



City of Birmingham

2025-2026 BENEFITS GUIDE



Contents



Welcome to the City of Birmingham

Thank you for choosing to serve the citizens of our great city! It is our goal to ensure that we give every employee top tier service. Top tier service means providing high quality benefits at an affordable cost. It means making enrollment easy. It means we continue to be available to answer our employees' questions. We appreciate your willingness to serve as it is indeed our pleasure to serve you!

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Welcome



OPEN ENROLLMENT PERIOD

You must complete your enrollment to avoid termination in benefits. Please speak with a Benefit Counselor onsite or by Call Center to review current benefits and get in depth information on the benefit changes for this enrollment.

Open enrollment is May 7 – 30, 2025.

A digital version of the 2025 Benefit Guide along with informative documents are posted on mycityofbirminghambenefits.com.



QUESTIONS?

**Call the Benefits Call Center at
1-877-871-4780**

WHAT'S NEW

- **Medical** – Rate change (see page 8)
- **Dental** – Rate change (see page 13)
- **Vision** – Your vision plan will change to Ameritas. There will now be two plan options and you will have the ability to choose between the VSP or EyeMed network.
- **Disability and Term Life** – Your Disability and Term Life will change to Standard. **NEW** for this enrollment, you will have the option of adding Long Term Disability in addition to the Short Term Disability.
- **Whole Life, Critical Illness, Accident and Hospital Indemnity** – Your Whole Life, Critical Illness, Accident and Hospital Indemnity will change to Unum. If you wish to continue your Aflac Whole Life you have the option on direct bill so your Aflac polices will no longer be payroll deducted. If you had a Unum Whole Life policy previously you can keep your coverage through payroll deduction.

OPTIONS TO ENROLL



Onsite – Benefit Counselors will be available onsite during Open Enrollment to help educate and complete your enrollment. Your Payroll Coordinator will provide a schedule including the date, time and location you can meet with a Benefit Counselor. You can also access the Enrollment Schedule online at mycityofbirminghambenefits.com.



Call Center – Benefit Counselors will be available by phone to answer questions and complete your enrollment. Employees may call 1-877-871-4780 (8am – 5pm). If counselors are assisting other employees, you can leave your name and phone number and a counselor will return the call.



Online – You can enroll online. Log into unum.benselect.com/CITYOFBIRMINGHAM.

- **Username:** EID or SSN
- **PIN:** Last 4 digits of Social and 2 digit birth year

All employees are encouraged to speak with a Counselor prior to logging online to review current coverage and gain a better understanding of the benefit changes effective July 1st.



NEW HIRES

Newly hired employees can enroll through the Call Center (8am-5pm) or online at any time during the year.

WHAT YOU'LL NEED TO ENROLL

Please be prepared to provide or verify the following information:

- Your full name
- Your date of birth
- Full names, dates of birth and social security numbers of dependents and beneficiaries

Eligibility



Employees of the City of Birmingham working 30 or more hours per week are eligible to participate in benefits. Health and Basic Term Life & AD&D Insurance are effective 30 days after your date of hire. Dental and Vision coverage are effective on the first day of the month following 30 days of service.

Your eligible dependents include your legal spouse; domestic partner; a child under age 26; an unmarried, incapacitated child age 26 and over who is unable to support him/herself and depends on you for support if the incapacity occurred before reaching age 26; and/or a child for which you maintain legal guardianship, including your natural child, stepchild residing in your household, legally adopted child, or disabled child.

NOTICE ABOUT DEPENDENTS: If you are adding a dependent for the first time, you must be prepared with their date of birth and social security number at time of enrollment **and** email supporting documentation (e.g. birth certificate, marriage license and legal adoption papers) to benefits@birminghamal.gov.

NOTICE ABOUT DIVORCE: You must provide Human Resources with a final divorce decree and a forwarding address for your former spouse within 30 days of divorce. **Former spouses are not covered under any City benefit plan.** If a claim is filed for the benefit of a former spouse, that claim will be reversed, you will forfeit your plan premiums, and you will be responsible for those charges.

When Can I Enroll or Make Changes to My Benefits?

You must make your initial benefit elections within 21 days of your hire date or new employee orientation date. You may make changes to your benefits every year during Open Enrollment and during the plan year if you experience a qualifying event. You must notify Human Resources within 30 days of the event.

Qualifying events include:

- Birth, adoption, or placement for adoption
- Marriage, legal separation, divorce, or annulment
- Change in employment status
- Loss of coverage or ineligibility
- Medical child support order
- Death

When Do My Benefits End?

Plan coverage ends as a result of the first to occur of the following (generally, coverage will continue to the end of the month in which the event occurs):

- The date on which the employee fails to satisfy the conditions for eligibility to participate in the plan, such as termination of employment or reduction in hours (except during vacation or as otherwise provided in the Leaves of Absence rules below);
- For spouses and domestic partners, the date of divorce or other termination of marriage or dissolution of domestic partnership;
- For children, the date a child ceases to be a dependent;
- For the employee and his or her dependents, the date of the employee's death;
- You fail to pay your group any contribution amount due within 30 days after the day due; or
- Upon discovery of fraud or intentional misrepresentation of a material fact by you.

In all cases, the termination occurs automatically and without notice. All the dates of termination assume that payment for coverage for you and your dependents in the proper amount has been made to that date. If it has not, termination will occur back to the date for which coverage was last paid.

FMLA

You may retain your coverage under the plan during an FMLA leave and/or other approved leave, provided that you continue to pay your premiums. You should contact LOA@birminghamal.gov or 205-254-2798 to determine whether a leave qualifies as FMLA leave.

Military

Call 205-254-2798 for information about your rights and to continue or waive coverage under the plan **prior to** taking military leave covered by the Uniformed Services Employment and Reemployment Rights Act of 1994.

Standard Evidence of Insurability

If adding Term Life over the guaranteed issue limits be prepared to complete an Evidence of Insurability Form. **Forms must be submitted no later than May 31, 2025** for the 2025-2026 Open Enrollment Period.

Payroll Calendar



JANUARY							FEBRUARY							MARCH							APRIL						
Su	M	Tu	W	Th	F	Sa	Su	M	Tu	W	Th	F	Sa	Su	M	Tu	W	Th	F	Sa	Su	M	Tu	W	Th	F	Sa
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26	27	28	29	30	31		23	24	25	26	27	28		23	24	25	26	27	28	29	27	28	29	30			
													30	31													

MAY							JUNE							JULY							AUGUST						
Su	M	Tu	W	Th	F	Sa	Su	M	Tu	W	Th	F	Sa	Su	M	Tu	W	Th	F	Sa	Su	M	Tu	W	Th	F	Sa
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11	12	13	14	15	16	17	15	16	17	18	19	20	21	13	14	15	16	17	18	19	10	11	12	13	14	15	16
18	19	20	21	22	23	24	22	23	24	25	26	27	28	20	21	22	23	24	25	26	17	18	19	20	21	22	23
25	26	27	28	29	30	31	29	30						27	28	29	30	31			24	25	26	27	28	29	30
																			31								

SEPTEMBER							OCTOBER							NOVEMBER							DECEMBER						
Su	M	Tu	W	Th	F	Sa	Su	M	Tu	W	Th	F	Sa	Su	M	Tu	W	Th	F	Sa	Su	M	Tu	W	Th	F	Sa
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21	22	23	24	25	26	27	19	20	21	22	23	24	25	16	17	18	19	20	21	22	21	22	23	24	25	26	27
28	29	30					26	27	28	29	30	31		23	24	25	26	27	28	29	28	29	30	31			
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HOLIDAY
 PAYDAY
 FINALIZE PAYROLL AND TRANSMIT ACH

2025 HOLIDAY SCHEDULE

The following holidays for 2025 are for all employees of the City of Birmingham, except those performing essential services.

Date	Holiday	Date	Holiday
January 1, 2025	New Year's Day	July 4, 2025	Independence Day
January 10, 2025	Martin Luther King Day	September 1, 2025	Labor Day
April 18, 2025	Good Friday	November 11, 2025	Veteran's Day
May 26, 2025	Memorial Day	November 27 & 28, 2025	Thanksgiving
June 19, 2025	Juneteeth	December 24 & 25, 2025	Christmas



Flexible Spending Accounts



The City of Birmingham is pleased to offer employees a flexible spending account (FSA) benefit. An FSA allows employees to budget and save up to a certain amount of pre-tax dollars to pay for qualified medical and childcare expenses throughout the plan year (July 1, 2025- June 30, 2026). Enrollment is only available once per plan year, either during open enrollment or as a new hire.

MEDICAL FSA

Benefits of a Medical FSA

- You can set aside pre-tax dollars to cover out-of-pocket medical, dental and vision expenses.
- Your funds can be used for expenses incurred by you, your spouse or eligible dependents.
- Your entire election amount is available on the first day of your plan year.

Eligible Expenses

Enrolling in a Medical FSA allows you to use pre-tax dollars to pay for eligible out-of-pocket medical, dental or vision expenses incurred by you, your spouse or eligible dependents. The eligibility of expenses is determined by IRS Code Section 213(d). A comprehensive list of eligible expenses can be found at [DiscoveryBenefits.com/eligibleexpenses](https://www.discoverybenefits.com/eligibleexpenses).

Some examples of eligible expenses include:

- Prescriptions
- Hearing aids
- Orthopedic goods

IRS Contribution Limit	
2025	\$3,300 annually

Medical FSA Carryover

A carryover allows you to transfer up to \$660 of your remaining balance at the end of the plan year into the following year. Think of it like a safety net for your FSA. If you end up spending less than you anticipate when making your elections during open enrollment, you can tap into those funds next year. Funds will be available in the next plan year after your 90 day run out period has expired for the current plan year.

DEPENDENT CARE FSA

Benefits of a Dependent Care FSA

You can set aside pre-tax dollars to pay for day care expenses for children under age 13 or for expenses related to care for a disabled spouse or dependent of any age.

Account Eligibility

In order to be eligible for an account, you must meet one of the following:

- You and your spouse (if applicable) are gainfully employed.
- You are looking for work.
- You are attending school on a full-time basis.

You can find a comprehensive list of eligible expenses at <https://www.wexinc.com/insights/benefits-toolkit/eligible-expenses/>.

IRS Contribution Limit

\$5,000 annually (Note: If you're married and file separate returns, you can each elect \$2,500 for the calendar year.)

Recurring Reimbursement

You can submit claims online or use your debit card. You can also save time by using our Recurring Dependent Care Form. You'll only need to submit one form per year for each day care provider you use.



Medical Plans

Type Service	Premier Medical Plan	Value Medical Plan
Plan Year Deductible	\$1,500 per person \$3,000 aggregate maximum per family	\$1,500 per person \$3,000 aggregate maximum per family
Annual Out-of-Pocket	\$4,000 per person \$8,000 aggregate maximum per family	\$4,000 per person \$8,000 aggregate maximum per family
Inpatient Hospital	In-Network: 100% after \$250 per admission copay Out-of-Network: 50% after plan year deductible	In-Network: 90% after plan year deductible Out-of-Network: 70% after plan year deductible
Outpatient Hospital	In-Network: 100% after \$100 facility copay Out-of-Network: 50% after plan year deductible	In-Network: 90% after plan year deductible Out-of-Network: 70% after plan year deductible
Outpatient Diagnostic Lab and Pathology	In-Network: 100% no copay or deductible. Out-of-Network: 50% after plan year deductible	In-Network: 90% after plan year deductible Out-of-Network: 70% after plan year deductible
Outpatient Diagnostic Imaging (X-Ray)	In-Network: 100% after \$50 copay Out-of-Network: 50% after plan year deductible	In-Network: 90% after plan year deductible Out-of-Network: 70% after plan year deductible
Outpatient Dialysis, IV Therapy, Chemotherapy, and Radiation Therapy	In-Network: 100% no copay or deductible Out-of-Network: 50% after plan year deductible	In-Network: 90% after plan year deductible Out-of-Network: 70% after plan year deductible
Emergency Room – Medical Emergency or Accident	In-Network: 100% after \$200 facility copay for the first two visits, 100% after \$300 copay for any additional visits Out-of-Network: 100% after \$200 facility copay for the first two visits, 100% after \$300 copay for any additional visits	In-Network: 90% after plan year deductible Out-of-Network: 90% after plan year deductible
Primary Care Physician Office Visit	In-Network: 100% after \$25 office visit copay Out-of-Network: 50% after plan year deductible	In-Network: 100% after \$25 office visit copay Out-of-Network: 70% after plan year deductible
Specialist Office Visits	In-Network: 100% after \$40 office visit copay Out-of-Network: 50% after plan year deductible	In-Network: 100% after \$75 office visit copay Out-of-Network: 70% after plan year deductible
Urgent Care Visit	In-Network: 100% after \$50 copay Out-of-Network: 50% after plan year deductible	In-Network: 100% after \$70 copay Out-of-Network: 70% after plan year deductible
Preventive Benefits (See list of specific preventive services) <ul style="list-style-type: none"> • Routine Immunizations • Urinalysis • CBC • TB Skin Test • Bone Density Scan • Chest X-Ray • EKG • Cholesterol Screening and/or Lipid Panel 	In-Network: 100% no copay or deductible Out-of-Network: NOT COVERED; EXCEPTION: 50% after deductible for the following services only: <ul style="list-style-type: none"> • Routine Pap Smear (one each year) • Routine Human Papillomavirus (HPV) testing (one per female member ages 30 and older every three plan years) • Routine Chlamydia screenings (one per female member ages 15-24 each plan year) 	In-Network: 100% no copay or deductible Out-of-Network: NOT COVERED; EXCEPTION: 70% after deductible for the following services only: <ul style="list-style-type: none"> • Routine Pap Smear (one each year) • Routine Human Papillomavirus (HPV) testing (one per female member ages 30 and older every three plan years) • Routine Chlamydia screenings (one per female member ages 15-24 each plan year)
Other Covered Services	In-Network: 100% no deductible or co-pay Out-of-Network: 50% after plan year deductible Note: Some services are subject to the plan year deductible.	In-Network: 90% after plan year deductible Out-of-Network: 70% after plan year deductible



Prescription Drug Benefits

	Premier Plan	Value Plan
Retail Pharmacy	Generic Drugs: \$7 copay Preferred Brand Name Drugs: \$40 copay Other Brand Name Drugs: \$60 copay Specialty Drugs: \$70 copay	Generic Drugs: \$7 copay Preferred Brand Name Drugs: \$65 copay Other Brand Name Drugs: \$80 copay Specialty Drugs: \$100 copay
Retail 90 Maintenance Network Program	Generic Drugs: \$12 copay Preferred Brand Name Drugs: \$45 copay Other Brand Name Drugs: \$75 copay Specialty Drugs: \$90 copay	Generic Drugs: \$12 copay Preferred Brand Name Drugs: \$55 copay Other Brand Name Drugs: \$85 copay Specialty Drugs: \$95 copay
Mail Order	Generic Drugs: \$10 copay Preferred Brand Name Drugs: \$40 copay Other Brand Name Drugs: \$65 copay <i>Applies to maintenance medications only.</i> Specialty Drugs: \$70 copay	Generic Drugs: \$10 copay Preferred Brand Name Drugs: \$60 copay Other Brand Name Drugs: \$75 copay <i>Applies to maintenance medications only.</i> Specialty Drugs: \$100 copay
Weight Loss Medications	Covered at retail only up to a 30-day supply. Covered at 80% of the allowed amount, subject to plan year deductible.	Covered at retail only up to a 30-day supply. Covered at 80% of the allowed amount, subject to plan year deductible.
Out-of-Pocket Maximum Eligible Pharmacy expenses such as copays accumulate towards the Out of Pocket Maximum	Individual: \$1,600 Family: \$3,200	Individual: \$1,600 Family: \$3,200

MEDICAL PLAN PREMIUMS

Benefit Plan Type	Coverage	Employee Monthly*	Employer Monthly	Employee Biweekly	Employer Biweekly
Premier Medical Plan	Individual	\$114.32	\$442.24	\$52.76	\$204.20
	Employee+1	\$352.52	\$1,354.31	\$162.70	\$625.07
	Family	\$491.22	\$1,896.58	\$226.72	\$875.34
Value Medical Plan	Individual	\$33.80	\$238.23	\$15.60	\$109.95
	Employee+1	\$150.98	\$1,081.28	\$69.68	\$499.05
	Family	\$220.82	\$1,583.20	\$101.92	\$730.71

*Employee and Retiree monthly amounts will vary depending on the number of payroll cycles in a given month. Retiree rates are on page 28.

Spousal Surcharge: Spouses who are eligible to participate in group health plan coverage through their own employers and do not elect coverage are subject to a \$25 per pay period surcharge in the value plan and \$50 per pay period surcharge in the premier plan. City of Birmingham health plans will only provide secondary coverage to spouses who enroll in their own employer's group health plan and in a City of Birmingham plan.

Nicotine Surcharge: Employees who use nicotine are subject to a \$7 per pay period surcharge in the value plan and a \$25 per pay period surcharge in the premier plan. If you enroll in a City of Birmingham health plan you will be required to certify whether you use nicotine.

The City of Birmingham is committed to helping you achieve your best health. The premium cost for not using nicotine is available to all employees. If you think you might be unable to meet a standard for avoiding the nicotine surcharge, you might qualify for an opportunity to earn the non-nicotine-use premium by different means. Contact us at 205-254-2798 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same premium discount that is right for you in light of your health status.



Behavioral Health/EAP

	Premier Plan	Value Plan
Employee Assistance Program	<ul style="list-style-type: none"> All employees and dependents may receive up to six (6) visits/consults at no charge each year when BHS PPO Network is used Coverage for all In-Network Qualified/Licensed Professionals May be used for Legal and Financial Consultation, Elder Care Guidance, as well as Assessment and Counseling for other Individual and Family issues 	<ul style="list-style-type: none"> All employees and dependents may receive up to six (6) visits/consults at no charge each year when BHS PPO Network is used Coverage for all In-Network Qualified/Licensed Professionals May be used for Legal and Financial Consultation, Elder Care Guidance, as well as Assessment and Counseling for other Individual and Family issues
Outpatient	<p><i>Mental Health and Substance Abuse</i></p> <ul style="list-style-type: none"> Covered at 100% of Allowed Amount \$25 Copay per Visit No Deductible <p><i>Substance Abuse Intensive Outpatient Program (IOP)</i></p> <ul style="list-style-type: none"> Covered at 100% of Allowed Amount No Copay No Deductible Completion of BHS-Approved Aftercare Program May be Required for Future Benefit Eligibility 	<p><i>Mental Health and Substance Abuse</i></p> <ul style="list-style-type: none"> Covered at 100% of Allowed Amount \$25 Copay per Visit No Deductible <p><i>Substance Abuse Intensive Outpatient Program (IOP)</i></p> <ul style="list-style-type: none"> Covered at 90% of Allowed Amount, Subject to the Benefit Period Deductible Completion of BHS-Approved Aftercare Program May be Required for Future Benefit Eligibility
Inpatient	<p><i>Mental Health and Substance Abuse</i></p> <ul style="list-style-type: none"> Covered at 100% of Allowed Amount \$250 Copay Per Admission No Deductible Completion of BHS-Approved Aftercare Program May be Required for Future Benefit Eligibility 	<p><i>Mental Health and Substance Abuse</i></p> <ul style="list-style-type: none"> Covered at 90% of Allowed Amount, Subject to the Benefit Period Deductible Completion of BHS-Approved Aftercare Program May be Required for Future Benefit Eligibility
Out-of-Network Benefits	<ul style="list-style-type: none"> Match those of the Group Health Plan Subject to Applicable Copays and Deductibles All Plan Requirements for Precertification, Medical Necessity and Covered Services Apply 	<ul style="list-style-type: none"> Match those of the Group Health Plan Subject to Applicable Copays and Deductibles All Plan Requirements for Precertification, Medical Necessity and Covered Services Apply



Behavioral Health/EAP

BHS FREQUENTLY ASKED QUESTIONS

Q: Can I get evening or Saturday appointments?

A: Many of our providers do offer appointments at these times. However, most mental health providers have office hours like those of your family physician. Therefore, it is not always possible to schedule special appointment times.

Q: How does BHS select the providers for its network?

A: To participate in our open network, a provider must meet our standards for licensure, experience, education, etc. He or she must agree with our philosophy of using the least restrictive treatment setting. Also, the provider must be willing to accept payment rates that are the same as other BHS providers.

Q: Why must I have an independent assessment by a BHS network provider?

A: Your care needs cannot be determined or approved without a face-to-face assessment by a qualified, independent case manager. The assessment results in a treatment plan designed especially for you. After a referral for treatment, your BHS Care Coordinator will follow up with your treatment provider to make sure your care is going smoothly. If you have concerns about your care, you may discuss them with BHS or with your provider. Remember, your provider is there to help you and to provide an objective opinion on your care needs.

Q: Do I have to file claims myself?

A: No. Our network providers have agreed to file claims directly with us. However, you will need to pay your copayment at the time of your visit. If you receive a bill by mistake for services that have been approved by BHS, call your provider and remind them that you were referred through BHS; or, call BHS.

Q: Can I see a Master's-prepared counselor through BHS?

A: Yes. Your company provides benefits for many excellent Master's-prepared counselors, therapists, and social workers included in our network.

Q: Why am I not provided with a list of BHS network providers?

A: BHS is your gatekeeper for mental health and substance abuse benefits. You should call us to use your benefits and schedule an appointment with a provider. Since we update our network daily with new providers, any list would be outdated before it reached you. Also, we know which network providers have the skills to meet your special needs.

Q: Do managed care programs result in a reduction of care and quality?

A: Treatment plans are decided on an individual, case by case basis. Employees are finding that managed care is more effective and can reduce costs. A good, managed mental health program offers: a) a wide range of treatment choices, b) quality care and follow-up, c) access to qualified professionals, d) a more generous benefit plan, e) lower out-of-pocket costs, and f) a better outcome.

Q: Is there a cost to use the EAP Services?

A: No. The EAP is a benefit provided to you, at no charge, by your employer. The EAP sessions that are authorized by BHS are covered at 100% and you do not have to process any claims.

Q: What if I am not satisfied with the BHS services?

A: Our goal is to ensure that you receive the care that is needed for your specific situation. In the event that you are dissatisfied with the services provided, contact Clinical Services at BHS regarding the grievance process.

Q: Are out-of-network benefits available?

A: Because BHS offers an open network, there is virtually no need for an out-of-network benefit. At your request, we will contact any provider not currently affiliated with BHS, and in most cases, arrangements can be made for you to receive services with the same level of benefit coverage as that offered through our PPO network. When necessary, out-of-network coverage matching that of your current group health plan is available.



BWELL BHM Employee Clinic

A HEALTH CENTER JUST FOR YOU!

Why Should I Use Dr. Kre for Medical Care?

- Quality care with no copays or deductibles!
- High focus on health maintenance & prevention
- Conveniently located
- Same day or next day appointments
- NO copay Tele-Health consultations (phone, video, text or emails)

How Can I Make an Appointment or Get More Information?

- **Visit:** <http://www.cobclinic.com/>
- **Email:** brownstonehealthcare@gmail.com
- **Call:** 205-202-5650

Services include:



Sick Visits



In-House Labs/Blood Work



Preventive Care



Prescription Medications



Blood Pressure Screenings



Tele-Health Consultations



Chronic Disease Management



Specialist Referrals



Men's & Women's Health



Personalized Care



LOCATIONS

Downtown

Brownstone Healthcare: BWELL Birmingham
Employee Clinic (BHBEC)
1700 5th Avenue North
Birmingham, AL 35203
www.cobclinic.com

Trussville

Brownstone Healthcare & Aesthetics
4643 Camp Coleman Rd. #117
Trussville, AL 35173
www.brownstonehealthcare.com



BWELL BHM Employee Clinic

What You Need to Know

What is the Brownstone Healthcare: BWELL BHM Employee Clinic (BHBEC)?

- The BHBEC is a partnership between the City of Birmingham and Brownstone Healthcare.
- Brownstone Healthcare is operated by Dr. Ankehah Trimble Johnson (Dr. Kre).
- Services are available to all City employees and dependents who are on City of Birmingham health plan.

What services are provided by the BHBEC?

- Employees and their insured dependents can use Dr. Kre with the BHBEC as their primary care physician.
- The BHBEC can also be used for other urgent or non-emergency services.
- In most instances, employees will be able to schedule a same day or next day visit.

What are the benefits of using the BWELL BHM Clinic?

- Birmingham employees insured by the City will have NO CO-PAYS for physician visits, meaning there is NO COST for the doctor visit.

See an example below of how you can save with the BHBEC!

	PREMIER PLAN <i>Employees and Dependents</i>	VALUE PLAN <i>Employees and Dependents</i>	BWELL BHAM CLINIC <i>Employees and Dependents</i>
Primary Care Office Visits	\$25 Copay per visit	\$25 Copay per visit	No Copay
Tele-Health Visits Video and Audio Capability	\$25 Copay	\$25 Copay	No Copay Access to physician & staff via secure text messaging, email messaging, & phone
Primary Care Specialist Referrals	Yes	Yes	Yes
Labs	No Copay	\$1,500 per person deductible; then 10% coinsurance	No Copay • In-House Labs (strep, flu, urinalysis, blood, glucose, hematocrit, pregnancy test) • Labs processed outside the clinic will go through your health insurance plan.
Prescription Drugs	Generic Drugs: \$7 copay Brand Name Drugs: \$40 copay Other Brand Name Drugs: \$60 copay Specialty Drugs: \$70 copay	Generic Drugs: \$7 copay Brand Name Drugs: \$65 copay Other Brand Name Drugs: \$80 copay Specialty Drugs: \$100 copay	
Average Wait for Primary Care Appointments	Appointments for primary care visits can take 1-3 weeks	Appointments for primary care visits can take 1-3 weeks	Same Day or Next Day Appointments



Dental Plans

Dental Plan Highlights			
Eligibility	Primary enrollee, spouse and eligible dependent children to age 26		
Deductibles* Deductibles are waived for Diagnostic & Preventive	\$25 per person / \$75 per family each plan year		
Maximums* Diagnostic & Preventive counts toward Maximum	\$1,000 per person each plan year Value Plan \$1,500 per person each plan year Premier Plan		
Waiting Period(s)	Basic Benefits 0 Months	Major Benefits 0 Months	Orthodontics 0 Months

Benefits and Covered Services**	Premier Dental Plan		Value Dental Plan	
	In-Network Dentists	Out of Network Dentists	In-Network Dentists	Out of Network Dentists
Diagnostic & Preventive Services Exams, Cleanings, X-rays, Sealants	100%	100%	100%	100%
Basic Services Fillings, Simple Tooth Extractions	80%	80%	50%	50%
Endodontics (root canals) Covered under Basic Services	80%	80%	50%	50%
Periodontics (gum treatment) Covered under Basic Services	80%	80%	50%	50%
Oral Surgery Covered under Basic Services	80%	80%	50%	50%
Major Services Crowns, Inlays, Onlays and Cast Restorations, Bridges and Dentures, Implants	50%	50%	50%	50%
Orthodontic Benefits Adults and Dependent Children	50%	50%	Not Covered	Not Covered
Orthodontic Maximums Lifetime	\$1,500	\$1,500	Not Covered	Not Covered

* If you switch plans during the calendar year your Deductible and Annual Maximum may be adjusted accordingly.

** Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on contract allowances and not necessarily each dentist's actual fees.

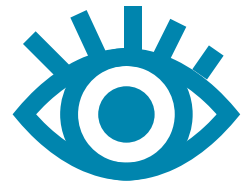
DENTAL PLAN PREMIUMS

Benefit Plan Type	Coverage	Employee Monthly*	Employer Monthly	Employee Biweekly	Employer Biweekly
Premier Dental Plan	Individual	\$6.90	\$14.02	\$3.18	\$6.47
	Employee+1	\$27.59	\$19.99	\$12.73	\$9.23
	Family	\$42.84	\$32.31	\$19.77	\$14.91
Value Dental Plan	Individual	\$0.00	\$12.30	\$0.00	\$5.68
	Employee+1	\$3.57	\$20.22	\$1.65	\$9.33
	Family	\$4.82	\$32.27	\$2.22	\$14.89

* Employee monthly amounts will vary depending on the number of payroll cycles in a given month

Retiree rates are on page 30.

Vision Plans



Type Service	VSP Plan	
	In Network	Out-of-Network
Deductibles	\$20 Exam \$20 Eyeglass Lenses or Frames	\$20 Exam \$20 Eyeglass Lenses or Frames
Annual Eye Exam	Covered in full	Up to \$43
Lenses - Once every 12 months Single Vision Bifocal Trifocal Lenticular Progressive	Covered in full Covered in full Covered in full Covered in full See lens options	Up to \$26 Up to \$43 Up to \$60 Up to \$91 N/A
Contact Lens Fit & Follow-up Exams Elective Medically Necessary	Member cost up to \$60 Up to \$200 Covered in full	No benefit Up to \$100 Up to \$210
Frame Allowance - Once every 24 months	\$200**	Up to \$40

Type Service	EyeMed Plan	
	In Network	Out-of-Network
Deductibles	\$20 Exam \$20 Eyeglass Lenses or Frames	No deductible
Annual Eye Exam	Covered in full	Up to \$35
Lenses - Once every 12 months Single Vision Bifocal Trifocal Lenticular Progressive	Covered in full Covered in full Covered in full 20% discount See lens options	Up to \$25 Up to \$40 Up to \$55 No benefit N/A
Contact Lens Fit & Follow-up Exams Standard Premium Elective Medically Necessary	Member cost up to \$60 10% off of retail Up to \$200 Covered in full	No benefit No benefit Up to \$144 Up to \$200
Frame Allowance - Once every 24 months	\$200**	Up to \$90

VISION PLAN PREMIUMS

Plan	Coverage	Employee Monthly*	Employer Monthly	Employee Bi-Weekly	Employer Bi-Weekly
VSP	Individual	\$5.00	\$0.00	\$2.31	\$0.00
	Employee+1	\$9.84	\$0.00	\$4.54	\$0.00
	Family	\$15.36	\$0.00	\$7.09	\$0.00
EyeMed	Individual	\$5.00	\$0.00	\$2.31	\$0.00
	Employee+1	\$9.84	\$0.00	\$4.54	\$0.00
	Family	\$15.36	\$0.00	\$7.09	\$0.00

*Employee monthly amounts will vary depending on the number of payroll cycles in a given month



Life and AD&D Insurance



GROUP BASIC TERM LIFE AND AD&D INSURANCE

The City of Birmingham offers employer-paid Group Basic Term Life & AD&D insurance through Standard Insurance Company. Product plan provisions are as follows:

Employee Eligibility	30 or more hours per week
Basic Life and AD&D Amount	1.75% of your basic annual earnings to a maximum of \$1,000,000. Acceptable evidence of good health may be required to become insured for the amount of coverage in excess of \$625,000
Dependent Life Amount	Spouse \$1,000 Dependent Child(ren) Birth to age 25 is \$1,000
Basic Life and AD&D Insurance Reduction Schedule	Employee Life / AD&D benefit reduces to 65% of the original benefit at age 65 and 50% of the original benefit at age 70.
Basic Life and AD&D Rates	Your Employer currently pays the cost of this coverage.
Benefit Waiting Period	30 Days

Life Insurance provides protection against the economic loss caused by the death of the person insured. Simply put, life insurance provides a lump sum payment (sometimes known as a death benefit) to beneficiaries in the event of the insured's death. Life Insurance can help replace lost income due to death. This money can also help to pay funeral costs, medical expenses not covered by health insurance, and other outstanding debts. The City of Birmingham pays 100% of the cost of this coverage for you.

The Accidental Death Benefit protects your loved ones from the financial burden that an accidental death can bring. If you die as a direct result of an injury due to a covered accident, the death benefit paid to your beneficiary will be doubled.

Please be sure to add beneficiaries. You may update and/or change beneficiaries at any time.



Life and AD&D Insurance

VOLUNTARY TERM LIFE AND AD&D INSURANCE

The City of Birmingham offers Voluntary Term Life & AD&D insurance product through Standard. Product plan provisions are as follows:

Employee Eligibility	30 or more hours per week
Voluntary Life and AD&D Available Benefit Amounts	<p>You have the flexibility to choose coverage for yourself in units of \$10,000 to a maximum of \$200,000.</p> <p>You may insure your spouse and dependent children for Life Insurance only. Cover amounts are as follows:</p> <ul style="list-style-type: none"> • Spouse - \$5,000-\$25,000 in increments of \$5,000 • Birth to age 26 regardless of student status - 1,000 - \$10,000 in increments of \$1,000 • Handicapped children over the age of 26 are eligible for coverage. <p><i>A spouse or child who is also an employee cannot be insured as a dependent. If both spouses are insured employees of the same group, their children can be insured as dependents of one spouse only.</i></p>
Guaranteed Issue Amounts	<p>If you and your eligible dependents enroll within the initial eligibility period as defined by the policy, you and your eligible dependents may purchase a specific amount of insurance on a guaranteed basis. No medical questions will be asked for coverage at or under the Guaranteed Issue Amount.</p> <ul style="list-style-type: none"> • Employee - \$200,000 • Spouse - \$25,000 <p>Guaranteed Issue coverage will become effective for eligible employees on the later of the effective date as defined by the group policy or the date the application is approved by Standard. Proof of good health satisfactory to Standard is required for amounts above the Guarantee Issue Amount or beyond the initial eligibility period.</p>
Group Voluntary Accidental Death and Dismemberment	If you elect Additional Life Insurance, you may elect AD&D insurance in increments of \$10,000 from \$10,000 - \$200,000. Your elected AD&D amount cannot exceed your Additional Life amount.
Portability	If you leave your employment prior to age 65, the coverage is “portable” for you, your spouse under age 65 and all eligible dependent children. You may elect to exercise this option in accordance with the provisions as defined by the policy. The coverage would not include Waiver of Premium or Group Voluntary AD&D
Conversion	Employees have 31 days from the date of termination to convert their Group Voluntary Life Insurance to an individual permanent life policy without evidence of insurability. The premium will be based on Standard’s usual rate for the insured’s age on the date of conversion. Coverage will not include Waiver of Premium or Group Voluntary AD&D.
Waiver of Premium	If you become totally disabled prior to age 60 and remain totally disabled for the period stated in the policy, Standard will continue your insurance without any further payment of premiums subject to the provisions of the contract.
Accelerated Death Benefit	If you become terminally ill, you may be eligible to receive up to 80% of your combined Basic and Additional Life benefit to a maximum of \$500,000



Life and AD&D Insurance

VOLUNTARY TERM LIFE AND AD&D INSURANCE PREMIUMS

Employee			Spouse		Dependent Child	
Age	Monthly Rate per \$1,000 of Life Coverage	Monthly Rate per \$1,000 of AD&D Coverage	Age	Monthly Rate per \$1,000 of Life Coverage	Age	Monthly Rate per \$1,000 of Life Coverage
<25	\$0.055	\$0.05	<25	\$0.043	14 days to age 26	\$0.303
25-29	\$0.063	\$0.05	25-29	\$0.050		
30-34	\$0.080	\$0.05	30-34	\$0.065		
35-39	\$0.105	\$0.05	35-39	\$0.097		
40-44	\$0.149	\$0.05	40-44	\$0.141		
45-49	\$0.239	\$0.05	45-49	\$0.220		
50-54	\$0.382	\$0.05	50-54	\$0.341		
55-59	\$0.589	\$0.05	55-59	\$0.521		
60-64	\$0.930	\$0.05	60-64	\$0.880		
65-69	\$1.624	\$0.05	65-69	\$1.488		
70-74	\$2.901	\$0.05	70-74	\$2.648		
75+	\$5.630	\$0.05	75+	\$5.380		



SHORT-TERM DISABILITY INSURANCE

Short-Term Disability coverage replaces a portion of your income when you can't work because of a qualifying disability. Even if you're healthy now, it's important to protect yourself and the people who count on your income. This insurance can help you pay the bills when you're unable to work. This benefit is paid 100% by you.

Eligibility	30 or more hours per week
Benefit Provides	60% of your eligible earnings, up to a minimum benefit of \$1,500 per week. Plan minimum \$25 per week
Benefit Waiting Period	14 days for accidental injury, physical disease, pregnancy or mental disorder
Benefits Last	90 days
Return to Work Incentive	Your disability benefit will not be reduced by any work earnings you receive until the combined amount of the benefit and your work earnings exceeds 100% of your pre-disability earnings
Help with Returning to Work	If a worksite modification would enable you to return to work, we can help your employer make approved modification by covering some or all of the cost
Late Enrollment Penalty	If you do not apply for coverage within 31 days of becoming eligible, your benefit waiting period for any qualifying disability caused by physical disease, pregnancy or metal disorder occurring during the first 12 months of coverage will be 60 days

LONG-TERM DISABILITY INSURANCE

Long-Term Disability coverage is designed to replace a portion of your income when you're disabled for an extended period of time due to a qualifying disability and help you get back to work when ready. Long-Term Disability benefits can help you pay your bills and safeguard your savings when you're unable to work. Whether you're out for a few months or several years, this benefit can help you protect your income and those who depend on it. This benefit is paid 100% by you.

Eligibility	30 or more hours per week
Benefit Provides	60% of your eligible earnings, up to a minimum benefit of \$10,000 per month. Plan minimum per month - \$100 or 10% of the LTD benefit.
Benefit Waiting Period	90 days
Benefits Last	Until your Social Security Normal Retirement Age (SSNRA) Depending on your age at the time of disability, your benefits may be subject to a different schedule.
Survivors Benefit	If you die while receiving benefits, your survivor may be eligible to receive a one-time additional payment
Help with Returning to Work	This plan provides incentives to help you get back to work. For instance you'll get help paying for some of the expenses associated with participating in an approved rehabilitation plan. You may also be eligible to receive an additional benefit of 10% of your predictability earnings for participating in an approved rehabilitation plan.



Voluntary Benefits

WHOLE LIFE INSURANCE

Group Whole Life Insurance can pay money to your family if you die. It can help them with basic living expenses, tuition and later, final expenses.

How does it work?

You can keep Group Whole Life Insurance as long as you want. Once you've bought coverage, your cost won't increase as you age. Coverage is guaranteed as long as you pay premiums. That means you get protection during your working years and into retirement. Your plan also has a coverage reduction provision. See the disclosures to learn more.

Group Whole Life Insurance also builds cash value at a guaranteed rate of 3.75%*. Your plan has a 10-year period during which cash value accumulates, but is not accessible.

Why should I buy coverage now?

- Once you purchase coverage, your premium remains the same as long as premiums are paid.
- When you purchase coverage when first eligible, you qualify for coverage without medical underwriting.
- The cost is conveniently deducted from your paycheck.
- Group Whole Life insurance gives you valuable protection in addition to any term life insurance you might have.
- Your coverage, as well as coverage for your spouse and child (if applicable), is portable, meaning you can take it with you if you leave your company. Your premiums would remain the same but you would be billed directly.

Who can get coverage?

Employee (issue ages 15-75)

You can purchase between \$5,000 and \$150,000 in increments of \$5,000 during this enrollment. You can purchase up to \$150,000 without medical underwriting to qualify for coverage.

Spouse (issue ages 15-75):

You can purchase between \$5,000 and \$25,000 in increments of \$5,000 for your spouse during this enrollment. You can purchase up to \$25,000 without medical underwriting to qualify for coverage. You may have to purchase coverage

for yourself before purchasing coverage for your spouse.

Children's Term Rider

The rider covers all eligible children, as well as future children (newborns, adopted children) for one fixed premium amount. Eligible children must be between live birth and 26 years old, your or your spouse's child, your lawfully adopted child, foster child or any other child residing with you that is dependent on you for primary financial support.**

You can purchase one of the following amounts:

\$10,000

\$20,000*

The amount of Group Whole Life Insurance for a spouse and the amount of coverage under Children's Term Rider will not be more than 100% of the employee Group Whole Life amount.

What's included?

Accelerated Death Benefit for Terminal Illness

You can request an advance payout of your death benefit if you're diagnosed with a terminal illness and expected to live 12 months or less. You can receive up to 100% of the death benefit to a maximum of \$150,000 and it can help cover your costs while you're still alive. Benefits received under this provision are taxable and any payout would reduce the benefit that's paid when you die. When benefits are accelerated under this rider, premiums will be waived for up to 12 months. As with all tax matters, individuals should consult a tax advisor to assess the impact of this benefit.

Accidental Death Benefit Rider

This rider increases the payment your family would receive if you die from a covered accident before age 70. Coverage is available for you and your spouse. The death benefit could be doubled, which could add up to \$150,000 extra coverage.

Waiver of Premium Rider

If you're totally disabled for at least six months before age 65 and you remain totally disabled, you won't have to pay premiums until you recover and return to work. During the six-month elimination period, premiums must continue to be paid. During the period of total disability the cash value does not increase.



Voluntary Benefits

CRITICAL ILLNESS INSURANCE

How does it work?

If you're diagnosed with an illness that is covered by this insurance, you can receive a lump sum benefit payment. You can use the money however you want.

Why should I buy coverage now?

- It's more accessible when you buy it through your employer and the premiums are conveniently deducted from your paycheck.
- Coverage is portable. You may take the coverage with you if you leave the company or retire. You'll be billed at home.

Why is this coverage so valuable?

- The money can help you pay out-of-pocket medical expenses, like deductibles.
- You can use this coverage more than once. Even after you receive a payout for one illness, you're still covered for the remaining conditions and for the reoccurrence of any critical illness with the exception of skin cancer. The reoccurrence benefit can pay 100% of your coverage amount. Diagnoses must be at least 180 days apart or the conditions can't be related to each other.

Be Well Benefit

Every year, each family member who has Critical Illness coverage can also receive \$75 for getting a covered Be Well Benefit screening test, such as:

- Annual exams by a physician include sports physicals, well-child visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

What's covered?

Critical Illnesses

- | | |
|----------------------------|-----------------------|
| • Heart attack | Major (50%): |
| • Stroke | Coronary artery |
| • Major organ failure | bypass graft or valve |
| • End-stage kidney failure | replacement |
| • Sudden cardiac arrest | Minor (10%): |
| • Coronary artery disease | Balloon angioplasty |
| | or stent placement |

Cancer conditions

- Invasive cancer — all breast cancer is considered invasive
- Non-invasive cancer (25%)
- Skin cancer — \$1000

Progressive diseases

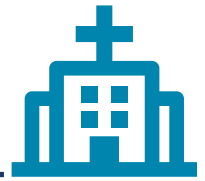
- Amyotrophic Lateral Sclerosis (ALS)
- Dementia, including Alzheimer's disease
- Multiple Sclerosis (MS)
- Parkinson's disease
- Functional loss
- Huntington's Disease
- Lupus
- Muscular Dystrophy
- Myasthenia Gravis
- Systemic Sclerosis (Scleroderma)
- Addison's Disease

Supplemental conditions

- Loss of sight, hearing or speech
- Benign brain tumor
- Coma
- Permanent Paralysis
- Occupational HIV, Hepatitis B, C or D
- Occupational PTSD Paid at 25%
- Infectious Diseases
- Pulmonary Embolism
- Transient Ischemic Attack (TIA)
- Bone Marrow/Stem Cell

Who can get coverage?

- **You:** Choose from \$5,000 to \$50,000 of coverage in increments of \$1,000 with no medical underwriting to qualify if you apply during this enrollment.
- **Your spouse:** Spouses can only get 100% of the employee coverage amount as long as you have purchased coverage for yourself.
- **Your children:** Children from live birth to age 26 are automatically covered at no extra cost. Their coverage amount is 50% of yours. They are covered for all the same illnesses plus these specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome, spina bifida, type 1 diabetes, sickle cell anemia and congenital heart disease. The diagnosis must occur after the child's coverage effective date.



ACCIDENT INSURANCE

How does it work?

Accident Insurance provides a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur on and off the job. And it includes a range of incidents, from common injuries to more serious events.

Why is this coverage so valuable?

It can help you with out-of-pocket costs that your medical plan doesn't cover, like co-pays and deductibles. You'll have base coverage without medical underwriting. The cost is conveniently deducted from your paycheck. You can keep your coverage if you change jobs or retire. You'll be billed directly.

What's included?

Be Well Benefit

Every year, each family member who has Accident coverage can also receive \$50 for getting a covered Be Well screening test, such as:

- Annual exams by a physician include sports physicals, well-child visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

Organized Sports Benefit

Each family member that has Accident coverage is eligible for a 25% increase in payable benefits within the Injury and Treatment schedule of benefit categories. See disclosures and schedule of benefits for more information.

Who can get coverage?

- **You:** If you're actively at work*
- **Your spouse:** Can get coverage as long as you have purchased coverage for yourself.
- **Your children:** Dependent children from birth until their 26th birthday, regardless of marital or student status.

*Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage. See Schedule of benefits for a complete listing of what is covered.

HOSPITAL INDEMNITY INSURANCE

Group Hospital Insurance can pay benefits that help you with the costs of a covered hospital visit.

How does it work?

Group Hospital Insurance helps covered employees and their families cope with the financial impacts of a hospitalization. You can receive benefits when you're admitted to the hospital for a covered accident, illness or childbirth.

Why is this coverage so valuable?

- The money is payable directly to you — not to a hospital or care provider. The money can also help you pay the out-of-pocket expenses your medical plan may not cover, such as co-insurance, co-pays and deductibles.
- You get accessible rates when you buy this coverage at work.
- The cost is conveniently deducted from your paycheck.
- The benefits in this plan are compatible with a Health Savings Account (HSA).
- You may take the coverage with you if you leave the company or retire. You'll be billed directly.

Be Well Benefit

Every year, each family member who has Hospital coverage can also receive \$50 for getting a covered Be Well screening test, such as:

- Annual exams by a physician include sports physicals, wellchild visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

Who can get coverage?

- **You:** If you're actively at work.
- **Your spouse:** Can get coverage as long as you have purchased coverage for yourself.
- **Your children:** Dependent children newborn until their 26th birthday, regardless of marital or student status



LegalShield provides you and your family the legal protection you not only need but deserve.

The LegalShield plan provides benefits for the following*:

Estate Planning

- Codicils
- Living Wills
- Power of Attorney
- Trusts
- Wills

Family

- Administrative Hearing
- Adoption
- Conservatorship
- Domestic Violence Protection
- Elder Care Assistance
- Guardianship
- Immigration Assistance
- Incompetency Defense
- Juvenile Court Defense
- Name Change
- Parental Responsibility
- Prenuptial Agreements
- School Hearings
- Uncontested Divorce

Financial

- Affidavits
- Bankruptcy
- Civil Litigation
- Consumer Protection
- Debt Collection
- Identity Theft
- Medicaid/Medicare Disputes
- Personal Property Disputes
- Promissory Notes
- Small Claims Assistance
- Social Security Disputes
- Tax Audit Protection
- Veterans Benefits Disputes

Auto

- Driver's License Restoration
- Motor Vehicle Property Damage
- Moving Traffic Violations
- Traffic Tickets

Home

- Boundary/Title Disputes
- Contractor Disputes
- Deeds
- Foreclosure
- Home Equity Loans
- Landlord/Tenant Issues
- Mortgages
- Property Tax Assessments
- Purchase/Sale of Home (primary or secondary)
- Refinancing
- Zoning Applications

General

- 24/7 Emergency Legal Access
- Document Review
- Legal Forms
- Live Member Support
- Mobile App
- Office Consultation
- Telephone Advice

For more information visit: benefits.legalshield.com/birmingham

*Limitations may apply. This is a general overview of coverage. See a summary plan description for full details. The following items are not covered with any service, including advice and consultation: business or commercial matters; fines, court costs, filing fees, ad litem fees, penalties, expert witness fees, bonds, bail bonds and any out-of-pocket expense; matters or disputes between the participant and/or the employer, and/or Provider Attorney and/or LegalShield; any matter covered by any insurance policy; Native American legal issues; requested service that lacks merit, is frivolous or would violate any ethical rule or law; items related to patent, trademark, or copyright matters. Services outside the United States. For all other personal legal matters, advice and consultation is provided.

Employee Benefits



PAID TIME OFF

The City provides paid time off for designated holidays and vacation. Paid leave is also available for birthday, sick leave, bereavement leave and jury duty. Employees in the National Guard or Reserves may be granted military leave with pay not to exceed 21 working days provided the employee is in a full-time permanent position. Any employee summoned for jury duty or as a witness in court shall be granted leave with pay.

You are eligible for paid vacation leave after 90 days of continuous employment. You are eligible for paid sick leave after 60 days of continuous employment. No more than 320 hours of accrued vacation may be carried forward from one calendar year to the next. Sick leave may be carried forward from one calendar year to the next with no maximum amount. An employee will **NOT** accrue vacation or sick leave when in a non-pay status.

Years of Service Completed	Hours of Vacation Time Accrued per Month	Hours of Sick Time Accrued per Month
1 to 11	8	8
12 to 24	12	8
25 or More	16	8
Firefighter Personnel Only		
1 to 11	10.64	10.64
12 to 24	15.96	10.64
25 or More	21.28	10.64

Fire and Police monthly accruals are subject to change.

2025/2026 HOLIDAY SCHEDULE

The following holidays for 2025/2026 are for all employees of the City of Birmingham, except those performing essential services.

- Martin Luther King Day
- Good Friday
- Memorial Day
- Juneteenth
- Fourth of July
- Labor Day
- Veteran's Day
- Thanksgiving
- Day after Thanksgiving
- Christmas Eve
- Christmas
- New Year's Day

Employee Benefits



EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT

Per The United States Department of Labor Wage and Hour Division

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered service member's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the service member with a serious injury or illness. An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule. Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave. Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions. An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the

FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave.

The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified. Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employee Benefits



EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT CONT.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility. Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:
1-866-4-USWAGE (1-866-487-9243)
TTY: 1-877-889-5627
<https://www.dol.gov/agencies/whd>

Paid Parental Leave (PPL)

City of Birmingham provides all regular, classified, exempt, and appointed full-time employees, as well as hourly employees who meet the criteria outlined in the policy, with up to 12 full weeks or 480 hours of paid parental leave in a 12-month period. Paid Parental Leave is not charged against an employee's accrued leave. Paid Parental Leave runs concurrently with any leave available under FMLA as outlined in the City's FMLA policy. Parental leave may be used for medical reasons and to support bonding with a newly born, newly placed adopted child, or newly placed foster child.

Employee Benefits



SICK AND VACATION LEAVE BANKS

Sick Leave Bank

The sick leave bank is a voluntary program that is available for any City employee who joins by donating hours to the sick bank. Once an employee donates hours, that employee is eligible to withdraw up to 240 hours (6 weeks) of paid leave for personal and family medical emergencies.

To join the sick leave bank, an employee must make an initial donation of 16 hours of sick leave for the first year. After the first year, an employee participating in the sick leave bank must donate an additional 8 hours of sick leave per year. (Provisions are provided for those who may have no leave time at the annual assessment, which is July 1. More information may be found at www.birminghamal.gov/leavebank.)

Employees are allowed no more than 240 hours of sick bank time during a 12-month period.

The sick leave bank will assist participating employees who have exhausted all accrued leave balances because of:

- A non-job related personal catastrophic medical event
- A sudden change in health
- A catastrophic medical event
- A sudden change in the health of an employee's immediate family member or an individual who resides in the employee's home

What's covered?

Illnesses and conditions that are generally covered by FMLA, qualify for sick bank time.

Vacation Bank

The vacation bank will assist participating City employees who have exhausted all accrued vacation balances because of a non-job-related personal catastrophe such as:

- A home fire
- A flood in the home
- Some other non-medical emergency

Employees who have exhausted vacation balances may seek to withdraw up to 40 hours of emergency vacation. To join the vacation bank, an individual must make an initial contribution of 8 hours.

Employees are allowed no more than 40 hours of vacation bank time during a 12-month period.

Maternity/Paternity Leave

The vacation bank will also allow new parents to request up to six weeks (240 hours) for paid maternity and paternity leave.

Where do I go to find the forms to sign up?

Please visit www.birminghamal.gov/leavebank. There, you will find the forms to sign.

NOTE: You MUST have Adobe on your computer in order to sign the form online. If you don't have Adobe, you may print out the form, sign it and turn it in to your payroll coordinator.

RETIREMENT AND PENSION PLAN

All eligible employees are required to contribute 7.5% into the Retirement and Relief Pension Plan (R&R) on a pre-tax basis. Sworn Fire and Police personnel are required to contribute an additional 5.22% to the Supplemental Pension Plan on a pre-tax basis. **For more information, contact the Pension Office at 205-254-2798.**

Deferred Compensation

For additional retirement savings, the City offers 457(b) Deferred Compensation Plans through Equitable and Nationwide Retirement Solutions. **For more information and to enroll, contact a deferred compensation plan agent (see back cover of this Benefits Guide for contact details).**

Employee Benefits



WELLNESS PROGRAM

BWELL BHM is the City of Birmingham’s wellness program. The mission of BWELL BHM is to drive employees to live healthier lives and Be Well. How do we define “be well?” Merriam-Webster Dictionary defines wellbeing as the state of being happy, healthy, and prosperous. Therefore, BWELL BHM takes a holistic approach to wellness, addressing our 1) physical health – nutrition, preventive services, disease management, fitness, 2) mental/emotional health, and our 3) financial health. BWELL BHM drives us to better living by hosting fitness activities, lunch seminars, and events to engage employees in healthier behaviors.

Alabama Tobacco Quitline

Quitting tobacco isn’t easy. That’s why we are here to help. The Alabama Tobacco Quitline (1-800 Quit Now) is a free telephone and online coaching service for any Alabamian who is ready to quit tobacco. Information, referrals and counseling are confidential, and sessions are designed on a schedule convenient for the caller. Those who enroll in the counseling program can

receive, if medically eligible, up to eight weeks of nicotine patches to assist in quitting.

Call 1-800 Quit Now (1-800-784-8669) or visit www.quitnowalabama.com to enroll in the program. All services are free for Alabama residents.

Parking Card

Full-time permanent employees, students, interns, and employees approved by the Mayor’s Office are eligible to obtain a parking card for parking Deck #2 located on 19th Street and 8th Avenue North. A one-time charge of \$60 is paid by the employee; replacement cards are \$15.00.

Tuition Reimbursement

Permanent full-time employees, with one year of service attending an accredited institution are eligible for up to \$2,500 per fiscal year toward an academic degree or a certification training program on a first-come, first-served basis. Coursework and certification training programs must be related to the employee’s present position and/or promotional opportunities with the City.

City Fitness Centers			
Fitness Center South	401 6th Avenue S Birmingham, Al 35205	Fitness Testing/ Personal Training/Free Weights/ Machine Weights/ Cardiovascular Equipment	(205) 254-6389
City Hall Fitness Studio	710 20th St. N Birmingham, Al. 35203	Cardiovascular Equipment/ Machine Weights/ Free Weights	
City Recreation Centers			
Smithfield Community Center	421 Reverend Abraham Wood Jr. Boulevard Birmingham, Al. 35204	Group Exercise Classes/Zumba/ Martial Arts/Free Weights/Machine Weights/ Cardiovascular Equipment	(205) 297-8130
Brownsville Heights	9225 Airport Road Birmingham, Al. 35207	Group Exercise Classes/ Community Basketball/ Youth Sports	(205) 841-2520
Central Park	4700 Terrace Q. Ensley Birmingham, Al. 35208	Group Exercise Classes/ Community Basketball/ Youth Sports	(205) 923-6747
East Pinson Valley	3000 Jefferson State Pkwy. Birmingham, Al. 35215	Group Exercise Classes/ Community Basketball/ Youth Sports	(205) 297-8102
Ensley	2800 Avenue K Birmingham, Al. 35218	Group Exercise Classes/ Community Basketball/ Youth Sports	(205) 786-3711
Fountain Heights	1101 15th Avenue North Birmingham, Al. 35204	Group Exercise Classes/ Community Basketball/ Youth Sports	(205) 322-1233

Employee Benefits



OTHER EMPLOYEE BENEFITS

CITY ATTRACTIONS

Birmingham Zoo

Employees enjoy free memberships to the Birmingham Zoo for up to two adults and six children. Membership cards will be provided to employees or may be picked up at the Zoo Membership Office with valid identification.

Birmingham Museum of Art

Employees enjoy free memberships to the Birmingham Museum of Art. The membership is renewable annually as long as the employee is working with the city. While the BMA offers free general admission to everyone throughout the year, this digital membership entitles city employees to the following benefits:

- A museum E-Newsletter subscription that will include communication on programs and events
- Discounted admission to ticketed events and programs
- 10% discount on purchases in the Museum Store and at Juniper at the Museum
- 10% discount on Studio School classes and Art Camps
- In order to receive the discount at the store and café, employees must show their city employee ID badge.

To sign up for your free membership:

1. Visit artsbma.org/membership
2. Scroll down and select the first membership level, "Individual"
3. Select "1 year membership"
4. Type in your first and last name and select "Add to cart."
5. Once in cart, use discount code "BMACOB" and hit "apply." The cart balance will become zero.
6. Finish filling out the registration form with name & address
7. Set up an online account under "Registration Information" (You will need this in order to login to buy Art on the Rocks tickets in the future.)
8. Hit check out! You will receive an email with your information.

Contact the Membership Office at 205-254-2389 for assistance.

Arlington Historic House and Gardens, Vulcan Park and Museum, and the Southern Museum of Flight

Employees also receive free admission for themselves and their families (employee plus four additional family members) to Arlington Historic House and Gardens, Vulcan Park and Museum, and the Southern Museum of Flight up to four times per year. Employees must present their admission ticket and employee ID.

HEALTH DISCOUNT

- **YMCA** – All employees will receive a 20% discount and the initiation fee is waived
- **24E Fitness**– waived initiation fee, discounted membership COB first responders

FOOD DISCOUNTS

- **Taco Mama** – 10% discount (first responders only)
- **The Modern House Coffee Shop**
422 6th Avenue South, Birmingham AL 35205 – COB 25% Employee Discount on all purchases
- **The Modern House Coffee Shop**– 25% discount
- **Drink Fresh Juice Bar/Food truck**– 20% discount

HIGHER EDUCATION

- **Faulkner University** – 50% tuition discount for full-time employees.
- **Columbia Southern University** – 10% tuition discount for full time employees.

ADDITIONAL DISCOUNTS

- **AT&T Wireless** – Employees receive a 15% discount
- **Closets by Design**– By appointment employee discount
- **Morris Ave Eyecare**– Free Eye exam/ Consultation, 10% purchase discount
- **Levite Jewish Community Center**– 15% discount, waived enrollment fees
- **C-LUXE Spa**
 - \$25 off Facial Services
 - 10% off Facial Products
 - 50% off Body Services
- 20% off Body Care Products



Retiree Benefits

Congratulations on your retirement! The City of Birmingham is proud to offer health, dental and life insurance benefits to its retirees. These benefits represent a significant portion of your retirement package and provide important protection for you and your family in the event of illness.

We encourage you to review the material contained in this section to assist you in making informed decisions about your benefits.

RETIREE MEDICAL PLAN

Type Service	In-Network	Out-of-Network
Plan Year Deductible	\$1,500 per person / \$3,000 aggregate maximum per family	
Annual Out-of-Pocket	\$4,000 per person / \$8,000 aggregate maximum per family	
Inpatient Hospital	90% after plan year deductible	70% after plan year deductible
Outpatient Hospital	90% after plan year deductible	70% after plan year deductible
Outpatient Diagnostic Lab, X-ray, and Pathology	90% after plan year deductible	70% after plan year deductible
Outpatient Dialysis, IV Therapy, Chemotherapy, and Radiation Therapy	90% after plan year deductible	70% after plan year deductible
Emergency Room – Medical Emergency or Accident	90% after plan year deductible	90% after plan year deductible
Primary Care Physician Office Visit	100% after \$25 office visit copay	70% after plan year deductible
Urgent Care Office Visit	100% after \$70 office visit copay	70% after plan year deductible
Specialist Office Visits	100% after \$75 office visit copay	70% after plan year deductible
Preventive Benefits (See list of specific preventive services) <ul style="list-style-type: none"> • Routine Immunizations • Urinalysis • CBC • TB Skin Test • Bone Density Scan • Chest X-Ray • EKG • Cholesterol Screening and/or Lipid Panel 	100% no copay or deductible	<p>NOT COVERED</p> <p>EXCEPTION: 70% after deductible for the following services only:</p> <ul style="list-style-type: none"> • Routine Pap Smear (one each year) • Routine Human Papillomavirus (HPV) testing (one per female member ages 30 and older every three plan years) • Routine Chlamydia screenings (one per female member ages 15-24 each plan year)
Other Covered Services	90% after plan year deductible	70% after plan year deductible
Prescription Drug Coverage		
Retail Pharmacy	Generic Drugs: \$7 copay Preferred Brand Name Drugs: \$65 copay Other Brand Name Drugs: \$80 copay Specialty Drugs: \$100 copay	
Retail 90 Maintenance Network	Generic Drugs: \$12 copay Preferred Brand Name Drugs: \$55 copay Other Brand Name Drugs: \$85 copay Specialty Drugs: \$95 copay	
Mail Order	Generic Drugs: \$10 copay Preferred Brand Name Drugs: \$60 copay Other Brand Name Drugs: \$75 copay <i>Applies to maintenance medications only.</i> Specialty Drugs: \$100 copay	
Weight Loss Medications	Covered at retail only up to a 30-day supply. Covered at 80% of the allowed amount, subject to plan year deductible.	



Retiree Benefits

RETIREE MEDICAL PLAN CONTINUED

Medical Plan Monthly Premium			
Benefit Plan Type	Coverage	City Pays	Retiree Pays
BCBS PPO Value Medical Plan	Retiree	\$722.15	\$271.44
	Retiree+1	\$1,619.89	\$609.44
	Family	\$3,535.78	\$1,329.12

Spousal Surcharge: Spouses who are eligible to participate in group health plan coverage through their own employers are subject to a \$50 per pay period surcharge. City of Birmingham health plans will only provide secondary coverage to spouses eligible to participate in their own employer's group health plan who enroll in a City of Birmingham plan.

Nicotine Surcharge: Retirees who use nicotine are subject to a \$14 per pay period surcharge. If you enroll in a City of Birmingham health plan you will be required to certify whether you use nicotine.

The City of Birmingham is committed to helping you achieve your best health. The premium cost for not using nicotine is available to all retirees. If you think you might be unable to meet a standard for avoiding the nicotine surcharge, you might qualify for an opportunity to earn the non-nicotine-use premium by different means. Contact us at 205-254-2798 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same premium discount that is right for you in light of your health status.

Health Plan Eligibility

Full-time and permanently appointed employees of the City of Birmingham working 30 or more hours per week who retire when enrolled in a City of Birmingham health plan are eligible to participate in the City of Birmingham Retiree health plan.

Your eligible dependents include your legal spouse up to age 65; a child under age 26; an unmarried, incapacitated child age 26 and over who is unable to support him/herself, depends on you for support, if the incapacity occurred before reaching age 26; and/or a child for which you maintain legal guardianship, including your natural child, stepchild residing in your household, legally adopted child, or disabled child.

How long can I keep health and dental coverage under the City of Birmingham's Retiree health plan?

You can keep your coverage under the health plan until the first day of the month in which you turn age 65 (unless your birthday is on the 1st day of the month, then your coverage ends on the 1st day of the preceding month). Your eligible dependents can remain on the plan even if you lose coverage.

What if I need to make changes to my benefits?

If you need to make changes to your benefits, contact the Human Resources Benefits & Pension Division at 205-254-2798.

What if I need to change my name or contact information?

Name, address, and telephone number changes should be communicated to the Payroll Office at 205-254-2196.



Retiree Benefits

RETIREE DENTAL PLAN

Highlights			
Eligibility	Primary enrollee, spouse and eligible dependent children to age 26		
Deductibles* Deductibles are waived for Diagnostic & Preventive	\$25 per person / \$75 per family each plan year		
Maximums* Diagnostic & Preventive counts toward Maximum	\$1,000 per person each plan year Value Plan \$1,500 per person each plan year Premier Plan		
Waiting Period(s)	Basic Benefits 0 Months	Major Benefits 0 Months	Orthodontics 0 Months

Benefits and Covered Services**	Premier Dental Plan		Value Dental Plan	
	In-Network Dentists	Out of Network Dentists	In-Network Dentists	Out of Network Dentists
Diagnostic & Preventive Services Exams, Cleanings, X-rays, Sealants	100%	100%	100%	100%
Basic Services Fillings, Simple Tooth Extractions	80%	80%	50%	50%
Endodontics (root canals) Covered under Basic Services	80%	80%	50%	50%
Periodontics (gum treatment) Covered under Basic Services	80%	80%	50%	50%
Oral Surgery Covered under Basic Services	80%	80%	50%	50%
Major Services Crowns, Inlays, Onlays and Cast Restorations, Bridges and Dentures, Implants	50%	50%	50%	50%
Orthodontic Benefits Adults and Dependent Children	50%	50%	Not Covered	Not Covered
Orthodontic Maximums Lifetime	\$1,500	\$1,500	Not Covered	Not Covered

* If you switch plans during the calendar year your Deductible and Annual Maximum may be adjusted accordingly.

** Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on contract allowances and not necessarily each dentist's actual fees.

The City of Birmingham's Dental Plans are administered by Blue Cross Blue Shield of Alabama.

Dental Plan Premiums					
Benefit Plan Type	Coverage	Retiree Pays	Benefit Plan Type	Coverage	Retiree Pays
Premier Dental Plan	Retiree	\$20.93	Value Dental Plan	Retiree	\$12.30
	Retiree+1	\$47.58		Retiree+1	\$23.79
	Family	\$75.15		Family	\$37.09



Retiree Benefits



RETIREE GROUP LIFE INSURANCE

The City of Birmingham offers retirees Group Basic Life insurance through Standard in two amounts:

Basic Life Benefit Class 2	Basic Life Benefit Class 3
\$1,000 to a maximum of \$50,000.	Your amount inforce with prior carrier not to exceed \$10,000
Benefit Reductions	Benefit Reductions
No age reduction in benefit	No age reduction in benefit
Monthly Plan Premium	Monthly Plan Premium
\$0.398 per \$1,000 of total coverage	\$0.398 per \$1,000 of total coverage

Life Insurance provides protection against the economic loss caused by the death of the person insured. Simply put, life insurance provides a lump sum payment (sometimes known as a death benefit) to beneficiaries in the event of the insured’s death. Life Insurance can help replace lost income due to death. This money can also help to pay funeral costs, medical expenses not covered by health insurance, and other outstanding debts.

If you have questions about your coverage or need to update your beneficiaries or contact information, contact Human Resources.

Annual Notices



Important Notice about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Birmingham and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The City of Birmingham has determined that our prescription drug coverage is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 1, 2025 through January 15, 2026 for coverage starting as early as January 1, 2026. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

Active

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City of Birmingham coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you may enroll back into the prescription drug benefit plan during an open enrollment period under the City of Birmingham as an **Active** employee.

Retiree

As a **Retiree**, if you decide to join a Medicare drug plan and drop your current City of Birmingham coverage be aware that you and your dependents will not be able to get this coverage back from the City of Birmingham.

Please note, once you reach the age of 65 you will no longer be eligible for coverage under the City of Birmingham's medical and prescription drug plan.

Contact Human Resources at 205-254-2798 for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with City of Birmingham and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

Annual Notices



Contact Human Resources at 205-254-2798 for more information about this notice or your current prescription drug coverage. NOTE: You will receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan, and if this coverage through your employer changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

There is a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins November 1, 2025, through January 15th, 2026, for coverage starting as early as January 1, 2026.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution –as well as your employee contribution to employer-offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

Annual Notices



How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources at benefits@birminghamal.gov or call 205-254-2798. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information about Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name: City of Birmingham		
4. Employer Identification Number (EIN): 63-6001201		
5. Employer Address: Birmingham City Hall, 710 North 20th Street, 8th Floor		
6. Employer Phone Number: 205-254-2798		
7. City: Birmingham	8. State: AL	9. Zip: 35203
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different than above):		
12. Email address: benefits@birminghamal.gov		

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to: all full-time employees working 30 or more hours per week.
- With respect to dependents: we offer coverage to your legal spouse; a child under age 26; an unmarried, incapacitated child age 26 and over who is unable to support him/herself, depends on you for support, if the incapacity occurred before reaching age 26; and/or a child for which you maintain legal guardianship, including your natural child, stepchild residing in your household, legally adopted child, or disabled child.

This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be

affordable, based on employee wages. Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process.

Women's Health and Cancer Rights Notice

The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. These services include:

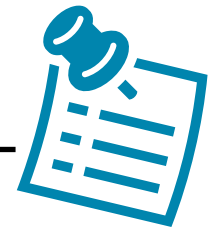
- Reconstruction of the breast upon which the mastectomy was performed,
- Surgery/reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Physical treatment of complication during all states of mastectomy, including lymphedema.

In addition, the Plan may not:

- Interfere with a woman's rights under the Plan to avoid these requirements, or
- Offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law.

However, the Plan may apply deductibles and cost sharing consistent with other coverage provided by the plan. For Plan deductible and cost share amounts, please see the Summary Plan Description. This law also requires written notice of the availability of the coverage be delivered to all plan participants upon enrollment and annually thereafter. This notice fulfills that requirement. All questions about this notice should be directed to Human Resources.

Annual Notices



Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these

programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of March 17, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	FLORIDA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268

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<p>GEORGIA – Medicaid</p> <p>GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2</p>	<p>MAINE – Medicaid</p> <p>Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofa/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p>
<p>INDIANA – Medicaid</p> <p>Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584</p>	<p>MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
<p>IOWA – Medicaid</p> <p>Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki – Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562</p>	<p>MINNESOTA – Medicaid</p> <p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>
<p>KANSAS – Medicaid</p> <p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>	<p>MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
<p>KENTUCKY – Medicaid</p> <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihhip.aspx Phone: 1-855-459-6328 Email: KIHIPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p>MONTANA – Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov</p>
<p>LOUISIANA – Medicaid</p> <p>Website: www.medicicaid.la.gov or www.lahipp.la.gov Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>	<p>NEBRASKA – Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>

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<p>NEVADA – Medicaid</p> <p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p>PENNSYLVANIA – Medicaid</p> <p>Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)</p>
<p>NEW HAMPSHIRE – Medicaid</p> <p>Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov</p>	<p>RHODE ISLAND – Medicaid</p> <p>Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)</p>
<p>NEW JERSEY – Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)</p>	<p>SOUTH CAROLINA – Medicaid</p> <p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p>
<p>NEW YORK – Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>	<p>SOUTH DAKOTA – Medicaid</p> <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>
<p>NORTH CAROLINA – Medicaid</p> <p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>	<p>TEXAS – Medicaid</p> <p>Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493</p>
<p>NORTH DAKOTA – Medicaid</p> <p>Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825</p>	<p>UTAH – Medicaid and CHIP</p> <p>Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/</p>
<p>OKLAHOMA – Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p>VERMONT – Medicaid</p> <p>Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427</p>
<p>OREGON – Medicaid</p> <p>Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075</p>	<p>VIRGINIA – Medicaid and CHIP</p> <p>Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924</p>

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<p>WASHINGTON – Medicaid</p> <p>Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022</p>	<p>WISCONSIN – Medicaid and CHIP</p> <p>Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002</p>
<p>WEST VIRGINIA – Medicaid</p> <p>Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p>	<p>WYOMING – Medicaid</p> <p>Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269</p>

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
 Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
 1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
 Centers for Medicare & Medicaid Services
www.cms.hhs.gov
 1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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MEDICARE PART D CREDITABLE DRUG COVERAGE NOTICE

CREDITABLE DRUG COVERAGE NOTICE

NOTE TO EMPLOYER: Please complete the information below before distributing to individuals covered by your plan who are eligible for Medicare.

Date: OCTOBER 1, 2025

Employer Name: CITY OF BIRMINGHAM

Plan Name: BLUE CROSS AND BLUE SHIELD OF ALABAMA

Contact: BENEFITS@BIRMINGHAMAL.GOV

Address: 710 N. 20TH ST. 2ND FLOOR, BIRMINGHAM, AL 35203

Phone Number: 205-254-2798

Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your employer and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Your employer has determined that the prescription drug coverage offered by your employer is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current employer group coverage may be affected. For example, you and your dependents may not be able to keep your current employer coverage if you join a Medicare drug plan.

If you decide to join a Medicare drug plan and drop your current employer group coverage, be aware that you and your dependents may not be able to get this coverage back. Please contact us at the address and/or telephone number at the top of this notice for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.



MEDICARE PART D CREDITABLE DRUG COVERAGE NOTICE CONTINUED

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with your employer and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact our office at the address and/or telephone number at the top of this notice for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your employer changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare.

You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).



REMEMBER

Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

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COBRA GENERAL NOTICE

Introduction

You are receiving this notice because you have recently become covered under one or more group health plans. The plan (or plans) under which you have become covered are listed at the end of this notice and are referred to collectively in this notice as “the plan.” **This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the plan when they would otherwise lose their group health coverage.

For more information about your rights and obligations under the plan and under federal law, you should review the plan’s summary plan description or contact the Plan Administrator for the plan. You will find the name, address and telephone number of the Plan Administrator at the end of this notice.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. 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 plan is lost because of the qualifying event. However, you and your family members are not entitled to COBRA coverage if you are employed as a nonresident alien who received no U.S. source income. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

What are Qualifying Events for a Covered Employee?

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

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

What are Qualifying Events for a Covered Spouse?

If you are the spouse of a covered employee, you will become a qualified beneficiary if you lose your coverage under the plan because any 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 his or her gross misconduct;
- Your spouse becomes enrolled in Medicare (under Part A, Part B, or both); or
- You become divorced from your spouse.

If your spouse cancels your coverage under the plan in anticipation of divorce and a divorce later occurs, the divorce may be considered a qualifying event even though you actually lost coverage under the plan earlier. If you timely notify the Plan Administrator of the divorce

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COBRA GENERAL NOTICE CONTINUED

What are Qualifying Events for a Covered Spouse Continued

and can establish that the covered employee canceled your coverage under the plan in anticipation of divorce, COBRA coverage may be available to you beginning on the date of your divorce (but not for the period between the date your coverage ended and the date of the divorce). See the rules below under **“You Must Give Notice of Some Qualifying Events”** regarding your obligation to provide timely notice to the Plan Administrator and the procedures for doing so.

What are Qualifying Events for Covered Dependent Children?

Your dependent children will become qualified beneficiaries if they lose coverage under the plan 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 his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare (under Part A, Part B, or both);
- The parents become divorced; or
- The child is no longer eligible for coverage under the plan as a “dependent child.”

A child of the covered employee or former employee who is receiving benefits under the plan pursuant to a qualified medical child support order is entitled to the same rights under COBRA as a dependent child of the covered employee. A child born to, adopted by or placed for adoption with a former employee during the period of COBRA coverage may also be a qualified beneficiary if the former employee is a qualified beneficiary who has elected COBRA coverage.

Additional Qualifying Event for Covered Retirees

If the plan provides retiree health coverage, sometimes filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer sponsoring the plan, and that bankruptcy results in the loss of coverage of any retired employee

covered under the plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.

When is COBRA Coverage Available?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer if the plan provides retiree health coverage, or the employee’s becoming enrolled in Medicare (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must timely notify the Plan Administrator in writing (using the procedures specified in the paragraph below entitled “Qualifying Event Notice Procedures”) within 60 days after the qualifying event occurs or within 60 days after the date on which coverage would be lost because of the event, whichever is later. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, any spouse or dependent child who loses coverage under the plan will not be offered the option to elect COBRA coverage as a result of these qualifying events.

Qualifying Event Notice Procedures: Any notice of a qualifying event that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must mail or hand deliver your notice to the Plan Administrator identified at the end of this notice. Your notice must be received by the Plan Administrator, identified at the end of this notice, no later than the last day of the required 60-day notice period unless you mail it. If mailed, your notice must be postmarked no later than the last day of the required 60-day period.

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COBRA GENERAL NOTICE CONTINUED

You Must Give Notice of Some Qualifying Events Continued

The notice you provide must state:

- the name of the plan or plans under which you lost or are losing coverage,
- the name and address of the employee covered under the plan,
- the name(s) and address(es) of the qualified beneficiary(ies), and
- the qualifying event and the date of the qualifying event.

If the qualifying event is a divorce, your notice must include a copy of the divorce decree. For your convenience, we have provided a form of Notice by Qualified Beneficiaries of Initial Qualifying Event that you may use to notify the Plan Administrator of a qualifying event. You may also get a copy of this form, at no cost to you, from the Plan Administrator.

Other Notices You Must Give: You must also give notice of other events that are described later in this notice. For example, please refer to the later paragraphs in this notice entitled **“Disability extension of 18-Month Period of Continuation Coverage”** and **“Second Qualifying Event Extension of 18-Month Period of Continuation Coverage”** for the notice procedures and notice time periods that apply to you in those circumstances.

How is COBRA Coverage Provided?

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage.

Duration of COBRA Coverage for Covered Employees

If you are the covered employee and the qualifying event is the end of employment or reduction in hours

of employment, COBRA continuation 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 COBRA premiums on time. If, apart from COBRA, your employer continues to provide coverage to you after your termination of employment or reduction in hours (regardless of whether such extended coverage is permitted under the terms of the plan), the extended coverage you receive will ordinarily reduce the time period over which you may buy COBRA benefits.

If you are the covered employee and 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 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.

Duration of COBRA Coverage for Covered Spouses and Dependent Children

If you are a covered spouse or dependent child and the qualifying event is the end of employment or reduction of the employee’s hours, COBRA continuation coverage generally lasts for up to a total of 18 months from the date of termination of employment or reduction in hours, provided that COBRA premiums are paid on time. However, if the covered employee became enrolled in any part of Medicare before the end of his or her employment or reduction in hours, COBRA continuation for the covered spouse and dependent children will continue for up to 36 months from the date of Medicare enrollment or 18 months from the date of termination of employment or reduction in hours, whichever period ends last. For example, if a covered employee becomes enrolled in any part of Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare enrollment, which is equal to 28 months after the date of the qualifying event that is termination of employment (36 months minus 8 months).

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COBRA GENERAL NOTICE CONTINUED

If you are a covered spouse or dependent child and the qualifying event is the death of the employee, the employee's becoming enrolled in Medicare (under Part A, Part B, or both), your divorce, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months, provided that COBRA premiums are paid on time.

There are two ways in which the 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the plan is determined by the Social Security Administration (SSA) to be disabled and you timely notify the Plan Administrator or its designee in writing, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. In order for this disability extension to apply, you must timely notify the Plan Administrator or its designee in writing (using the SSA Disability Notice procedures specified below) of the SSA disability determination before the end of the 18-month period of continuation coverage and within 60 days after the later of (i) the date of the initial qualifying event, (ii) the date on which coverage would be lost because of the initial qualifying event, or (iii) the date of the SSA disability determination.

SSA Disability Notice Procedures: Any SSA disability notices that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand deliver your notice to:

Blue Cross and Blue Shield of Alabama
Attention: Customer Accounts
450 Riverchase Parkway East Birmingham, AL
35244-2858
Fax: 205-220-6884 or 1-888-810-6884 (toll free)

Your notice must be received by Blue Cross and Blue Shield of Alabama no later than the last day of the required 60-day notice period unless you mail it. If mailed, your notice must be postmarked no later than the last day of the required 60-day notice period. The notice you provide must state:

- the name of the plan or plans under which you lost or are losing coverage,
- the name and address of the employee covered under the plan,
- the name(s) and address(es) of the qualified beneficiary(ies),
- the qualifying event and the date of the qualifying event,
- the name of the disabled qualified beneficiary,
- the date that the qualified beneficiary became disabled,
- the date that the SSA made its determination of disability.

Your notice must also include a copy of the SSA disability determination. For your convenience, we have prepared a form of Notice by Qualified Beneficiaries that you may use to notify Blue Cross and Blue Shield of Alabama of a SSA disability determination. You may get a copy of this form, at no cost to you, from either the Plan Administrator or Blue Cross and Blue Shield of Alabama. If these procedures are not followed or if the notice is not provided in writing to Blue Cross and Blue Shield of Alabama within the required time period, there will be no disability extension of COBRA continuation coverage. You must also notify Blue Cross and Blue Shield of Alabama within 30 days of any revocation of Social Security disability benefits.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if timely notice of the second qualifying event is properly given to the plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or

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COBRA GENERAL NOTICE CONTINUED

former employee dies, becomes enrolled in Medicare (under Part A, Part B, or both), or gets divorced, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

For example, the former employee becoming enrolled in Medicare will rarely be a second qualifying event that would entitle the spouse or dependent children to extended COBRA coverage. This is so because, for plans that are subject to COBRA and the Medicare Secondary Payer (MSP)

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage Continued

laws, this event would not cause the spouse or dependent children to lose coverage under the plan had the first qualifying event not occurred.

In order for this 18-month extension to apply, you must timely notify the Plan Administrator in writing (using the notice procedures specified in the above paragraph on which coverage would be lost because of the event, whichever is later. In addition, your notice must also name the second qualifying event and the date of the second qualifying event. For your convenience, we have prepared a form of Notice by Qualified Beneficiaries of Second Qualifying Event that you may use to notify the Plan Administrator of a second qualifying event. You may get a copy of this form, at no cost to you, from the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the required 60-day notice period, there will be no extension of COBRA coverage as a result of the second qualifying event.

Other coverage options besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of

these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage. If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit <https://www.medicare.gov/medicare-and-you>.

If You Have Questions

Questions concerning your plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA web site at www.dol.gov/ebsa (addresses and phone numbers of Regional and District EBSA Offices are

Resources



Benefit	Carrier	Phone Number	Web Address
General Information	www.mycityofbirminghambenefits.com		
Benefits Enrollment Call Center	1-877-871-4780		
View Current Benefits	www.unum.benselect.com/CityofBirmingham		
Dependent Support Documentation	Dependent verification required to activate benefits To submit your supporting documentation, email: benefits@birminghamal.gov		
Medical Active Group #65215 Retiree Group #75861	BCBS of AL	1-866-208-6459	www.bcbsal.org
Pharmacy	BCBS Prime Therapeutics	1-855-457-0007	www.primetherapeutics.com
Dental Active Group #65215 Retiree Group #75861	BCBS of AL	1-866-208-6459	www.bcbsal.org
Vision Group #1031715	Ameritas - billing VSP EyeMed	1-800-659-2223 1-800-877-7195 1-866-289-0614	www.ameritas.com www.vsp.com www.eyemed.com
Mental Health/Substance Abuse	Behavioral Health Systems	1-800-245-1150	www.behavioralhealthsystems.com
BWELL BHM Clinic	Brownstone Healthcare	1-205-202-5650	www.cobclinic.com
Flexible Spending Accounts	Wex Health Discovery Benefits	1-866-451-3399	benefitslogin.wexhealth.com
Basic Term Life & AD&D Voluntary Term Life & AD&D Short-Term Disability Long-Term Disability	Standard	1-888-937-4783	www.standard.com
Group Whole Life Group Accident Insurance Group Critical Illness Group Hospital Indemnity	Unum	1-800-635-5597	www.unum.com
Guaranteed Issue Whole Life Insurance	New York Life Byron Carter Michelle M. Owens	1-770-730-2000	www.newyorklife.com
Prepaid Legal	LegalShield	1-888-807-0407	www.shieldbenefits.com/Birmingham
Deferred Compensation	Nationwide Elaine Smith	1-205-249-8423	www.nrsforu.com
	Equitable Gary Finley Fatima Finley	1-205-970-5215 1-205-970-5213	www.garyfinley.equitableadvisors.com
Benefits & Pension Division	COB	1-205-254-2798	benefits@birminghamal.gov cobpension@birminghamal.gov
Leave of Absence Requests	COB	1-205-254-2798	loa@birminghamal.gov
Sick & Vacation Leave Bank	COB	1-205-254-2819	www.birminghamal.gov/leavebank
City of Birmingham Intranet	N/A	N/A	http://cobweb/default.aspx