.800.248.5123 toll-free.

Your request is recorded and will be mailed to you the next working day if you answer all the questions completely. Allowing mailing time, you should receive your requested materials within 3-5 days (excluding weekends and holidays).

Blue Cross Blue Shield Appeals

In General

The rules in this section of the summary allow you or your authorized representative to appeal any adverse benefit determination by BCBS. An adverse benefit determination includes any one or more of the following:

- For in-network physical therapy, occupational therapy, or care from an in-network chiropractor:

Blue Cross Blue Shield of Alabama
Attention: Health Management – Appeals
P. O. Box 362025
Birmingham, Alabama 35236

Your written appeal should provide BCBS with your name, contract number, the name of the facility or provider involved, and the date or dates of service.

Please note that if you call or write BCBS without following the rules just described for filing an appeal, BCBS will not treat your inquiry as an appeal. BCBS will, of course, use best efforts to resolve your questions or concerns.

Conduct of the Appeal

BCBS will assign your appeal to one or more persons within the organization who are neither the persons who made the initial determination nor subordinates of those persons. If resolution of your appeal requires BCBS to make a medical judgment (such as whether services or supplies are medically necessary), BCBS will consult a health care professional who has appropriate expertise. If BCBS consulted a health care professional during its initial decision, it will not consult that same person or a subordinate of that person during our consideration of your appeal.

If BCBS needs more information, BCBS will ask you to provide it to them. In some cases BCBS may ask your provider to furnish that information directly to them. If so, BCBS will send you a copy of its request. However, you will remain responsible for seeing that BCBS gets the information. If BCBS does not get the information, it may be necessary for BCBS to deny your appeal.

BCBS will consider your appeal fully and fairly.

Time Limits for Consideration of Your Appeal

If your appeal arises from the denial of a post-service claim, BCBS will notify you of its decision within 60 days of the date on which you filed your appeal.

If your appeal arises from the denial of a pre-service claim, and if your claim is urgent, BCBS will consider your appeal and notify you of its decision within one business day or, if during a long weekend, within 72 hours. If your pre-service claim is not urgent, BCBS will give you a response within 30 days.

If your appeal arises out of a determination by BCBS to limit or reduce a course of treatment that was previously approved for a period of time or number of treatments, (see Concurrent Care Determinations above), BCBS will make a decision on your appeal as soon as possible, but in any event before it imposes the limit or reduction.

If your appeal relates to a decision not to extend a previously approved length of stay or course of treatment (see Concurrent Care Determinations above), BCBS will make a decision on your appeal within one business day or 72 hours if over a long weekend (in urgent pre-service cases), 30 days (in non-urgent pre-service cases), or 60 days (in post-service cases).

In some cases, BCBS may ask for additional time to process your appeal. If you do not wish to give BCBS additional time, they will go ahead and decide your appeal based on the information they have. This may result in a denial of your appeal.

If You Are Dissatisfied After Exhausting your Mandatory Plan Administrative Remedies

If you have filed an appeal and are dissatisfied with the response, you may do one or more of the following:

- You may ask the BCBS Customer Service Department for further help; or
- You may file a voluntary appeal (discussed below); or
- You may file a claim for external review for a claim involving medical judgment or rescission of your plan coverage (discussed below).

Voluntary Appeals: If BCBS has given you its appeal decision and you are still dissatisfied, you may file a second appeal (called a voluntary appeal). If your voluntary appeal relates to a pre-service adverse benefit determination,

you may file your appeal in writing or over the phone. If over the phone, you should call the phone number you called to submit your first appeal. If in writing, you should send your letter to the same address you used when you submitted your first appeal. Your written appeal must state that you are filing a voluntary appeal.

If you file a voluntary appeal (whether oral or written), BCBS will not assert in court a failure to exhaust administrative remedies if you fail to exhaust the voluntary appeal. BCBS will also agree that any defense based upon timeliness or statutes of limitations will be tolled during the time that your voluntary appeal is pending. In addition, BCBS will not impose any fees or costs on you as part of your voluntary appeal. You may ask BCBS to provide you with more information about voluntary appeals. This additional information will allow you to make an informed judgment about whether to request a voluntary appeal.

External Reviews

For claims involving medical judgment and/or rescissions of coverage, you may also file a request with BCBS for an independent, external review of our decision. You must request this external review within 4 months of the date of your receipt of our adverse benefit determination or final adverse appeal determination. Your request for an external review must be in writing, must state you are filing a request for external review, and must be submitted to the following address:

Blue Cross and Blue Shield of Alabama
Attention: Customer Service Appeals
P.O. Box 10744, Birmingham, AL 35202-0744.

If you request an external review, an independent organization will review our decision. You may submit additional written comments to the review organization. Once your external review is initiated, you will receive instructions about how to do this. If you give the review organization additional information, the review organization will give BCBS copies of this additional information to give BCBS an opportunity to reconsider its denial. Both you and BCBS will be notified in writing of the review organization's decision. The decision of the review organization will be final and binding on both you and BCBS.

Expedited External Reviews for Urgent Pre-Service Claims

If your pre-service claim meets the definition of urgent under law, the external review of your claim will be conducted as expeditiously as possible. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe that your pre-service claim is urgent you may request an external review by calling BCBS at 1-800-551-2294 (toll-free) or by faxing your request to 205-220-0833 or 1-877-506-3110 (toll-free).



SEIB APPEALS PROCESS

General Information

Members of the LGHIP have a right to question the decisions of the State Employees' Insurance Board (SEIB). However, all issues regarding benefit determinations should be addressed through the BCBS appeal process. Issues involving eligibility and enrollment must be addressed directly with the SEIB.

Informal Review

If you feel that an enrollment or eligibility ruling was not in conformity with the rules and procedures of the LGHIP or, after exhausting all administrative procedures with BCBS you still feel that the LGHIP's benefits were incorrectly applied, you may then contact the SEIB for an Informal Review. In many cases the problem can be handled over the phone through the Informal Review process without the need for a Formal Review or appeal.

Administrative Review

If you are unsatisfied with the Informal review decision, you may then request an administrative review. All requests for administrative review must be submitted to the SEIB legal department. If it is determined by the SEIB that an administrative review is merited, you will be sent a form LG06 to complete and return to the SEIB. Receipt of your Administrative Review will be acknowledged by returning a copy of the received form to you.

An administrative review request must be received in the SEIB office within 60 days following receipt of the final notice of a partial or total denial of your claim from BCBS, or within 60 days of the receipt of the enrollment for eligibility ruling of the SEIB. A copy of the decision of the BCBS or the SEIB ruling must be attached to the Administrative Review request form. Upon receipt of the completed form, the Administrative Review Committee will review the grievance usually within sixty (60) days. Oral arguments will not be considered in an Administrative Review unless approved by the SEIB. The Administrative Review Committee shall issue a decision in writing to all parties involved in the grievance.

Note: Decisions of the claims administrator and/or the utilization review administrator will be reviewed to determine if the review was conducted in a fair and equitable manner. Medical decisions will not be questioned.

Formal Appeal

If you do not agree with the response to your Administrative Review, you may file a request for a Formal Appeal before the Board of Directors. Requests for a Formal Appeal must be received in the SEIB office within 60 days following the date of the Administrative Review decision.

The subject of a Formal Appeal shall be limited to exclusions or exceptions to coverage based on extenuating or extraordinary circumstances, or policy issues not recently addressed or previously contemplated by the Board.

If your request for a Formal Appeal is granted, generally, a decision will be issued within ninety (90) days following the date the request for Formal Appeal was approved. The number of days may be extended by notice from the SEIB. The decision by the Board is the final step in the administrative proceedings and will exhaust all administrative remedies.

Items That Will Not Be Reviewed Under the Administrative Review or Formal Appeal Process:

- Medical Necessity
- Cosmetic Surgery
- Investigational Related Services
- Custodial Care
- Allowed Amounts

If you have not received a decision or notice of extension of the Administrative Review or Formal Appeal within 90 days, you may consider your request denied.



DEFINITIONS

Accidental Injury: A traumatic injury to you caused solely by an accident that occurs while you are covered by the contract.

Affordable Care Act: The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Educational Reconciliation Act, and its implementing rules and regulations.

Allowed Amount: Benefit payments for covered services are based on the amount of the provider's charge that BCBS recognizes for payment of benefits. This amount is limited to the lesser of the provider's charge for care or the amount of that charge that is determined by BCBS to be allowable depending on the type of provider utilized and the state in which services are rendered, as described below:

In-Network Providers: Blue Cross and/or Blue Shield plans contract with providers to furnish care for a negotiated price. This negotiated price is often a discounted rate, and the in-network provider normally accepts this rate (subject to any applicable copayments, coinsurance, or deductibles that are the responsibility of the patient) as payment in full for covered care. The negotiated price applies only to services that are covered under the plan and also covered under the contract that has been signed with the in-network provider.

Each local Blue Cross and/or Blue Shield plan determines (1) which of the providers in its service area will be considered in-network providers, (2) which subset of those providers will be considered BlueCard PPO providers, and (3) the services or supplies that are covered under the contract between the local Blue Cross and/or Blue Shield plan and the provider.

See "Out-of-Area Services," earlier in this booklet, for a description of the contracting arrangements that exist outside the state of Alabama.

Out-of-Network Providers: The allowed amount for care rendered by out-of-network providers is often determined by the Blue Cross and/or Blue Shield plan where services are rendered. This amount may be based on the negotiated rate payable to in-network providers or may be based on the average charge for the care in the area. In other cases, Blue Cross and Blue Shield of Alabama determines the allowed amount using historical data and information from various sources such as, but not limited to:

- The charge or average charge for the same or a similar service;
- Pricing data from the local Blue Cross and/or Blue Shield plan where services are rendered;
- The relative complexity of the service;
- The in-network allowance in Alabama for the same or a similar service;
- Applicable state healthcare factors;
- The rate of inflation using a recognized measure; and,
- Other reasonable limits, as may be required with respect to outpatient prescription drug costs.

For services provided by an out-of-network provider, the provider may bill the member for charges in excess of the allowed amount. The allowed amount will not exceed the amount of the provider's charge.

For emergency services for medical emergencies provided within the emergency room department of an out-of-network hospital, the allowed amount will be determined in accordance with the requirements of the Patient Protection and Affordable Care Act.

Alternative Benefits: A benefit program that gives you and your family an alternative to lengthy hospitalizations. It is designed to provide the patient with the best environment for recovery and in the most cost effective long-term arrangement. Also known as "Comprehensive Managed Care" and "Individual Case Management." This program is administered by BCBS.

Ambulatory Surgical Center: A facility that provides surgical services on an outpatient basis for patients who do not need to occupy an inpatient, acute care hospital bed. In order to be considered an ambulatory surgical facility under the plan, the facility must meet the conditions for participation in Medicare.

Assisted Reproductive Technology (ART): Any combination of chemical and/or mechanical means of obtaining gametes and placing them into a medium (whether internal or external to the human body) to enhance the chance that reproduction will occur. Examples of ART include, but are not limited to, In vitro fertilization, gamete intra fallopian transfer, zygote intra-fallopian transfer, pro-nuclear stage tubal transfer, artificial insemination and/or intrauterine insemination.

BCBS: Blue Cross Blue Shield of Alabama.

Blue Card Program: An arrangement among Blue Cross Plans whereby a member of one Blue Cross Plan receives benefits available through another Blue Cross Plan located in the area where services occur.

Blue Cross Blue Shield of Alabama: The company chosen by the State Employees' Insurance Board, through competitive bid, to process benefit claims filed by members (also referred to as BCBS) and to administer your Utilization Review Program such as Preadmission Certification and Individual Case Management.

Certification of Medical Necessity: The written results of BCBS's review using recognized medical criteria to determine whether a member requires treatment in the hospital before he is admitted, or within 48 hours of the next business day after the admission in the case of emergency admissions. Certification of medical necessity means only that a hospital admission is medically necessary to treat your condition. Certification of medical necessity does not consider whether your admission is excluded by the LGHIP.

Chiropractic Fee Schedule: The schedule of Chiropractic procedures and fee amounts for those procedures under the Participating Chiropractic benefits that is on file at the Claims Administrator's office.

Claims Administrator: The company chosen by the State Employees' Insurance Board, through competitive bid, to process benefit claims filed by members. The Claims Administrator is BCBS.

COBRA: See the explanation in the "Termination of Coverage" section of this booklet.

Concurrent Utilization Review Program (CURP): A program implemented by BCBS and In-network hospitals in the Alabama service area to simplify the administration of preadmission certifications and concurrent utilization reviews.

Cosmetic Surgery: Any surgical procedure that primarily improves or changes appearance and does not primarily improve physical bodily functions or correct deformities resulting from disease, trauma or congenital anomalies. For further information on "Cosmetic Surgery," see the "Exclusions" section.

Custodial Care: Care primarily for the purpose of providing room and board (with or without routine nursing care, training in personal hygiene and other forms of self care or supervisory care by a provider) for a person who is mentally or physically disabled. Custodial care does not include specific medical, surgical or psychiatric treatment that would reduce a member's disability to the extent necessary to enable him to live outside an institution providing medical care.

Dependent: See explanation in the "Eligibility and Enrollment Section".

Diagnostic: Services performed in response to signs or symptoms of illness, condition, or disease or in some cases where there is family history of illness, condition, or disease.

Durable Medical Equipment: Equipment approved by BCBS as medically necessary to diagnose or treat an illness or injury or to prevent a condition from becoming worse. To be durable medical equipment an item must be (a) made to withstand repeated use, (b) mainly for a medical purpose rather than for comfort or convenience, (c) useful only if you are sick or injured, (d) related to your condition and prescribed by your physician for your use in your home, and (e) determined by BCBS to be medically necessary to diagnose or treat your illness or injury, help a malformed part of your body work better, or keep your condition from becoming worse.

Effective Date: The date on which the coverage of each individual member begins as listed in the State Employees' Insurance Board records.

Elective Abortion: An abortion performed for reasons other than the compromised physical health of the mother, severe chromosomal or fetal deformity, or conception due to incest or rape.

Emergency Treatment: Treatment rendered in a hospital, clinic or doctor's office for an injury or illness that requires immediate care or treatment, and must be performed within 48 hours after the injury is sustained or the illness first becomes manifest. A condition that requires immediate care or treatment means only a permanent health-threatening condition. The condition must be one for which failure to receive care or treatment could result in deterioration to the point where the patient's permanent health would be in jeopardy, bodily functions would be significantly impaired, or serious dysfunction would occur in any organ or other part of the patient's body. Emergency treatment includes ambulance service to the facility where treatment is received.

Employee: See explanation in the "Eligibility and Enrollment Section".

Family Coverage: Coverage for an employee and one or more dependents.

Fee Schedule: The schedule of medical and surgical procedures and the fee amounts for those procedures under the Preferred Medical Doctor program and other Preferred Provider programs as applicable.

Home Health Coverage: Skilled nursing visits ordered by a physician, rendered in a patient's home by a Registered Nurse or Licensed Practical Nurse and billed by a home health agency. Any pre-certification requirements and/or any specified benefit maximums are applicable to the skilled nursing visits only. Other services included are home infusion therapy and medications administered by a home health agency. Services such as speech therapy, occupational therapy and physical therapy may be billed by a home health agency; however, they are considered under the major medical/other covered services portion of the contract and not considered under home health coverage.

Home Plan: The BCBS Plan that providers or subscribers send claims to when the subscriber receives medical care in a different Plan's geographic area. A group's Home Plan is the Plan that has control of the group.

Hospice Coverage: Hospice service includes supplies or drugs included in the daily fee for hospice care rendered by a hospice provider to a terminally ill member when a physician certifies the member's life expectancy to be less than six months.

Hospital: A Participating or Non-Participating hospital as defined in this section.

Host Plan: The BCBS Plan associated with the provider that furnishes services to a subscriber from a different Plan. It is a Plan that helps the Home Plan service the group.

Implantables: An implantable device is a biocompatible mechanical device, biomedical material, or therapeutic agent that is implanted in whole or in part and serves to support or replace a biological structure, support and/or enhance the command and control of a biological process, or provide a therapeutic effect. Examples include, but are not limited to, cochlear implants, neurostimulators, indwelling orthopedic devices, cultured tissues, tissue markers, radioactive seeds, and infusion pumps.

In-Network Provider: A provider is considered to be an in-network provider if, and only to the extent that, the provider is furnishing a service or supply that is specified as an in-network benefit under the terms of the contract between the provider and the Blue Cross and/or Blue Shield plan (or its affiliates). Examples include BlueCard

2014 LOCAL GOVERNMENT HEALTH INSURANCE PLAN

67

Medically Necessary or Medical Necessity: BCBS uses these terms to help determine whether a particular service or supply will be covered. When possible, BCBS will develop written criteria (called medical criteria) that BCBS will use to determine medical necessity. BCBS bases these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. BCBS puts these medical criteria in policies that BCBS make available to the medical community and our members. BCBS does this so that you and your providers will know in advance, when possible, what BCBS will pay for. If a service or supply is not medically necessary according to one of BCBS's published medical criteria policies, BCBS will not pay for it. If a service or supply is not addressed by one of BCBS's published medical criteria policies, BCBS will consider it to be medically necessary only if BCBS determines that it is:

- Appropriate and necessary for the symptoms, diagnosis, or treatment of your medical condition;
- Provided for the diagnosis or direct care and treatment of your medical condition;
- In accordance with standards of good medical practice accepted by the organized medical community;
- Not primarily for the convenience and/or comfort of you, your family, your physician, or another provider of services;
- Not "investigational"; and,
- Performed in the least costly setting, method, or manner, or with the least costly supplies, required by your medical condition. A "setting" may be your home, a physician's office, an ambulatory surgical facility, a hospital's outpatient department, a hospital when you are an inpatient, or another type of facility providing a lesser level of care. Only your medical condition is considered in deciding which setting is medically necessary. Your financial or family situation, the distance you live from a hospital or other facility, or any other non-medical factor is not considered. As your medical condition changes, the setting you need may also change. Ask your physician if any of your services can be performed on an outpatient basis or in a less costly setting.

It is important for you to remember that when BCBS makes medical necessity determinations, BCBS is making them solely for the purpose of determining whether to pay for a medical service or supply. All decisions concerning your treatment must be made solely by your attending physician and other medical providers.

Medicare: The Health insurance for the Aged Program under Title XVIII of the Social Security Act (P.L. 89-97) as amended.

Member: An active/retired local government unit employee or eligible dependent who has coverage under the LGHIP and whose application for coverage under the contract is made and accepted by the State Employees' Insurance Board. A member is also a former dependent and/or employee eligible for and covered under COBRA. Elected officers of the local government unit are eligible for coverage while they are in office.

Mental Health Preferred Provider Organization: Those providers who have contracted with the State Employees' Insurance Board (SEIB) through the Certified Community Mental Health Center (CMHC) to provide certain mental health and substance abuse services.

Mental Health Disorders and Substance Abuse: These are mental disorders, mental illness, psychiatric illness, mental conditions, and psychiatric conditions. These disorders, illnesses, and conditions are considered mental health disorders and substance abuse whether they are of organic, biological, chemical, or genetic origin. They are considered mental health disorders and substance abuse regardless of how they are caused, based, or brought on. Mental health disorders and substance abuse include, but are not limited to, psychoses, neuroses, schizophrenic-affective disorders, personality disorders, and psychological or behavioral abnormalities associated with temporary or permanent dysfunction of the brain or related system of hormones controlled by nerves. They are generally intended to include disorders, conditions, and illnesses listed in the current Diagnostic and Statistical Manual of Mental Disorders.

Non-Participating Chiropractor: A Doctor of Chiropractic (DC) who is not a Participating Chiropractor.

2014 LOCAL GOVERNMENT HEALTH INSURANCE PLAN

69

PPO providers, Preferred Medical Doctors (PMD physicians), and Participating Pharmacies. A provider will be considered an in-network provider only if the local Blue Cross and/or Blue Shield plan designates the provider as a BlueCard PPO provider for the service or supply being furnished. This means that if you receive a service or supply from a provider that has a contractual relationship with a Blue Cross and/or Blue Shield plan but is not designated by the local Blue Cross and/or Blue Shield plan as a BlueCard PPO provider, we will pay at the out-of-network level of benefits.

Inpatient: A registered bed patient in a hospital; provided that we reserve the right in appropriate cases to reclassify inpatient stays as outpatient services, as explained above in "Inpatient Hospital Benefits" and "Outpatient Hospital Benefits."

Investigational: Any treatment, procedure, facility, equipment, drugs, drug usage, or supplies that either BCBS has not recognized as having scientifically established medical value, or that does not meet generally accepted standards of medical practice. When possible, BCBS will develop written criteria (called medical criteria) concerning services or supplies that BCBS considers to be investigational. BCBS bases these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. BCBS puts these medical criteria in policies that BCBS makes available to the medical community and our members. BCBS does this so that you and your providers will know in advance, when possible, what BCBS will pay for. If a service or supply is considered investigational according to one of BCBS's published medical criteria policies, BCBS will not pay for it. If the investigational nature of a service or supply is not addressed by one of BCBS's published medical criteria policies, BCBS will consider it to be non-investigational only if the following requirements are met:

- The technology must have final approval from the appropriate government regulatory bodies;
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
- The technology must improve the net health outcome;
- The technology must be as beneficial as any established alternatives; and,
- The improvement must be attainable outside the investigational setting.

It is important for you to remember that when BCBS makes determinations about the investigational nature of a service or supply BCBS is making them solely for the purpose of determining whether to pay for the service or supply. All decisions concerning your treatment must be made solely by your attending physician and other medical providers.

Local Government Health Insurance Plan (LGHIP): A self-insured health benefit plan administered by the State Employees' Insurance Board.

Local Government Unit: Any agency of the state, any county, any municipality, any municipal foundation, any fire or water district, or authority, or cooperative, any regional planning and development commission, the Association of County Commissions of Alabama, the Alabama League of Municipalities, the Alabama Retired State Employees' Association, the Alabama State Employees Credit Union, Easter Seals Alabama, Alabama State University, the Alabama Rural Water Association, Rainbow Omega, Inc., the ARC of Alabama, Inc. and any of the affiliated local chapters of the ARC of Alabama, Inc., United Ways of Alabama and its member United Ways, the Alabama Network of Children's Advocacy Centers and its member Children's Advocacy Centers, any railroad authority, or any solid waste disposal authority organized pursuant to the Code of Alabama, 1975, Section 36-29-14, as last amended.

Management Program: A program known as "Baby Yourself" is administered by BCBS that offers a mechanism for identifying high-risk pregnancies and completely managing them to prevent complications at the time of delivery.

Medical Emergency: A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

68

2014 LOCAL GOVERNMENT HEALTH INSURANCE PLAN

Non-Participating Hospital: Any hospital (other than a Participating Hospital) that has been approved by the Alabama Hospital Association or the American Hospital Association as a "general" hospital or meets the requirements of the American Hospital Association for registration or classification as a "general medical and surgical" hospital. "General" hospitals do not include those classified or classifiable under standards of the American Hospital Association as "special" hospitals, such as those classified as for psychiatric, alcoholism and other chemical dependency, rehabilitation, mental retardation, chronic disease, or any other specialty. "General" hospitals also do not include facilities primarily for convalescent care or rest or for the aged, school or college infirmaries, sanatoria, or nursing homes.

Non-Participating Pharmacy: Any pharmacy which is not a BCBS Participating Pharmacy.

Non-PPO Provider: Any provider that is not a PPO Provider with any Blue Cross and/or Blue Shield Plan.

Non-Preferred Home Health Care Agency: Any home health care agency that is not a Preferred Home Health Care Agency.

Non-Preferred Hospice: Any hospice that is not a Preferred Hospice.

Officer: An elected official of the local government unit.

Out-of-Area Mental Health Benefits: Benefits for mental health services, including services for chemical dependency, if the subscriber lives permanently outside of Alabama and the subscriber or his dependents or both receive treatment outside Alabama.

Open Enrollment: The annual open enrollment period is held each November for a January 1 effective date.

Out-of-Network Provider: A provider who is not an in-network provider.

Participating Ambulatory Surgical Facility: Any facility with which BCBS has a contract for furnishing health care services.

Participating Chiropractor: A Doctor of Chiropractic that has a contract with the Claims Administrator for the furnishing of chiropractic services.

Participating Hospital: Any hospital with which the Claims Administrator (BCBS) has a contract for furnishing health care services.

Participating Pharmacy: Any pharmacy with which Blue Cross Blue Shield of Alabama has a contract for providing pharmacy services.

Participating Renal Dialysis Facility: Any free-standing hemodialysis facility with which Blue Cross Blue Shield of Alabama has a contract for furnishing health care services.

Physician: Any healthcare provider when licensed and acting within the scope of that license or certification at the time and place you are treated or receive services.

Plan Administrator: The State Employees' Insurance Board.

Plan Sponsor: The State of Alabama.

Preadmission Certification and Post-admission Review: The procedures used to determine whether a member requires treatment as a hospital inpatient prior to a member's admission, or by the next business day after the admission in the case of emergency admissions, based upon medically recognized criteria. The program is administered by BCBS.

PPO: Preferred Provider Organization.

70

2014 LOCAL GOVERNMENT HEALTH INSURANCE PLAN

PPD Allowance: The amount that any Blue Cross and/or Blue Shield Plan has agreed to pay its PPD Provider for plan benefits.

PPD Fee Schedule: The schedule of medical and surgical procedures and the fee amounts for those procedures under the Preferred Medical Provider program and other Preferred Provider programs as applicable.

Preferred Care: A program whereby providers have agreements with Blue Cross Blue Shield of Alabama to furnish certain medically necessary services and supplies according to an agreed upon fee schedule for medical and surgical procedures, such services and supplies to members entitled to benefits under the Preferred Care program.

Preferred Provider: Any provider of health care services or supplies when licensed and acting within the scope of that license at the time and place you are treated and receive services (such as a Preferred Physician, Preferred Medical Laboratory, Preferred Outpatient Facility, Preferred Physician Assistant or Preferred Nurse Practitioner Provider) who has an agreement with Blue Cross Blue Shield of Alabama to furnish services or supplies to members entitled to benefits under the Preferred Care program.

Pregnancy: The condition of and complications arising from a woman having a fertilized ovum, embryo or fetus in her body - usually, but not always - in the uterus, lasting from the time of conception to the time of childbirth, abortion, miscarriage or other termination.

Preventive or Routine: Services performed prior to the onset of signs or symptoms of illness, condition or disease or services which are not diagnostic.

Private Duty Nursing: A session of four or more hours during which continuous skilled nursing care is furnished to you alone.

Psychiatric Specialty Hospital: An institution that is classified as a psychiatric specialty facility by such relevant credentialing organizations as BCBS or any Blue Cross and/or Blue Shield plan (or its affiliates) determines. A psychiatric specialty hospital does not include a substance abuse facility.

Skilled Nursing Facility: Any Medicare participating skilled nursing facility which provides non-acute care for patients needing skilled nursing services 24 hours a day. This facility must be staffed and equipped to perform skilled nursing care and other related health services. A skilled nursing facility does not provide custodial or part-time care.

Substance Abuse: The uncontrollable or excessive abuse of addictive substances, such as (but not limited to) alcohol, drugs, or other chemicals and the resultant physiological and/or psychological dependency that develops with continued use.

Substance Abuse Facility: Any institution that is classified as a substance abuse facility by such relevant credentialing organizations as BCBS or any Blue Cross and/or Blue Shield plan (or its affiliates) determine and that solely provides residential and/or outpatient substance abuse rehabilitation services.

Retired Employee: See explanation in the "Eligibility and Enrollment Section".

Semi-Private Room Accommodations: A hospital room containing 2, 3 or 4 beds.

Special Care Unit: A specially equipped unit, set aside as a distinct patient care area, staffed and equipped to treat seriously ill patients requiring extraordinary care on a concentrated and continuous basis. Some examples are intensive care, coronary care, or burn care units.

State Employees' Insurance Board: The State agency charged with the administration of the LGHIP Program. This agency is also referred to as SEIB.

Subscriber: The individual whose application for coverage is made and accepted.

Teleconsultation: Consultation, evaluation, and management services provided to patients via telecommunication systems without personal face-to-face interaction between the patient and healthcare provider. Teleconsultations include consultations by e-mail or other electronic means.

Total Disability: The complete inability of an active employee to perform any and every duty pertaining to his occupation or employment, or the complete inability of a retired employee or a dependent to perform the normal activities of a person of like age and sex.

Urgent-Care Center: A primary care provider that provides professional services by a licensed provider in a clinic setting, not requiring an appointment, and offering services outside traditional office hours.

Utilization Review Administrator: The company chosen by the State Employees' Insurance Board to administer your Utilization Review Program such as Preadmission Certification and Individual Case Management. The Utilization Review Administrator is BCBS.

We, Us, Our: BCBS, the SEIB or the LGHIP as shown by the context.

You, Your: The contract holder or member as shown by the context.

**Local Government Health Insurance Program
Benefit Plan Administered By:**

State Employees' Insurance Board
Post Office Box 504900
Montgomery, Alabama 36150-4900

Phone: 554.265.8526
Toll-Free: 1.866.836.9137
Web site: www.staelb.org

**Claims Administrator
& Utilization Management**

Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35298

Customer Service: 1.800.521.4391
Rapid Response: 1.800.248.5125
Fraud Hot Line: 1.800.824.4391
Baby Yourself Maternity Program: 1.800.551.2294
Case Management: 1.800.551.2294
Medical/Surgical Precertification: 1.800.551.2294
Web site: www.bcbsal.com

Local Government Dental Benefit Plan



Local Government Plan
Effective January 1, 2014



INTRODUCTION

This summary of dental benefits available is designed to help you understand your coverage. This booklet supplements the Local Government Health Insurance Plan booklet. Both booklets must be used in conjunction when determining the terms, conditions and limitations of your dental benefits. However, not all terms, conditions and limitations are covered in these booklets. All benefits are subject to the terms, conditions and limitations of the contract or contracts between the State Employees Insurance Board (SEIB) and Blue Cross Blue Shield of Alabama or other third party administrators that the SEIB may contract with that it deems is necessary to carry out its statutory obligations. Copies of all contracts are kept on file at the SEIB office and are available for review. The SEIB shall have absolute discretion and authority to interpret the terms and conditions of the plan and reserves the right to change the terms and conditions and/or end the plan at any time and for any reason.

Local Government Health Insurance Plan Dental Benefits Administered By:

State Employees' Insurance Board
Post Office Box 304900
Montgomery, Alabama 36130-4900
Phone: (334) 263.8326
Toll-Free: 1.866.836.9137
Website: www.alseib.org

Claims Administrator

Blue Cross Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35298
Customer Service: 1.800.321.4391
Rapid Response: 1.800.248.5123
Fraud Hot Line: 1.800.824.4391
Website: www.bcbsal.com

TABLE OF CONTENTS

OVERVIEW OF THE PLAN	1
Purpose of the Plan.....	1
Using myBlueCross to Get More Information over the Internet.....	1
Definitions.....	1
Receipt of Dental Care.....	1
Beginning of Coverage.....	1
Limitations and Exclusions.....	1
Dental Necessity.....	1
In-Network Benefits.....	2
Relationship between Blue Cross and/or Blue Shield Plans and the Blue Cross and Blue Shield Association.....	2
Claims and Appeals.....	2
Termination of Coverage.....	2
SUMMARY OF BENEFITS	3
BENEFIT CONDITIONS	4
COST SHARING	5
Calendar Year Out-of-Pocket Maximum for In-Network Dental Services for Children Up to Age 19.....	5
Calendar Year Maximum Benefits.....	5
Other Cost Sharing Provisions.....	5
DENTAL BENEFITS	6
Basic – Diagnostic and Preventive Services.....	6
Basic – Restorative Services.....	6
Supplemental Services.....	7
Prosthetic Services.....	7
Periodontic Services.....	7
Orthodontic Services.....	7
DENTAL BENEFIT LIMITATIONS	9
DENTAL BENEFIT EXCLUSIONS	10
FILING A CLAIM	12
Filing of Claims Required.....	12
Who Files Claims.....	12
Who Receives Payment.....	12
How to File Claims.....	12
Pre-Determination of Benefits for Bridgework, Crowns, Onlays and Osseous Surgery.....	12
When Claims Must Be Submitted.....	13
Receipt and Processing Claims.....	13
Post-Service Claims.....	13
What Constitutes a Post-Service Claim.....	13
Processing of Claims.....	13
Courtesy Pre-Determination of Treatment Plan.....	13
DEFINITIONS	15

OVERVIEW OF THE PLAN

The following provisions of this booklet contain a summary in English of your rights and benefits under the plan. If you have questions about your benefits, please contact Customer Service at 1-800-292-8868. If needed, simply request a Spanish translator and one will be provided to assist you in understanding your benefits.

Atención por favor

Este folleto contiene un resumen en inglés de sus beneficios y derechos del plan. Si tiene alguna pregunta acerca de sus beneficios, por favor póngase en contacto con el departamento de Servicio al Cliente llamando al 1-800-292-8868. Solicite simplemente un intérprete de español y se proporcionará uno para que le ayude a entender sus beneficios.

Purpose of the Plan

The dental benefits offered through the Local Government Health Insurance Plan (LGHIP) are intended to help you and your covered dependents pay for the costs of dental care. The LGHIP does not pay for all of your dental care. For example, you may also be required to pay deductibles and coinsurance.

Using myBlueCross to Get More information over the Internet

Blue Cross and Blue Shield of Alabama's home page on the internet is www.bcbsal.com. If you visit, you will see a section of our home page called myBlueCross. Registering for myBlueCross is easy and secure. Once you have registered, you will have access to information and forms that will help you take maximum advantage of your benefits under the LGHIP.

Definitions

Near the end of this booklet you will find a section called "Definitions," which identifies words and phrases that have specialized or particular meanings. In order to make this booklet more readable, we generally do not use initial capitalized letters to denote defined terms. Please take the time to familiarize yourself with these definitions so that you will understand your benefits.

Receipt of Dental Care

Even if the LGHIP does not provide benefits, you and your provider may decide that care and treatment are necessary. You and your provider are responsible for making this decision.

Beginning of Coverage

To be eligible for dental benefits, you must be enrolled in the LGHIP.

Limitations and Exclusions

The LGHIP contains a number of provisions that limit or exclude benefits for certain services and supplies, even if dentally necessary. You need to be aware of these limits and exclusions in order to take maximum advantage of your benefits.

Dental Necessity

The LGHIP will only pay for care that is dentally necessary and not investigational, as determined by us. The definitions of dental necessity and investigational are found in the "Definitions" section of this booklet.

SUMMARY OF BENEFITS

In-Network Benefits

One way in which the LGHIP tries to manage dental care costs and provide enhanced dental benefits is through negotiated discounts with in-network dentists. In-network dentists are dentists that contract with Blue Cross and Blue Shield of Alabama (directly or indirectly) for furnishing dental care services at a reduced price. Preferred Dentists are in-network dentists in the state of Alabama. National Dental Network (Dentemax) are in-network dentists located outside the state of Alabama. To locate in-network dentists for the LGHIP, go to www.bcsal.com. Assuming the services are covered, you will normally only be responsible for out-of-pocket costs such as deductibles and coinsurance when using in-network dentists.

If you receive covered services or supplies from an out-of-network dentist, in most cases, you will have to pay significantly more than what you would pay an in-network dentist because these out-of-network dental care providers can bill you amounts in excess of the allowable amounts under the LGHIP.

Relationship between Blue Cross and/or Blue Shield Plans and the Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Alabama is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. The Blue Cross and Blue Shield Association permits us to use the Blue Cross and Blue Shield service marks in the state of Alabama. Blue Cross and Blue Shield of Alabama is not acting as an agent of the Blue Cross and Blue Shield Association. No representation is made that any organization other than Blue Cross and Blue Shield of Alabama and your employer will be responsible for honoring this contract. The purpose of this paragraph is for legal clarification; it does not add additional obligations on the part of Blue Cross and Blue Shield of Alabama not created under the original agreement.

Claims and Appeals

When you receive services from in-network dentists, your dentist will generally file claims for you. In other cases, you may be required to pay the provider and then file a claim with us for reimbursement under the terms of the LGHIP. If we deny a claim in whole or in part, you may file an appeal with us. We will give you a full and fair review.

Termination of Coverage

If coverage terminates, no benefits will be provided thereafter, even if for a condition that began before the LGHIP or your coverage termination. In some cases you will have the opportunity to buy COBRA coverage after your group coverage terminates.

PREFERRED DENTAL BENEFITS		
BENEFITS	PREFERRED	NON-PREFERRED
Deductible	\$25 per member each calendar year; maximum of three deductibles per family.	\$25 per member each calendar year; maximum of three deductibles per family. Member responsible for any difference between billed charge and fee schedule reimbursement.
Diagnostic & Preventive Services	Covered at 100% of the Preferred Dental Fee Schedule with no deductible.	Covered at 100% of the Preferred Dental Fee Schedule with no deductible. Member responsible for any difference between billed charge and fee schedule reimbursement.
Basic & Major Services (Fillings, Oral Surgery, Periodontics, Endodontics, Prosthodontics)	Covered at 50% of the Preferred Dental Fee Schedule subject to a \$25 annual deductible.	Covered at 50% of the Preferred Dental Fee Schedule subject to a \$25 annual deductible. Member responsible for any difference between billed charge and fee schedule reimbursement.
Orthodontic Services	Covered at 50% of the Preferred Dental Fee Schedule subject to a \$25 annual deductible. No dollar limit for medically necessary services for members under age 19. All other services limited to a separate lifetime maximum of \$1,000 per person for Dependent Children under age 19 <u>only</u> .	Covered at 50% of the Preferred Dental Fee Schedule subject to a \$25 annual deductible. No dollar limit for medically necessary services for members under age 19. All other services limited to a separate lifetime maximum of \$1,000 per person for Dependent Children under age 19 <u>only</u> . Member responsible for difference in billed charges and allowed fee schedule.
Annual Benefit Maximum	No maximum for members under age 19. \$1,500 per member age 19 and over for all covered services.	
Annual Out-of-Pocket Maximum	For members under age 19, deductibles and coinsurance for in-network (preferred) dental services will apply to the annual health in-network out-of-pocket maximum.	

This is not a contract. Benefits are subject to the terms, limitations and conditions of the group contract.

2

3

BENEFIT CONDITIONS

To qualify as plan benefits, dental services and supplies must meet the following:

- They must be furnished after your coverage becomes effective.
- BCBS must determine before, during, or after services and supplies are furnished that they are dentally necessary.
- Preferred Dentist benefits must be furnished while you are covered by the LGHIP and the provider must be a Preferred Dentist when the services are furnished to you.
- Separate and apart from the requirement in the previous paragraph, services and supplies must be furnished by a provider (whether Preferred Provider or not) who is recognized by Blue Cross as an approved provider for the type of service or supply being furnished. Call Blue Cross Customer Services if you have any question whether your provider is recognized by Blue Cross as an approved provider for the services or supplies you plan on receiving.
- Services and supplies must be furnished when the LGHIP and your coverage are both in effect and fully paid for. No benefits will be provided for services you receive after the LGHIP or your coverage ends, even if they are for a condition that began before the LGHIP or your coverage ends.

COST SHARING

Calendar Year Deductible	\$25 (Does not apply to diagnostic and preventive services.)
Calendar Year Out-of-Pocket Maximum for In-Network Benefits for children up to age 19 only	\$6,250 per member \$12,500 aggregate per family (This is a combined maximum applicable in-network cost-sharing for health and dental services for children up to age 19 <u>only</u> .)
Calendar Year Maximum Benefits for Adults (ages 19 and over)	\$1,500 (does not apply to orthodontic services)

Calendar Year Out-of-Pocket Maximum for In-Network Dental Services for Children Up to Age 19

The calendar year out-of-pocket maximum for in-network dental services for children up to age 19 is specified in the table above. Cost-sharing amounts for in-network services incurred under the health and dental plan are combined for children up to age 19. (Please refer to the LGHIP document for a description of applicable cost-sharing amounts for health services.) Only in-network cost-sharing amounts (calendar year deductible and coinsurance) for covered services for children up to age 19 apply to the calendar year out-of-pocket maximum.

Once the calendar year out-of-pocket maximum has been reached, children up to age 19 will no longer be subject to in-network cost-sharing for affected in-network covered health and dental services for the remainder of the calendar year (we will pay 100% of the allowable amount for the remainder of the calendar year).

Calendar Year Maximum Benefits

Charges applied toward annual and/or lifetime maximums incurred by you or your covered dependents age 19 and over while covered under another Blue Cross dental contract issued through your same employer or group will be applied toward the annual and/or lifetime maximums under this contract.

Other Cost Sharing Provisions

The LGHIP may impose other types of cost sharing requirements such as the following:

Coinurance: Coinsurance is the amount that you must pay as a percent of the allowable amount.

Amount in excess of the allowable amount: As a general rule, the allowable amount may often be less than the dentist's actual charges. When you receive benefits from an out-of-network dentist, you may be responsible for paying the dentist's charges in excess of the allowable amount.

4

5

DENTAL BENEFITS

The LGHIP's dental network is Preferred Dentist. We pay benefits toward the lesser of the allowable amount or the dentist's actual charge for services whether you receive services from an in-network or out-of-network dentist. There are three differences:

- All in-network dentists agree our payment is payment in full except for your deductible and coinsurance. If you are covered under another group dental plan, an in-network dentist may bill that plan for any difference between the allowable amount and his usual charge for a service.
- Out-of-network dentists may charge you the difference between the allowable amount and their billed charges.
- In-network dentists may not collect their fee for plan benefits from you except for deductibles and coinsurance. They must bill us first except for services which are not plan benefits, such as implants.

SERVICE	BENEFIT
Basic – Diagnostic and Preventive Services	100%

- Dental exams, up to twice per calendar year.
- Dental X-ray exams:
 - o Full mouth X-rays, one set during any 36 months in a row;
 - o Bitewing X-rays, up to twice per calendar year; and
 - o Other dental X-rays, used to diagnose a specific condition.
- Tooth sealants on 1st permanent molars, teeth numbers 3, 14, 19 and 30, limited to two application per tooth per benefit period. Benefits are limited to a maximum payment of \$20 per tooth and limited to children under age 19.
- Fluoride treatment for children through age 18, twice per calendar year.
- Routine cleanings, twice per calendar year.
- Space maintainers (not made of precious metals) that replace prematurely lost teeth for children through age 18.

SERVICE	BENEFIT
Basic – Restorative Services	50%

- Fillings made of silver amalgam and tooth color materials (tooth color materials include composite fillings on the front upper and lower teeth numbers 5-12 and 21-28; payment allowance for composite fillings used on posterior teeth is reduced to the allowance given on amalgam fillings).
- Simple tooth extractions.
- Direct pulp capping, removal of pulp, and root canal treatment.
- Repairs to removable dentures.
- Emergency treatment for pain.

6

Exclusions and limitations on orthodontic benefits:

- The benefits for orthodontic services shall be paid only for months that you have orthodontic coverage. There are no benefits for orthodontic services to you before your coverage by this contract is in effect. If you started orthodontic services before this coverage began and complete them while covered, we'll prorate the benefits for the services you actually get while covered.
- Any charge for the replacement and/or repair of any appliance furnished under the treatment plan shall not be paid.

8

SERVICE	BENEFIT
Supplemental Services	50%

- Oral surgery, i.e., tooth extractions and impacted teeth and to treat mouth abscesses of the intra-oral and extra-oral soft tissue.
- General anesthesia when given for oral or dental surgery. This means drugs injected or inhaled to relax you or lessen the pain, or make you unconscious, but not analgesics, drugs given by local infiltration, or nitrous oxide.
- Treatment of the root tip of the tooth including its removal.

SERVICE	BENEFIT
Prosthetic Services	50%

- Full or partial dentures.
- Fixed or removable bridges.
- Inlays, onlays, veneers, or crowns to restore diseased or accidentally broken teeth, if less expensive fillings will not restore the teeth.

Limits on prosthetic services:

- Partial dentures – If a removable partial denture can restore the upper or lower dental arch satisfactorily, we will pay as though it were supplied even if you chose a more expensive means.
- Precision attachments – There are no benefits for precision attachments.
- Dentures – We pay only toward standard dentures.
- Replacement of existing dentures, fixed bridgework, veneers, or crowns – We pay toward replacing an existing denture, fixed bridgework, veneer, or crown only if the old one can't be fixed. If one can be fixed, we will pay toward fixing it (this includes repairs to fixed dentures). We only pay to replace these items every five years.
- There are no benefits to replace lost or stolen items.

SERVICE	BENEFIT
Periodontic Services	50%

- Periodontic exams twice each 12 months.
- Removal of diseased gum tissue and reconstructing gums.
- Removal of diseased bone.
- Reconstruction of gums and mucous membranes by surgery.
- Removing plaque and calculus below the gum line for periodontal disease.

SERVICE	BENEFIT
Orthodontic Services Limited to a per member lifetime maximum of \$1,000	Covered at 50% of the Preferred Dental Fee Schedule subject to a Subject to a \$25 annual deductible. Limited to a separate lifetime maximum of \$1,000 per person for Dependent Children under age 19 only.

Orthodontic benefits are provided for the initial and subsequent treatment and installation of orthodontic equipment.

7

DENTAL BENEFIT LIMITATIONS

Limits to all benefits:

- Examination and diagnosis no more than twice during any calendar year.
- Full mouth X-rays will be provided once each 36 months; bitewings no more than twice during any calendar year.
- Routine cleaning will be provided no more than twice during any calendar year.
- Fluoride treatment will be provided to members through age 18 no more than twice during any calendar year.
- Tooth sealants on 1st permanent molars, teeth numbers 3, 14, 19 and 30, limited to two application per tooth per benefit period. Benefits are limited to a maximum payment of \$20 per tooth and limited to children under age 19.
- If you change dentists while being treated, or if two or more dentists do one procedure, we'll pay no more than if one dentist did all the work.
- When there are two ways to treat you and both would otherwise be plan benefits, we'll pay toward the less expensive one. The dentist may charge you for any excess.
- Prosthetic – Cold, baked porcelain restorations, veneers, crowns and jackets – If a tooth can be restored with a material such as amalgam, we'll pay toward that procedure even if a more expensive means is used.
- Prosthetic – Payment will be made toward eliminating oral disease and replacing missing teeth.

9

DENTAL BENEFIT EXCLUSIONS

The following benefits will not be provided:

- A** Anesthetic services performed by and billed for by a dentist other than the attending dentist or his assistant.
- A** Appliances or restorations to alter vertical dimensions from its present state or restoring the occlusion. Such procedures include but are not limited to equilibration, periodontal splinting, full mouth rehabilitation, restoration of tooth structure lost from the grinding of teeth or the wearing down of the teeth and restoration from the mal-alignment of teeth. This does not apply to covered orthodontic services.
- B** Dental services to the extent coverage is available to the member under any other Blue Cross and Blue Shield contract.
- Dental services for which you are not charged.
- C** Services or expenses for intraoral delivery of or treatment by chemotherapeutic agents. Services or expenses for which a claim is not properly submitted.
- Services or expenses of any kind either (a) for which a claim submitted for a member in the form prescribed by Blue Cross has not been received by Blue Cross, or (b) for which a claim is received by Blue Cross later than 12 months after the date services were performed.
- Services or expenses of any kind for complications resulting from services received that are not covered benefits under this contract.
- Services or expenses for treatment of injury sustained in the commission of a crime (except for treatment of injury as a result of a medical condition or as a result of domestic violence) or for treatment while confined in a prison, jail, or other penal institution.
- D** Dental care or treatment not specifically identified as a covered dental expense.
- Dental services you receive before your effective date of coverage, or after your effective date of termination.
- Dental services you receive from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, a labor union, trustee or similar person or group.
- M** Charges to use any facility such as a hospital in which dental services are rendered, whether the use of such a facility was dentally necessary.
- M** Charges for your failure to keep a scheduled visit with the dentist.

10

FILING A CLAIM

The following explains the rules under the LGHIP for filing dental claims with Blue Cross.

Filing of Claims Required

A claim prepared and submitted to Blue Cross must be received by Blue Cross before it can consider any claim for payment of benefits for services or supplies. In addition, there are certain services that must be approved by BCBS in advance before they will be recognized as benefits. No communications with Blue Cross by you, your provider, or anyone else about the existence or extent of coverage can be relied on by you or your provider or will be binding in any way on Blue Cross when the communications are made before the services or supplies are provided and a claim for them is submitted and received.

Who Files Claims

Providers of services who have agreements with Blue Cross generally prepare and submit claims directly to BCBS. Claims for services or supplies furnished to you by providers without agreements with BCBS must be prepared and submitted by either you or the provider.

Who Receives Payment

Blue Cross' agreements with some providers require it to pay benefits directly to them. On all other claims it may choose to pay either you or the provider. If you or the provider owes BCBS any sums, it may deduct from its benefit payment the amount that it is owed. Its payment to you or the provider (or deduction from payments to either) of amounts owed will be considered to satisfy its obligation to you. Blue Cross does not have to honor any assignment of your claim to anyone, including a provider.

Nothing in the contract gives a provider the right to sue for recovery from BCBS for benefits payable under the contract.

If you die or become incompetent or are a minor, Blue Cross pays your estate, your guardian or any relative that, in its judgment, is entitled to the payment. Payment of benefits to one of these people will satisfy its obligation to you.

How to File Claims

When you use your benefits, a claim must be filed before payment can be made. The LGHIP will pay for covered services you receive after the effective date of your coverage.

Pre-determination of Benefits for Bridgework, Crowns, Onlays and Inlays and Osseous Surgery

Your dental plan includes a provision for pre-determination of benefits for bridgework, crowns, onlays and inlays and osseous surgery. The purpose of pre-determination of benefits is to assure you and the dentist that the proposed dental treatment is covered. If a patient expects to incur charges for one of the services listed above or for periodontic or prosthetic services (excluding full and partial dentures) in excess of \$500, a Request for Pre-Determination of Benefits should be filed by the dentist on a dental claim form. The treatment plan along with pre-operative radiographs should be submitted to BCBS.

Include the findings of the oral examination, recommended course of treatment, and other information to identify the services to be rendered. Verification is then made as to the availability of these benefits under the dental plan and you and the dentist are notified in advance of treatment.

Preferred Dentists will file your dental claims when dental work is completed. Preferred Dentists are provided claim forms by BCBS to use in filing your claims.

However, if your dentist is not a Preferred Dentist, you may have to file the claim yourself by completing a dental claim form. Send the completed form to BCBS, Attention: Dental Claims Department. Be sure to have your dentist complete his portion of the form and sign the claim.

12

G Gold foil restorations.

Charges for implants.

I Charges for infection control.

Any dental treatment or procedure, drugs, drug usage, equipment, or supplies that is investigational, including services that are part of a clinical trial.

L Services or expenses covered in whole or in part under the laws of the United States, any state, county, city, town or other governmental agency that provide or pay for care, through insurance or any other means. This applies even if the law does not cover all your expenses.

M Dental services with respect to malformations from birth or primarily for appearance.

N Services or expenses of any kind, if not required by a dentist, or if not dentally necessary.

O Charges for oral hygiene and dietary information.

Charges for dental care or treatment by a person other than the attending dentist unless the treatment is rendered under the direct supervision of the attending dentist.

P Charges for plaque control program.

R Services of a dentist rendered to a member who is related to the dentist by blood or marriage or who regularly resides in the dentist's household.

W Dental services or expenses in cases covered in whole or in part by workers' compensation or employers' liability laws, state or federal. This applies whether you fail to file a claim under that law, it applies whether the law is enforced against or assumed by the employer. It applies whether the law provides for dental services as such. Finally, it applies whether your employer has insurance coverage for benefits under the law.

11

When Claims Must Be Submitted

All claims for benefits must be submitted properly by you or your provider of services within 365 days of the date you receive the services or supplies. Claims not submitted and received by BCBS within this 365-day period will not be considered for payment of benefits.

Receipt and Processing Claims

Claims for dental benefits are always post-service.

You must act on your own behalf or through an authorized representative if you wish to exercise your rights under this section of your booklet. An authorized representative is someone you designate in writing to act on your behalf. BCBS has developed a form that you must use if you wish to designate an authorized representative. You can also go to the BCBS internet web site at www.bcbsal.com and ask BCBS to mail you a copy of the form. If a person is not properly designated as your authorized representative, BCBS will not be able to deal with him or her in connection with the exercise of your rights under this section of your booklet.

Post-Service Claims

What Constitutes a Post-Service Claim? For you to obtain benefits after dental services have been rendered or supplies purchased (a post-service claim), BCBS must receive a properly completed and filed claim from you or your provider.

In order for BCBS to treat a submission by you or your provider as a post-service claim, it must be submitted on a properly completed standardized claim form or, in the case of electronically filed claims, must provide BCBS with the data elements that BCBS specifies in advance. Most providers are aware of BCBS' claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call the BCBS customer service department and ask for a claim form. When you receive the form, complete it, attach an itemized bill, and send it to BCBS at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858. Claims must be submitted and received by BCBS within 12 months after the service takes place to be eligible for benefits.

If BCBS receives a submission that does not qualify as a claim, it will notify you or your provider of the additional information needed. Once BCBS receives that information, it will process the submission as a claim.

Processing of Claims: Even if BCBS has received all of the information needed to treat a submission as a claim, from time to time it might need additional information in order to determine whether the claim is payable. The most common example of this is dental records needed to determine whether services or supplies were dentally necessary. If additional information is needed, BCBS will ask you to furnish it, and will suspend further processing of your claim until the information is received. You will have 90 days to provide the information to BCBS. To expedite receipt of the information, BCBS may request it directly from your provider. BCBS will send you a copy of its request. However, you will remain responsible for seeing that BCBS gets the information on time.

Ordinarily, BCBS will notify you of the decision within 30 days of the date on which your claim is filed. If it is necessary to ask you for additional information, BCBS will notify you of its decision within 15 days after it receives the requested information. If BCBS does not receive the information, your claim will be considered denied at the expiration of the 90-day period BCBS gave you for furnishing the information.

In some cases, BCBS may ask for additional time to process your claim. If you do not wish to give BCBS additional time, it will go ahead and process your claim based on the information it has. This may result in a denial of your claim.

Courtesy Pre-Determinations of Treatment Plan: We encourage, but do not require, you or your provider to submit a treatment plan to BCBS for a courtesy pre-determination of benefits. If you ask for a courtesy pre-determination of a treatment plan, BCBS will do its best to provide you with a timely response. If BCBS decides that it cannot provide you with a courtesy pre-determination (for example, we cannot get the

13

information BCBS needs to make an informed decision), BCBS will let you know. In either case, courtesy pre-determinations are not claims under the LGHIP. When BCBS processes requests for courtesy pre-determinations, BCBS is not bound by the time frames and standards that apply to claims.

DEFINITIONS

Allowable Amount: The amount of a dentist's charge that Blue Cross will recognize as covered expenses for medically/dentally necessary services provided by the LGHIP. This amount is generally limited to the lesser of the dentist's charge for care or the fee for a procedure in the in-network dentists' fee schedule. In-network dentists normally accept this allowable amount (subject to any applicable copayments, coinsurance, or deductibles that are the responsibility of the patient) as payment in full for covered services. Out-of-network dentists may bill the member for charges in excess of the allowable amount.

Blue Cross Blue Shield of Alabama: Company chosen by the SEIB, through competitive bid, to process benefit claims filed by members (also referred to as BCBS).

Claims Administrator: The Company chosen by the SEIB, through competitive bid, to process benefit claims filed by members. The Claims Administrator is BCBS.

Dental Necessity: Services or supplies that are necessary to treat your illness, injury, or symptom. To be dentally necessary, services or supplies must be determined by BCBS to be:

- appropriate and necessary for the symptoms, diagnosis, or treatment of your dental condition;
- provided for the diagnosis or direct care and treatment of your dental condition;
- in accordance with standards of direct care and treatment of your dental condition;
- in accordance with standards of good dental practice accepted by the organized dental community;
- not primarily for the convenience and/or comfort of you, your family, your dentist, or another provider of services;
- is not "investigational."

Dentist: One of the following when licensed and when acting within the scope of his license at the time and place where the service is rendered: Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.).

Effective Date: The date on which the coverage of each individual member begins as listed in the SEIB records.

Family Coverage: Coverage for an employee and one or more dependents.

investigational: Any treatment, procedure, facility, equipment, drugs, drug usage, or supplies that either BCBS has not recognized as having scientifically established medical value, or that does not meet generally accepted standards of medical practice. When possible, BCBS will develop written criteria (called medical criteria) concerning services or supplies that BCBS considers to be investigational. BCBS bases these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. BCBS puts these medical criteria in policies that BCBS makes available to the medical community and our members. BCBS does this so that you and your providers will know in advance, when possible, what BCBS will pay for. If a service or supply is considered investigational according to one of BCBS's published medical criteria policies, BCBS will not pay for it. If the investigational nature of a service or supply is not addressed by one of BCBS's published medical criteria policies, BCBS will consider it to be non-investigational only if the following requirements are met:

- The technology must have final approval from the appropriate government regulatory bodies;
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
- The technology must improve the net health outcome;
- The technology must be as beneficial as any established alternatives; and,

14

15

- The improvement must be attainable outside the investigational setting.

It is important for you to remember that when BCBS makes determinations about the investigational nature of a service or supply BCBS is making them solely for the purpose of determining whether to pay for the service or supply. All decisions concerning your treatment must be made solely by your attending physician and other medical providers.

Local Government Health Insurance Plan (LGHIP): A self-insured benefit plan administered by the State Employees' Insurance Board.

Out-of-network dentist: A dentist licensed to practice dentistry in any state who is not an in-network dentist.

State Employees' Insurance Board (SEIB): The State agency charged with the administration of the dental benefit plan for state employees and their dependents. This agency is also referred to as SEIB.

Subscriber: The individual whose application for coverage is made and accepted.

We, Us, Our: BCBS, the LGHIP or SEIB as shown by the context.

You, Your: The contract holder or member as shown by the context.

Local Government Dental Benefit Plan Administered By:

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

Phone: 334.265.8526
Toll-Free: 1.866.856.9137
Web site: www.alaelb.org

Claims Administrator

Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35298

Customer Service: 1.800.321.4391
Rapid Response: 1.800.248.5125
Fraud Hot Line: 1.800.824.4391
Web site: www.bcbsal.com

16

EXHIBIT B

**Description of any State Law, Investment Policy
or other Guidelines or Limitations Relating to Investments**

(attached)

RESOLUTION NO. 09-053

BE IT RESOLVED by the City Council of the City of Mountain Brook, Alabama, that the City's investment policy (as previously adopted by Resolution No. 01-354 dated October 22, 2001) is hereby amended as follows:

"CITY OF MOUNTAIN BROOK, ALABAMA INVESTMENT POLICY STATEMENT

1. Policy

It is the policy of the City of Mountain Brook, Alabama ("City") to invest public funds in a manner which maximizes return and provides maximum security in preserving and protecting funds while meeting the daily cash flow demands on the Treasury and conforming to all applicable federal, state and/or local statutes governing the investment of public funds.

2. Scope

This investment policy applies to all financial assets of the City except those (if any) which are governed in another manner by specific reference in federal, state and/or local statutes. All assets to which this policy applies are accounted for in the City's books and accounting records and include:

- A. General Fund
- B. Special Revenue Funds
- C. Debt Service Funds
- D. Capital Project Funds
- E. Any other existing or newly created fund, unless specifically exempted.
- F. Any Sec. 115 trust established for retiree welfare benefits pursuant to GASB 45

3. Maturities

All investments of current operating funds shall have a maturity of not greater than two years. All investments of capital projects, reserve, trust and agency, and debt service funds shall have a maturity of not greater than five years provided that the maturity of such funds is made to coincide as nearly as practicable with the expected use of the funds. Lesser, more restrictive, maturities may apply as specifically stated elsewhere in this policy.

4. Prudence

The standard of prudence to be used by investment staff shall be the "prudent person rule," which obligates a fiduciary to ensure that:

... Investments shall be made with the exercise to that degree of judgement and care, under circumstances then prevailing, which persons of prudence, discretion, and intelligence exercise in the management of their own affairs, not for speculation but for investment, considering the probable safety of their capital as well as the probable income to be derived.

5. Delegation of Authority

Unless investments are held in trust or otherwise managed by an investment manager under contract with the City, the responsibility for the City's investment program is held by the Finance Director who shall establish, monitor, evaluate, and devise procedures for the operation of the investment program consistent with this investment policy. The trustee or investment manager under contract with the City shall be responsible for managing the trust investments in accordance with a trust and/or investment management agreement. The Finance Director shall be responsible for all transactions undertaken and shall establish a system of controls to regulate the investment activities of all authorized officials including subordinate delegates.

6. Objectives

The primary objectives (in priority order) of the City's investment activities shall be:

A. **Safety.** Safety of principal is the foremost objective of the City. Investments of the City shall be undertaken in a manner that seeks to ensure the preservation and protection of capital in the overall portfolio. To attain this objective, diversification shall be utilized to hedge against potential losses to in the portfolio.

B. **Liquidity.** The City's investment portfolio will remain sufficiently liquid to enable the City to meet all operating requirements which might be reasonably anticipated. This policy mandates that appropriate forecasting of receipts and disbursements be developed and/or maintained to facilitate the knowledge of liquidity needs.

C. **Return on Investments.** The City's investment portfolio shall be designed with the objective of attaining at least a market rate of return throughout budgetary and economic cycles, taking into account the City's investment risk constraints and the cash flow characteristics of the portfolio. The Finance Committee, from time to time, may adopt benchmarks for use in making performance comparisons. The benchmark rate (or rates) should be a widely accepted, published rate (or rates) for a portfolio (or multiple portfolios) whose investments and/or investment structure (or structures) is reasonably similar to that of the City's portfolio taking into account the levels of investment.

7. Reporting

The Finance Director is charged with the responsibility of preparing a quarterly investment report within forty (40) days of each quarter end for presentation to the Mayor, City Council, and Finance Committee. Within forty (40) days after the end of the fiscal year, the Finance Director is may be required to present a comprehensive annual report on the investment program for insertion into the Comprehensive Annual Financial Report (CAFR) of the City. The annual investment program report may include suggested policies and/or recommendations for improving procedures, operations and controls to assure the continuation of a prudent, productive investment program for public funds managed by and for the Treasury of the City.

8. Qualifications of brokers, investment companies, and depositories

Municipal funds may only be invested with companies registered under the Investment Company Act of 1940, FDIC (or similar federal insuring agency) member financial institutions, or registered broker/dealers.

9. Investment instruments, terms and conditions, authorized and permitted by this policy are as follows:

A. As provided in §11-81-19 and §11-81-21 of the Code of Alabama, the City may invest in direct obligations of the Department of Treasury of the United States of America and/or obligations of certain federal agencies which represent the full faith and credit of the United States (including obligations issued or held in book entry form):

1. The maximum time period from date of acquisition to maturity of securities may not exceed five (5) years.

2. Up to one hundred percent (100%) of the portfolio may be invested in direct obligations of the U.S. Government or federal agencies thereof in accordance with §11-81-19 and §11-81-21 of the Code of Alabama.

B. Certificates of Deposit and other evidences of deposit at state and federally chartered and insured banks and savings and loan associations up to amounts which are fully insured to the holder by the FDIC or similar federal insuring agency or which are fully collateralized in accordance with standards applicable to secured deposits of the State of Alabama.

10. Safekeeping and Custody

Securities are to be delivered to and held in an account entitled City of Mountain Brook or in the legal name of the City's trust, if applicable. Securities may be held in book entry form by the City's custodian agent. The custodian agent is to be selected and designated by the Finance Director and/or Treasurer. Release of the securities by the custodian agent may be accomplished only by appropriate release executed by the Finance Director or Treasurer.

11. Internal Controls

The City Manager shall be responsible for establishing a process of independent review of the investment program by an external auditor. This review should include the internal control(s) and an assessment of whether the appropriate policies and procedures are being established and complied with. Such review may specifically result in recommendations to change operating procedures to improve internal control(s).

12. Performance Standards

The City of Mountain Brook investment program will be designed to obtain a market average rate of return during budgetary and economic cycles, taking into account the City's investment risk constraints and cash flow needs. The basis used by the Finance Director and Treasurer to determine whether market yields are being achieved in the portfolio shall be the average of the three-month United States Treasury bill rates for the equivalent comparison and/or reporting period(s). This calculated

benchmark rate is intended to comprise a minimum standard with actual performance typically exceeding this threshold.

13. Periodic Review

This investment policy may be reviewed periodically in its entirety by the Finance Committee. The review process shall not inhibit desirable modifications to the policy at other times during the year. Any modifications of to the policy shall be submitted to the City Council for approval.

14. The following policy will apply to acquisitions of any of the above authorized securities:

A. Securities shall be purchased through authorized broker/dealers for the security to be acquired.

B. All transactions will be executed on a delivery versus payment basis. Due bills or notes are not acceptable as collateral in lieu of the purchased security.

C. All transactions will be traded in U.S. dollars.

D. Reverse repurchase agreements are prohibited.

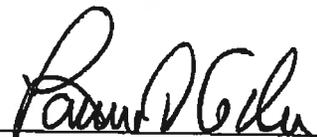
E. No securities will be purchased on margin and no short sales of securities will be made."

ADOPTED: This 27th day of April, 2009.



Virginia C. Smith, Council President

APPROVED: This 27th day of April, 2009.



Lawrence T. Oden, Mayor

CERTIFICATION

I, Steven Boone, City Clerk of the City of Mountain Brook, Alabama hereby certify the above to be a true and correct copy of a resolution adopted by the City Council of the City of Mountain Brook at its meeting held on April 27, 2009, as same appears in the minutes or record of said meeting.



Steven Boone, City Clerk

Section 11-81-19

Investment of sinking funds generally; reports as to investment or deposit of sinking funds; contracts for purchase of savings certificates.

All sinking funds provided for the retirement of bonds shall be invested in bonds of such subdivision or in bonds of the United States or in bonds of the State of Alabama or in bonds of any county in the State of Alabama or any municipal corporation of the State of Alabama, or deposited in a bank on interest; provided, however, that the proceedings authorizing any funding or refunding bonds may prohibit the investment of the sinking fund for such bonds and require that such sinking fund shall be used exclusively in the purchase for retirement or in the redemption of such funding or refunding bonds.

All sinking funds created by resolutions or ordinance heretofore adopted must be properly set aside each year in accordance with the resolution or ordinance providing for the same and a report made thereof and filed with the clerk of the municipality or with the probate judge of the county, as the case may be, showing in detail how said sinking fund is invested or deposited.

All contracts now in effect for purchasing savings certificates under the law as it heretofore existed shall continue as legal investments.

(Acts 1927, No. 478, p. 534; Acts 1935, No. 195, p. 575; Code 1940, T. 37, §265.)

EXHIBIT A

Section 11-81-21**Investment of funds obligation in which sinking funds may be invested.**

Any municipal funds or county funds not presently needed for other purposes may be invested in any obligations in which sinking funds are now authorized to be invested, pursuant to Section 11-81-19, and in addition in any of the following:

- (1) Direct obligations of (including obligations issued or held in book entry form on the books of) the Department of the Treasury of the United States of America;
- (2) Obligations of any of the following federal agencies, which obligations represent the full faith and credit of the United States of America:
 - a. Farmers Home Administration.
 - b. General Services Administration.
 - c. U. S. Maritime Administration.
 - d. Small Business Administration.
 - e. Government National Mortgage Association (GNMA).
 - f. U. S. Department of Housing and Urban Development (HUD).
 - g. Federal Housing Administration (FHA).
- (3) U. S. dollar denominated deposit accounts and certificates of deposit with banks or savings associations which are qualified public depositories under Chapter 14A of Title 41.
- (4) Pre-refunded public obligations, defined as follows:

Any bonds or other obligations of any state of the United States of America or of any agency, instrumentality or local governmental unit of any such state (i) which are not callable at the option of the obligor prior to maturity or as to which irrevocable notice has been given by the obligor to call on the date specified in the notice, and (ii) which are fully secured as to principal and interest and redemption premium, if any, by a fund consisting only of cash or obligations described in subdivision (1) above, which fund may be applied only to the payment of such principal of and interest and redemption premium, if any, on such bonds or other obligations on the maturity date or dates thereof or the specified redemption date or dates pursuant to such irrevocable instructions, as appropriate, and (iii) which fund is sufficient, as verified by an independent certified public accountant, to pay principal of and interest and redemption, if any, on the bonds or other obligations described in this paragraph on the maturity date or dates thereof or on the redemption date or dates specified in the irrevocable instructions referred to in subclause (i) of this paragraph, as appropriate, and (iv) which are rated, based on the escrow, in the highest rating category of Standard & Poor's Corporation and Moody's Investors Service, Inc., or any successors thereto.

- (5) Interests, however evidenced, in any common trust fund or other collective investment fund maintained by any national or state chartered bank, trust company or savings association having trust powers, or securities of or other interests in any open-end or closed-end management type investment company or investment trust registered under the Investment Company Act of 1940, as from time to time amended, so long as all of the following requirements are met at the time of purchase and during the term of investment: (i) At least 65% of the portfolio of such common trust fund, collective investment fund or investment company or investment trust

must consist of investments authorized in subdivisions (1), (2), (3), or (4) above, and (ii) the remainder of the portfolio (if any, but not more than 35%) may consist only of the following investments: (x) obligations issued or guaranteed by the following agencies: Federal National Mortgage Association (FNMA), Federal Home Loan Mortgage Corporation (FHLMC), including FNMA, and FHLMC participation certificates, Federal Land Banks, Central Bank for Cooperatives, Federal Intermediate Credit Banks, Student Loan Marketing Association, and Federal Home Loan Banks, (y) mortgage related securities (as that term is defined in Section 3 (a) (41) of the Securities Exchange Act of 1934 (15 U.S.C. 78c(a) (41)), or (z) repurchase agreements fully collateralized by obligations, securities or investments otherwise authorized under subdivisions 5(i)-(ii), so long as the common trust fund, collective investment fund, investment company or investment trust takes possession and delivery of the collateral for any repurchase agreement either directly or through an authorized custodian. The fact that any financial institution making such investment on behalf of the municipality or county, or any affiliate of such financial institution, is providing services to the investment company or investment trust as an investment advisor, sponsor, distributor, custodian, transfer agent, registrar, or otherwise, and is receiving reasonable remuneration for such services, shall not preclude such institution from making the investment in the securities of such investment company or investment trust; provided, however, that with respect to any account for municipal funds or county funds to which fees are charged for such services, the said financial institution shall disclose (by prospectus, account statement or otherwise) to the beneficiary of such account or to any third party directing investments the basis (expressed as a percentage of asset value or otherwise) upon which the fee is calculated.

The terms "municipal funds" and "county funds" as used in this section shall include all general, special, permanent, trust and other funds, regardless of source or purpose, held or administered by any county, city or town, or by any officer or agency thereof, in the State of Alabama.

Investments of municipal funds or county funds shall be made by the officer or agency controlling their disposition. Such county, city or town, or official or agency thereof, may at any time sell such obligations purchased pursuant to this section, and the money received from such sale and the interest and profits on such investment shall be credited to the fund from which the investment was made. Any such obligation may be deposited for safekeeping with any bank, trust company or savings association organized either under the laws of the State of Alabama or of the United States.

(Acts 1943, No. 246, p. 203; Acts 1975, No. 1120, §1; Acts 1989, No. 89-655, p. 1298, §1; Acts 1990, No. 90-481, p. 708; Acts 1991, No. 91-482, p. 872, §1; Acts 1993, No. 93-340, p. 523, §1; Act 2000-748, p. 1669, §2).

EXHIBIT A

RESOLUTION NO. 2015-004

BE IT RESOLVED by the City Council of the City of Mountain Brook, Alabama, that the City Council hereby authorizes the execution a Notice of Assignment, in the form as attached hereto as Exhibit A, with respect to the assignment by Ajlouny Investments, LLC of its Development Agreement (2014-070) and Parking Agreement (2014-072) as collateral for its Iberia Bank loan.

ADOPTED: This ____ day of January 2015.

Council President

APPROVED: This ____ day of January 2015.

Mayor

CERTIFICATION

I, Steven Boone, City Clerk of the City of the City of Mountain Brook, Alabama, hereby certify the above to be a true and correct copy of a resolution adopted by the City Council of the City of Mountain Brook at its meeting held on January ____, 2015, as same appears in the minutes of record of said meeting.

City Clerk



Sirote & Permutt, PC
2311 Highland Avenue South
Birmingham, AL 35205-2972

PO Box 55727
Birmingham, AL 35255-5727

Joseph T. Ritchey
Attorney at Law
jritchey@sirote.com
Tel: 205-930-5292
Fax: 205-212-3813

December 26, 2014

VIA HAND DELIVERY

Whit Colvin, Esq.
Bishop, Colvin, Johnson & Kent, LLC
1910 First Avenue North
Birmingham, Alabama 35203

Re: Ajlouny Investments, LLC / Iberia Bank

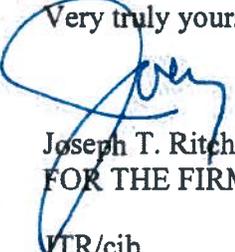
Dear Whit:

Enclosed please find two execution copies of the Notice of Assignment between Ajlouny Investments, LLC and the City of Mountain Brook, Alabama. This Notice is requested by Iberia bank to acknowledge the assignment by Ajlouny Investments, LLC of the Development Agreement and the Parking Agreement as collateral for the Iberia loan.

As we previously discussed, will you ask the City Council to approve the execution of the Notice of Assignment? Upon approval, if the City will sign both execution copies, please send one of the executions copies to me and retain the other for the records of the City of Mountain Brook.

Thank you for your assistance and cooperation. If you have any questions, please let me know.

Very truly yours,



Joseph T. Ritchey
FOR THE FIRM

VTR/cjb

C: William B. Hairston, III, Esq.

NOTICE OF ASSIGNMENT

December 18, 2014

TO: City of Mountain Brook, Alabama
50 Church Street,
Mountain Brook, Alabama 35213

RE: Tax Revenue Sharing and Incentive Agreement

Ladies and Gentlemen:

By a *Mortgage, Leasehold Mortgage, Assignment of Rents and Leases, and Security Agreement* (the "Mortgage") dated this date and a *Loan Agreement* (the "Loan Agreement") referenced therein, **AJLOUNY INVESTMENTS, L.L.C.**, an Alabama limited liability company (the "Owner") has collaterally assigned to **IBERIABANK**, a Louisiana state banking corporation (the "Mortgagee"), the *Tax Revenue Sharing and Incentive Agreement* (the "Development Agreement") Owner entered into with the **CITY OF MOUNTAIN BROOK, ALABAMA** (the "City") on December 16, 2014 and the Parking Agreement, dated on December 16, 2014 (the "Parking Agreement"). [Capitalized terms used herein not otherwise defined shall be defined in accordance with the terms of the Development Agreement.]

In connection with this collateral assignment of the Development Agreement, Mortgagee has requested that we obtain the City's acknowledgement as to the following:

1. The Development Agreement and the Parking Agreement are in full force and effect;
2. The City is aware that the Development Agreement and Parking Agreement have been collaterally assigned by Owner to Mortgagee;
3. The City recognizes and acknowledges that Owner has mortgaged the Project to Mortgagee in accordance with the terms of the Mortgage and Loan Agreement;
4. No default has occurred under the Development Agreement or the Parking Agreement;
5. The City recognizes and acknowledges that Owner has agreed with Mortgagee that no changes or modifications to the Development Agreement shall be made which would decrease the amount due Owner under the Development Agreement without the expressed written consent of Mortgagee;
6. Upon delivery to Mortgagee of the \$1,200,000 Lump Sum Payment set forth in section 3.1(a) of the Development Agreement, Mortgagee will cause the Church Street Access Parcel and the Parking Lot Parcel to be released from the lien of the Mortgage.
7. The City recognizes and acknowledges Owner has agreed with Mortgagee that if Owner is in default with its obligations to Mortgagee under the Mortgage, and in the event

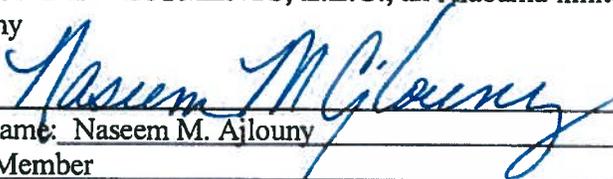
Mortgagee sends notice to City that Owner is in default in connection with its obligations to Mortgagee under the Mortgage, then upon receipt of such notice City shall be permitted to deliver to Mortgagee, payable to the Owner/Mortgagee, any and all Sales Tax Incentive Payments that City would be obligated to remit to Owner under section 3.1(b) of the Development Agreement.

8. The City recognizes and acknowledges that Owner has agreed with Mortgagee that the Option granted to the City in the Development Agreement is subject to the Mortgage; and
9. Copies of all notices the City sends to the Owner under the terms of the Development Agreement and the Parking Agreement, will simultaneously be sent to Mortgagee at the following address:

IBERIABANK
2340 Woodcrest Place
Birmingham, AL 35209
ATTN: Joe Medori, Senior Vice President

Very Truly Yours

AJLOUNY INVESTMENTS, L.L.C., an Alabama limited liability company

By: 
Print Name: Naseem M. Ajlouny
Title: Member

ACKNOWLEDGED, AGREED AND ACCEPTED this _____ day of December, 2014.

CITY OF MOUNTAIN BROOK, ALABAMA

By: _____
Virginia C. Smith, Council President

WITNESS:

Lawrence T. Oden, Mayor

RESOLUTION NO. 2015-005

BE IT RESOLVED by the City Council of the City of Mountain Brook, Alabama, that the Fire Department uniform bid submitted by Municipal and Commercial Uniforms and Equipment (MAC Uniforms), being the only bid submitted and determined to be in conformance with the expressed specifications, is hereby accepted.

BE IT FURTHER RESOLVED by the City Council of the City of Mountain Brook, Alabama, that the City Manager is hereby authorized and directed, for and on behalf of the City, to issue a [blanket] purchase order to MAC Uniforms and to execute any other documents that may be determined to be necessary with respect to said uniform purchases.

ADOPTED: This 12th day of January, 2015

Council President

APPROVED: This 12th day of January, 2015

Mayor

CERTIFICATION

I, Steven Boone, City Clerk of the City of the City of Mountain Brook, Alabama, hereby certify the above to be a true and correct copy of a resolution adopted by the City Council of the City of Mountain Brook at its meeting held on January 12, 2015, as same appears in the minutes of record of said meeting.

City Clerk



CITY OF MOUNTAIN BROOK FIRE DEPARTMENT

102 Tibbett Street, Mountain Brook, Alabama – 35213 Phone: (205) 802-3838, Fax: (205) 879-5919



INTEROFFICE MEMORANDUM

TO: Sam Gaston, City Manager
FROM: Robert Ezekiel, Fire Chief
DATE: January 6, 2015
SUBJECT: Uniform Bid

A handwritten signature in blue ink, appearing to read "R. Ezekiel", written over the "FROM" line.

In accordance with State bid laws and City purchasing policy, specifications were developed and a request for bids for fire department uniforms was posted on December 2, 2014. A formal bid opening was held in the office of the City Manager at 2:00 PM on January 5, 2015.

There was one bid submitted and received. Municipal and Commercial Uniforms and Equipment (MAC) was the bidder at \$774.84.

Note: The bid price of \$774.84 is not an amount that will be paid for uniforms. It is simply an indicator of the cost of all uniform items overall with a factor of life expectancy built in (magnitude factor). The department has an annual uniform allowance of \$450 per employee. So, the FY2015 operating budget is reflective of the clothing allowance and not the bid price amount.

Our historical experience with MAC uniforms has been very good. Therefore, we respectfully request that this bid be awarded to MAC uniforms and that it be placed on the City Council agenda for consideration and hopefully affirmation.

As always, if anyone has any questions, I will be available to respond.

CITY OF MOUNTAIN BROOK
56 Church Street
MOUNTAIN BROOK, ALABAMA 35213
OFFICE OF PURCHASING AGENT (CITY MANAGER)

BID COVER SHEET

Bid Request Posted this Date: Tuesday, December 02, 2014

Bids to be Opened this Date and Time: Monday, January 5, 2015 at 2:00 p.m.

To Whom It May Concern:

Bids shall be sealed and delivered to the Office of the Purchasing Agent in the City Hall, City of Mountain Brook, Alabama, prior to the above specified date and time. Bids shall be publicly opened at the date and time specified above or as soon as practicable thereafter.

To be considered by the City, a bid must comply with Alabama law, including, but not limited to, Ala. Code (1975) §§41-16-50 *et seq.* and 31-13-1 *et seq.*, and provide documentation of enrollment in the E-Verify program pursuant to Ala. Code §31-13-9.

All bidders must use the bid form provided by the City for the project. This Bid Cover Sheet should be completed and submitted with the bid. Bids completed in pencil will not be accepted. Bids should be clearly marked "SEALED BID" and indicate on the outside of the envelope "UNIFORM BID - FIRE DEPT" and the date of bid opening.

The City reserves the right to require a bid bond, in which case specific information shall be provided with the request for bids.

The City reserves the right to utilize life cycle cost analysis in determining the lowest responsible bidder, in which case specific information shall be provided with the request for bids.

The City reserves the right to accept or reject any or all bids and to waive formalities.

Sam S. Gaston, City Manager and Purchasing Agent

Sam S. Gaston

BIDDER: Municipal & Commercial Uniform Equip Phone: 205-384-6011

ADDRESS: 2208 3rd Ave Nc EMAIL: EdmarSmith@gmail.com

CITY: Birmingham STATE: Al. ZIP: 35203

BID AMOUNT (AS PER SPECIFICATIONS) \$ 774.84

Note: MUNICIPALITIES ARE EXEMPT FROM STATE SALES TAX

This bid must be signed below by bidder's principal/officer/agent and notarized:

Auth. Signature: Edward C. Smith
Name: Edward C. Smith
Title: President

Sworn to and subscribed before me on
this 29 day of Dec, 2014.
Kathleen M. Whitley
Notary Public
My Commission Expires: 11-11-2015

**MOUNTAIN BROOK FIRE DEPARTMENT
UNIFORM SPECIFICATIONS, NOVEMBER 2014**

ITEM	UNIT PRICE	MAGNITUDE	EXTENSION	COMPLY	
				YES	NO
1. Uniform Trousers	69.95	2	139.90	✓	
2. Work Trousers	37.95	1	37.95	✓	
3. Shirts, Short Sleeve, (3a) GRAY OR (3b) WHITE	32.95	1	32.95	✓	
4. Shirts, Long Sleeve, (4a) GRAY OR (4b) WHITE	34.95	2	69.90	✓	
5. Dress Uniform, Officer's Coat	199.95	0.1	20.00	✓	
6. Dress Uniform, Officer's Trousers	79.95	0.1	8.00	✓	
7. Dress Uniform, Firefighter's Coat	119.95	0.1	12.00	✓	
8. Dress Uniform, Firefighter's Trousers	42.95	0.1	4.30	✓	
9. Work Coat / EMS Jacket	209.95	0.25	52.49	✓	
10. Quarter Zip Job Shirt	60.95	0.25	15.24	✓	
11. Dress Cap, Officer's	44.95	0.1	4.50	✓	
12. Dress Cap, Firefighter's	44.95	0.1	4.50	✓	
13. Tie	4.00	0.1	.40	✓	
14. Ball Cap	14.00	1	14.00	✓	
15. T-Shirt	18.00	2	36.00	✓	
16. Gym Shorts	18.00	2	36.00	✓	
17. Sweat Shirt	15.00	1	15.00	✓	
18. Sweat Pant	15.00	1	15.00	✓	
19. Dress Shoe	104.95	0.25	26.24	✓	
20. Work Shoe	99.95	0.25	24.99	✓	

*Municipal & Commercial
Uniform & Equipment*

MOUNTAIN BROOK FIRE DEPARTMENT
UNIFORM SPECIFICATIONS, NOVEMBER 2014

ITEM	UNIT PRICE	MAGNITUDE	EXTENSION	COMPLY	
				YES	NO
21. Training Shoe	79.95	0.25	19.99	✓	
22. Chucka Boot	109.95	0.25	27.49	✓	
23. 8" Zipper Boot	94.95	0.25	23.74	✓	
24. 8" Pull On Boot	94.95	0.25	23.74	✓	
25. 8" USAR Boot	189.95	0.25	47.49	✓	
26. Socks	11.00	0.25	2.75	✓	
27. Officer Shirt Badge	59.95	0.1	6.00	✓	
28. Firefighter Shirt Badge	45.95	0.1	4.60	✓	
29. Officer Cap Badge	55.95	0.1	5.60	✓	
30. Firefighter Cap Badge	45.95	0.1	4.60	✓	
31. Officer Name Plate	10.00	0.1	1.00	✓	
32. Officer Serving Since	10.00	0.1	1.00	✓	
33. Firefighter Name Plate	10.00	0.1	1.00	✓	
34. Firefighter Serving Since	10.00	0.1	1.00	✓	
35. Belt	10.00	0.25	2.50	✓	
36. Officer Belt Buckle	47.95	0.1	4.80	✓	
37. Firefighter Belt Buckle	47.95	0.1	4.80	✓	
38. A/O Collar Brass	5.00	0.1	.50	✓	
39. Lt. Collar Brass	5.00	0.1	.50	✓	
40. Battalion Chief Collar Brass	23.95	0.1	2.40	✓	

*Municipal & Commercial
 Uniform & Equipment*

MOUNTAIN BROOK FIRE DEPARTMENT				
UNIFORM SPECIFICATIONS, NOVEMBER 2014				
41. Rain Jacket	49.95	0.25	12.49	✓
42. Rain Pant	29.95	0.25	7.49	✓
TOTAL =			\$ 774.84	

TOTAL BID (THIS IS YOUR BID!)

\$ 774.84

BIDS WILL NOT BE CONSIDERED ON INDIVIDUAL UNITS - BIDS WILL BE CONSIDERED ON TOTAL BID.

No definite quantities for each item can be established at this time.

(62) Firefighters and Fire Officers will purchase the items listed in appropriate quantities and sizes according to need and price.

Bids should include the cost of any alterations or adjustments necessary. All members of the department will be clothed regardless of size and or gender, no exceptions.

Please indicate your delivery from time of awarding of contract: 3 days on New F.F.

No Greater Than 90 Days is acceptable, unless special orders are involved. Special orders must be completed in 120 days from the day of order. 30 days on large order

MUNICIPALITIES ARE EXEMPT FROM STATE SALES TAX

This bid must be notarized.

Sworn to and subscribed before me this 29 day of Dec, 20 14.


Notary Public

Municipal - Commercial

BIDDER: Uniform & Equipment BY: [Signature]

ADDRESS: 2208 3rd Ave No (ZIP) 35203

PHONE: 205-324-6011 DATE: 12-29-2014

FAX: 205-324-5032 E-mail: Edmacsmith@gmail.com

RESOLUTION NO. 2015-006

BE IT RESOLVED by the City Council of the City of Mountain Brook, Alabama, that either the Mayor or the City Manager of the City is hereby authorized and directed, for and on behalf of the City, to enter into an agreement with All In Mountain Brook, in the form as attached hereto as Exhibit A, subject to such minor changes as may be determined appropriate by the City Attorney.

ADOPTED: This ___ day of January, 2015.

Council President

APPROVED: This ___ day of January, 2015.

Mayor

CERTIFICATION

I, Steven Boone, City Clerk of the City of Mountain Brook, Alabama, hereby certify the above to be a true and correct copy of a resolution adopted by the City Council of the City of Mountain Brook at its meeting held on January ___, 2015, as same appears in the minutes of record of said meeting.

City Clerk

STATE OF ALABAMA)

COUNTY OF JEFFERSON)

CONTRACT AGREEMENT

THIS AGREEMENT is entered into on this the ___ day of January, 2015, by and between the City of Mountain Brook (hereinafter referred to as “City”) and All In Mountain Brook (hereinafter referred to as “Contractor”):

WHEREAS, municipalities in the State of Alabama are authorized to promote the public health, safety, morals, security, prosperity, contentment and the general welfare of the community;

WHEREAS, All In Mountain Brook is an organization which has as one of its goals the promotion of public health, safety, morals, security, prosperity, contentment and the general welfare in the City of Mountain Brook—specifically, the enhancement and protection of the lives of Mountain Brook youth;

WHEREAS, the City Council of the City of Mountain Brook, Alabama desires to enter into a contract with the Contractor for the purpose of providing services and resources to residents of the City of Mountain Brook which are designed to combat issues and problems that place the lives and well-being of Mountain Brook youth at risk;

WITNESSETH,

1. That the City, for and in consideration of the covenants and agreements hereinafter set out to be kept and performed by the Contractor, does hereby agree to pay the Contractor the sum of \$10,000.00 (Ten Thousand and No/100 Dollars) (hereinafter referred to as the “Contract Amount”) for performing the services herein provided for the period beginning October 1, 2014, through September 30, 2015.

2. **SCOPE OF SERVICES:**

In consideration of the covenants and agreements made herein by the City, the Contractor agrees that the Contractor shall be totally responsible for, and shall have exclusive control over, the management and disbursement of the Contract Amount, and that the Contract Amount shall be used only for the purposes herein described:

a. To underwrite All In Mountain Brook programming at the six Mountain Brook City schools, thereby targeting families and youth in grades Kindergarten through twelfth grade, including but not limited to All In Mountain Brook speakers, activities, services, materials, and communications designed to combat issues and problems that place the lives and well-being of Mountain Brook youth at risk.

b. Activities will be planned by appointed Parent Teacher Organization representatives in each school, along with administrators and school counselors.

To Contractor:

All In Mountain Brook
Leigh Ann Sisson
2653 Montevallo Road
Mountain Brook, Alabama 35223

9. Any time period stated in a notice will be computed from the time the notice is deemed received. Either party may change its mailing address or the individual to receive notice by notifying the other party as provided in this paragraph.

10. No oral agreement or communication with any officer, agent, employee, or consultant of the City either before or after execution of this Agreement will affect or modify any of the terms or obligations contained in this Agreement. Any such oral agreement or communication will be considered as unofficial information and in no way binding upon City or Contractor. Any amendment to this Agreement must be in writing and signed by both parties.

IN WITNESS WHEREOF, we have hereunto set our hands and seals on this the ____ day of January, 2015.

CITY OF MOUNTAIN BROOK,

A Municipal Corporation

BY: _____

Mayor, City of Mountain Brook

WITNESSED:

BY: _____

ALL IN MOUNTAIN BROOK

BY: _____

Its Authorized Agent

Print name: _____

Title: _____

STATE OF ALABAMA)

COUNTY OF JEFFERSON)

I, _____, a notary public in and for said County in said State, hereby certify that _____, whose name as Authorized Agent of All In Mountain Brook, a nonprofit corporation, is signed to the foregoing instrument and who is known to me, acknowledged before me on this day that, being informed of the contents of the instrument, s/he, as such officer and with full authority executed the same voluntarily for and as the act of said corporation.

Given under my hand this the ____ day of January, 2015.

NOTARY PUBLIC

My Commission Expires:

RESOLUTION NO. 2015-007

BE IT RESOLVED by the City Council of the City of Mountain Brook, Alabama that the City Council hereby approves the conditional service use application submitted by Rodney Fulmer for Mountain Brook Crossfit, LLC to allow exercise classes and personal training at 2703 Culver Road.

ADOPTED: This 12th day of January, 2015.

Council President

APPROVED: This 12th day of January, 2015.

Mayor

CERTIFICATION

I, Steven Boone, City Clerk of the City of Mountain Brook, Alabama hereby certify the above to be a true and correct copy of a resolution adopted by the City Council of the City of Mountain Brook at its regular meeting held on January 12, 2015, as same appears in the minutes of record of said meeting.

City Clerk



CITY OF MOUNTAIN BROOK

Dana O. Hazen, AICP
City Planner
56 Church Street
Mountain Brook, Alabama 35213
Telephone: 205/802-3821
Fax: 205.879.6913
hazend@mtnbrook.org
www.mtnbrook.org

MEMO

DATE: January 7, 2015

TO: Mayor
City Council
City Manager

FROM: Dana Hazen, City Planner

RE: Conditional Use – Mountain Brook Crossfit
2703 Culver Road (previous Little Hardware – original left side of space)

See attached letter from the applicant regarding the proposed operational characteristics. The hours of operation are primarily early morning and late afternoon (closed from noon-4:00 p.m.). There is to be only one employee (business owner). Given the fact that Little Hardware employed approximately 12 people during a peak hour and most likely had a similar or greater customer demand (proposed 5-8 people at one time), this proposed use represents a decrease in parking demand on the subject site.

The zoning ordinance requires council approval of service uses as a conditional use, and states that any proposed conditional use will be reviewed as to the following:

- Whether the use would disparately impact public parking in the area;
- Whether vehicular or pedestrian circulation would be impacted by the use;
- Whether the use is compatible with surrounding existing uses;
- Whether the hours of operation or peak traffic times would impact existing uses.

Mtn. Brook CrossFit Description Summary for City Council Review Approval

Hours of operation: Mon-Thurs 6a-12p, 4p-8p
Fri 6a-12p, 4p-6p
Sat 9a-11a
Sun Closed

My normal busy hours are targeted to be early morning (6a-8a) and evening (5p-8p). During these times, I will have approximately 5-8 people at any given time. Outside of these hours, I am either closed entirely, or accommodating 1-2 people in the late morning.

I am the only employee at this time, and will be for a several months. My aim is to hire someone by the summer, but even then it will pretty much be to fill my role during the day, so still just one person working at a time.

I find that parking along Culver on the west side of the building is the most accommodating for me and anyone who will be helping me out. It is away of the front row for patrons of the post office, or mine and is easier to get in and out of as well.

I hope this covers any concerns that may arise with my business venture. I appreciate the opportunity to come to your community and look forward to helping your residents any way I can.

Sincerely,
Rodney Fulmer

205-915-3246

RESOLUTION NO. 2015-008

BE IT RESOLVED by the City Council of the City of Mountain Brook, Alabama, that the City Council hereby authorizes the execution the Birmingham-Jefferson County Transit Authority (MAX) fiscal 2015 Transit Service Agreement, in the form as attached hereto as Exhibit A.

ADOPTED: This ____ day of January 2015.

Council President

APPROVED: This ____ day of January 2015.

Mayor

CERTIFICATION

I, Steven Boone, City Clerk of the City of the City of Mountain Brook, Alabama, hereby certify the above to be a true and correct copy of a resolution adopted by the City Council of the City of Mountain Brook at its meeting held on January ____, 2015, as same appears in the minutes of record of said meeting.

City Clerk



Executive Director
Ann D. August



Board Chairperson
Johnnye P. Lassiter

BIRMINGHAM-JEFFERSON COUNTY TRANSIT AUTHORITY
2121 Reverend Abraham Woods Jr. Blvd. ♦ Suite 500 ♦ Post Office Box 10212
Birmingham, Alabama 35202-0212
Phone (205) 521-0161 ♦ Fax (205) 252-7633 ♦ www.bjcta.org

September 22, 2014

The Honorable Lawrence Terry Oden, Mayor
City of Mountain Brook
56 Church Street
Mountain Brook, AL 35209

Dear Mayor Oden:

Re: Proposed MAX FY2015 Annual Capital and Operating Budget

In accordance with Act No 87-449 and Act No 71-993 of the Alabama Legislature, the Birmingham-Jefferson County Transit Authority (AKA- MAX) is submitting its Proposed Fiscal Year 2015 Operating and Capital Budgets request for funding. We apologize in advance for the late submittal of our Annual Budget request. Please note that our budget request does not include any major increases in costs. We are trying to hold things down, as low as possible at this time.

The proposed service hours to be provided for the City of Mountain Brook in FY 2015 are **1627** at a cost of **\$87,337.36** or **\$53.68** per service hour. The Operating Cost is included in the **\$87,337.36** request. If the proposed anticipated revenues of **\$87,337.36** are received; it would drastically assist with the Operating Costs of Max.

In this current year we received an annual payment. We are proposing that the same process continues in FY 2015. We look forward to meeting with you to discuss your continued support of BJCTA /MAX, the proposed service hours, capital projects and costs for fiscal year 2015. As you are aware, demographics and travel patterns have changed over the years; and MAX is reviewing its bus routing as well to accommodate the growth and economic development along Routes in your city. We ask that you permit Max appropriate staff and I, to revisit later in FY 2015 to discuss the possibility of other transit service improvements in your city.

Enclosed for your information is the following document: Max - FY2013 Annual Audit and Community Report. If you have any questions, please don't hesitate to contact me at (205) 521-0117 Ext. 7117 or Starr Culpepper, my executive assistant at the same number.

Sincerely,

Ann D. August
Ms. Ann D. August, CCTM
Executive Director

*2nd letter - attn:
Sam Gaston, City Manager*

Enclosures

Cc: Director Joyce Brooks

TRANSIT SERVICES AGREEMENT

This Transit Services Agreement ("Agreement") is made and entered into this 22nd day of September 2014, by and between the **Birmingham-Jefferson County Transit Authority**, an Alabama public corporation (the "BJCTA") and **THE CITY OF MOUNTAIN BROOK, ALABAMA**, a municipality organized under the laws of the state of Alabama (the "City").

Recitals

WHEREAS, the BJCTA is charged with providing public transportation service in Jefferson County, Alabama;

WHEREAS, Alabama Act 1987-449 provides that any municipality which receives service from the BJCTA shall pay for such service based on the total projected hours of operation in such municipality, multiplied by the hourly cost of operation of the transit system;

WHEREAS, the City desires to receive transit services from the BJCTA; and

WHEREAS, the BJCTA desires to provide transit services to the City.

Agreement

NOW, THEREFORE, in consideration of the foregoing recitals and other good and valuable consideration provided herein, the Parties agree as follows:

1. The BJCTA agrees to provide transit services in the City for the fiscal year beginning on October 1, 2014 and ending on September 30, 2015 (the "Fiscal Year"). Transit services will be provided on such routes and schedules as provided on the enclosed **schedule** ("Transit Services").

2. The City agrees to pay the BJCTA **\$87,337.36** for the Transit Services for the Fiscal Year. This sum represents **1627** hours of Transit Services at a rate of **\$53.68** per hour.

3. The BJCTA will invoice the City at the beginning of the Fiscal Year. The City agrees to use its best efforts to pay the BJCTA's invoice by the October 31, 2014 which occurs during the Fiscal Year. If payment is not received by the November 30, 2014 which occurs during the Fiscal Year, the City shall advise the BJCTA in writing of the reason for the delay and the expected payment date. The BJCTA's Board of Directors may grant a thirty-day extension, and, in that event a second invoice shall be sent to the City. In the event that the City does not pay one or both invoices, the BJCTA's Board of Directors may direct its staff to commence the process of canceling the Transit Services. If the Board should at any time determine to terminate the Transit Services because of nonpayment, this Agreement shall be terminated, and a written notice

of termination shall serve as authorization for the BJCTA to cease providing Transit Services within the City as of the date that the Agreement is terminated.

4. Notice whenever required or permitted under the provisions of this Agreement shall be in writing and shall be deemed to have been given three days after the deposit of such notice in the United States Mail, via certified mail, postage prepaid, addressed:

if to BJCTA: Attn: Executive Director
Birmingham-Jefferson County Transit Authority
Post Office Box 10212
Birmingham, AL 35202-0212

and, if to City: Attn: ~~Mayor Lawrence Terry Oden~~ *City Manager*
City of Mountain Brook Alabama
56 Church Street
Mountain Brook, AL 35213

5. This Agreement shall be terminated upon the conclusion of the Fiscal Year.

6. The BJCTA and the City do not intend that any benefit inure to a third party under any provision of this Agreement.

7. No Party shall be liable or responsible to the other Party, nor be deemed to have defaulted under or breached this Agreement, for any failure or delay in fulfilling or performing any term of this Agreement, when and to the extent such failure or delay is caused by or results from acts beyond the affected Party's reasonable control, including, without limitation: (a) acts of God; (b) flood, fire, earthquake, epidemic or explosion; (c) war, invasion, hostilities (whether war is declared or not), terrorist threats or acts, riot or other civil unrest; (d) government order or law; (e) actions, embargoes or blockades in effect on or after the Effective Date of this Agreement; (f) action by any governmental authority such as curfews or imposition of Marshall Law; (g) national or regional emergency affecting bus services; (h) strikes or labor stoppages by BJCTA's employees; (i) shortage of adequate power or telecommunication facilities; (a "Force Majeure Event"). The Party suffering a Force Majeure Event shall give written notice within thirty days of the Force Majeure Event to the other Party, stating the period of time the occurrence is expected to continue and shall use diligent efforts to end the failure or delay and ensure the effects of such Force Majeure Event are minimized.

8. In the event that the BJCTA should not provide the Transit Services throughout the entire Fiscal Year, the City shall pay a prorated amount to the BJCTA for the Transit Services provided up to the date such services cease. To the extent that the City has prepaid for such Transit Services, the BJCTA shall refund to the City the prorated amount paid by the City for Transit Services not provided by the BJCTA, or the

BJCTA may provide such Transit Services until the prepayments by the City are expended.

9. This Agreement constitutes the entire agreement between the Parties with respect to the subject matter hereof, and no modifications hereof shall be effective unless executed in writing by duly authorized personnel of the Parties hereto. All previous communications between the Parties, whether verbal or written, with reference to the subject matter hereof are null and void and are hereby superseded by this Agreement.

10. Either Party's delay in enforcing or exercising or failure to enforce or exercise any provision of this Agreement or rights existing hereunder shall not in any way be construed as or constitute a waiver of any such provision or right, or prevent that Party thereafter from enforcing each and every other provision or right of this Agreement. Any express waiver of any obligation by either Party in any one instance shall not limit or waiver in any other instance.

11. All provisions, terms and conditions of this Agreement shall be deemed to be severable in nature. If, for any reason, the provisions contained herein are held to be to any extent invalid or contrary to the Constitution of the State of Alabama or any statute or applicable law, then to the extent that such provisions are, or shall be, valid and enforceable under applicable law, then this Agreement shall be construed and interpreted to provide for maximum enforceability under applicable law.

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be duly executed by persons duly authorized as the date first written above.

BIRMINGHAM-JEFFERSON
COUNTY TRANSIT AUTHORITY

By: *Alan D. August*
Executive Director

ATTEST:

CITY OF MOUNTAIN BROOK
ALABAMA

City Clerk

By: _____
Mayor

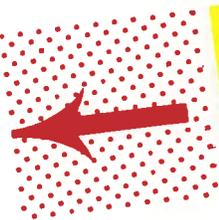


EXHIBIT A
Routes and Schedules for Transit Services Provided in the City

BIRMINGHAM - JEFFERSON COUNTY TRANSIT AUTHORITY
P. O. BOX 10212
(205-521-0149)
BIRMINGHAM AL 35202-

Invoice

10/1/2014

357

Invoice #

Bill To: CITY OF MOUNTAIN BROOK
56 CHURCH STREET
MOUNTAIN BROOK AL 35213-

000000013151

FY 2015 TRANSIT SERVICE OCTOBER 1, 2014 - SEPTEMBER 30, 2015

Terms: Net 30

Page 1

Line	Item #	Description	Quantity	U/M	Unit Price	Extended Price
1	2000	ROUTE SERVICE FY15 TRANSIT SERVICES October 1, 2014 - September 30, 2015	1,627.00	HR	\$53.68	\$87,337.36
					Sub Total:	\$87,337.36
					Invoice Total:	\$87,337.36

Please remit to the above address.

1926
Steve Boone <boones@mtnbrook.org>

RE: City Code amendment to Chapter 14 - Stormwater Detention Review and Permit Fees

1 message

Steve Stine <sstine@bishopcolvin.com>

Mon, Jan 5, 2015 at 2:39 PM

Reply-To: sstine@bishopcolvin.com

To: Steve Boone <boones@mtnbrook.org>, Jerry Weems <weemsj@mtnbrook.org>

Cc: Sam Gaston <gastons@mtnbrook.org>

Steve, this morning Jerry and I discussed the ordinance to revise the City's fees in Chapter 14 for Stormwater Retention Reviews and Stormwater Retention Permits. We want these fees to be \$500 each for single family and \$1000 for commercial and multifamily structures. Attached is a revised, Jan 5 version of the Ordinance.

In looking at this, I reviewed the Stormwater Detention part of our Code -- Section 113-224 et seq. -- to see whether the terms "single family residences" and "commercial and multifamily" structures are used in Section 113-224. In the Stormwater Detention part of the Code we make references to "projects" and "developments", not just to single family or multifamily.

Also, in Section 113-128 there are references to types of "projects" in zoning districts (i.e. Single Family Residential District, Multifamily District, Professional District, etc.) and to various other types of projects (i.e., a Single Lot Development, Ground, a Permanent Lake, Parking Lot, Dry Reservoir and Open Channel projects) where a stormwater detention plan review/permit may be needed. To make the terminology in the Fee Schedule in Chapter 14 consistent with the way projects are described in Section 113-228, in my revised draft I have referred to the two categories of fees as those payable for "Project in Single Family Residential District" and "Project in Multifamily District & All Other Projects Requiring Stormwater Detention Permit". Jerry and Steve, I think these two categories are more appropriate than "single family" and "multifamily", but let me know if you do not agree.

Of course, feel free to call me if you have any comments or questions.

Steve Stine

1910 First Avenue North

Birmingham, Alabama 35203

Phone : (205) 251-2881

Fax : (205) 254-3987

Email: sstine@bishopcolvin.com

ORDINANCE NO. 1926

AN ORDINANCE AMENDING CHAPTER 14 OF THE CITY CODE WITH RESPECT TO STORMWATER DETENTION PERMIT AND REVIEW FEES

BE IT ORDAINED by the City Council of the City of Mountain Brook that Chapter 14, of the Code of the City of Mountain Brook, Alabama (“City Code”) shall be amended as follows:

Section 1. Section 14-1 of the City Code shall be amended as follows with respect to the fees associated with Chapter 113 of the City Code:

<i>Section of Code</i>	<i>Description</i>	<i>Fee (in dollars)</i>
	CHAPTER 113 ENVIRONMENT AND NATRAL RESOURCE MANAGEMENT	
113-55	Soil erosion and sediment control permit fee	1,000.00
113-229(d)	Stormwater detention review fee - for project in single family residential district	400.00 500.00
113-229(d)	Stormwater detention review fee - for project in multifamily district & all other projects requiring Stormwater Detention Permit	1,000.00
113-229(d)	Stormwater detention permit fee - for project in single family residential district	500.00
113-229(d)	Stormwater detention permit fee - for project in multifamily district & all other projects requiring Stormwater Detention Permit	1,000.00
113-229(f)(2)	Fee for appeal of adverse action on stormwater detention application	100.00

Section 2. This ordinance is cumulative in nature and is in addition to any power and authority which the City of Mountain Brook may have under any other ordinance or law.

Section 3. If any part, section or subdivision of this ordinance shall be held unconstitutional or invalid for any reason, such holding shall not be construed to invalidate or impair the remainder of this ordinance, which shall continue in full force and effect notwithstanding such holding.

Section 4. This section shall become effective immediately upon adoption and publication as provided by law.

ADOPTED: This ___th day of _____, 2015.

Council President

APPROVED: This ___th day of _____, 2015.

Mayor

1926

CERTIFICATION

I, Steven Boone, City Clerk of the City of Mountain Brook, Alabama, hereby certify the above to be a true and correct copy of an ordinance adopted by the City Council of the City of Mountain Brook, Alabama, as its meeting held on _____, 2015, as same appears in the minutes of record of said meeting, and published by posting copies thereof on _____, 2015, at the following public places, which copies remained posted for five (5) days as required by law.

City Hall, 56 Church Street
Gilchrist Pharmacy, 2850 Cahaba Road
Overton Park, 3020 Overton Road
The Invitation Place, 3150 Overton Road

City Clerk

ORDINANCE NO. 1926**AN ORDINANCE AMENDING CHAPTER 14 OF THE CITY CODE WITH RESPECT TO STORMWATER DETENTION PERMIT AND REVIEW FEES**

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<i>Section of Code</i>	<i>Description</i>	<i>Fee (in dollars)</i>
	CHAPTER 113 ENVIRONMENT AND NATRAL RESOURCE MANAGEMENT	
113-55	Soil erosion and sediment control permit fee	1,000.00
113-229(d)	Stormwater detention review fee - for project in single family residential district	500.00
113-229(d)	Stormwater detention review fee - for project in multifamily district & all other projects requiring Stormwater Detention Permit	1,000.00
113-229(d)	Stormwater detention permit fee - for project in single family residential district	500.00
113-229(d)	Stormwater detention permit fee - for project in multifamily district & all other projects requiring Stormwater Detention Permit	1,000.00
113-229(f)(2)	Fee for appeal of adverse action on stormwater detention application	100.00

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ADOPTED: This 12th day of January, 2015.

Council President

APPROVED: This 12th day of January, 2015.

Mayor

1926

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City Hall, 56 Church Street
Gilchrist Pharmacy, 2850 Cahaba Road
Overton Park, 3020 Overton Road
The Invitation Place, 3150 Overton Road

City Clerk