Employee Benefits

Annual Notice Concerning Federal Laws and Acts

USA Health & Dental Plan Benefit Year 2015

University of South Alabama
The University of South Alabama is pleased to provide its employees and their dependents with a quality health and dental plan at an affordable cost to all employees. This notice provides important information about federal laws and acts that affect your coverage. It also includes information about the policies and procedures of your Plan. You should read this notice carefully and keep it with your important papers.

This notice, along with your USA Health & Dental Plan Member Handbook, will assist you in understanding your rights under the Plan and your responsibilities to the Plan.

WHAT YOU SHOULD KNOW ABOUT YOUR EMPLOYER-PROVIDED HEALTH INSURANCE & HEALTH CARE REFORM

The Affordable Care Act (ACA) provides individuals with a new way to compare and purchase health insurance through the Health Insurance Marketplace. Information about the Marketplace was provided to all employees via mail in a notice titled, “New Health Insurance Marketplace Coverage Options & Your Health Coverage.” You may view this notice on the benefits page of the Human Resources web site at www.southalabama.edu/hr or request a copy by contacting the USA Human Resources department.

You should understand the following important information about your employer-provided health coverage as it relates to health care reform:

1. The USA Health & Dental Base Plan & Standard Plan provide “minimum essential coverage” as required by the Affordable Care Act.

2. The USA Health & Dental Base Plan & Standard Plan meet the “minimum value” standard established by the Affordable Care Act. This standard is met when the health plan’s share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

3. The USA Health & Dental Base Plan & Standard Plan have employee cost-sharing rates which are intended to meet the “affordable” standard under the Affordable Care Act. This means that the employee cost for single coverage under the Plans is intended to be no more than 9.5% of the employee’s household income (based on the employee’s W-2 income).

4. The Employer offers health coverage to full-time employees working at least 30 hours of service a week or 130 hours of service a month on average beginning January 1, 2015.

NOTICE OF YOUR RIGHT TO COBRA CONTINUATION OF COVERAGE UNDER THE PLAN

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 additional information about your rights and obligations under the Plan and under federal law, you should review the USA Health & Dental Plan Member Handbook or contact the Human Resources department or Blue Cross Blue Shield of Alabama.

There are time limits for a member to apply for the COBRA continuation of coverage. It is important that you notify the Human Resources department when there is a COBRA qualifying event that may affect your coverage or that of your dependent, such as:

1) your hours of employment are reduced; 2) your employment ends for any reason; 3) your spouse dies; 4) your spouse’s hours of employment are reduced; 5) your spouse’s employment ends; 6) your spouse becomes entitled to Medicare benefits; 7) you become divorced or legally separated from your spouse; 8) the child’s parent-employee dies; 9) the parent-employee’s hours of employment are reduced; 10) the parent-employee’s employment ends; 11) the parent-employee becomes entitled to Medicare benefits; 12) the parents become divorced or legally separated; 13) the child is no longer eligible for coverage under the Plan as an eligible dependent.

ALTERNATIVES TO COBRA CONTINUATION COVERAGE

There may be health insurance coverage options for you and your family in addition to COBRA continuation coverage. The Health Insurance Marketplace offers a new way to shop for health insurance and you may be eligible for a tax credit that lowers your monthly premiums. Marketplace coverage may be less expensive than COBRA coverage for many individuals, and unlike COBRA coverage, is available indefinitely. Being eligible for COBRA does not limit your eligibility for coverage and the tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity through the Marketplace or another group health plan (such as your spouse’s plan), if you request enrollment within 30 days of a qualifying event. Visit or call the Health Insurance Marketplace at www.healthcare.org or 1-800-318-2596.
NOTICE OF THE PLAN’S OPT-OUT OF SOME FEDERAL REGULATIONS

The USA Health & Dental Plan has elected to opt-out of certain federal regulations including: the Health Insurance Portability & Accountability Act of 1996 (HIPAA), as amended by the Patient Protection and Affordable Care Act (PPACA); the Newborns’ and Mothers’ Health Protection Act of 1996 (NMHPA); the Mental Health Parity Act of 1996 (MHPA); the Mental Health Parity and Addiction Equity Act of 2008; and Michelle’s Law (2008). The Plan complies with the HIPAA provisions for special enrollment rules and discrimination based on health status rules.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA):

Many of the provisions of HIPAA do not apply to the Plan, or the Plan is already in compliance with these provisions. For example, HIPAA requires a special enrollment period for employees who incur a change-in-status event concerning eligibility of family members. This benefit has always been offered under the Plan. HIPAA prohibits group health plans from discriminating against employees on the basis of health status. The Plan has never imposed discriminatory rules.

NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT (NMHPA):

The NMHPA establishes minimum inpatient hospital stays for newborns and mothers following delivery, based on medical necessity. The Plan has never imposed limitations regarding the length of an inpatient hospital stay following delivery. The Plan’s decision to opt-out of NMHPA will have no effect on current or new employees.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA):

The MHPAEA expands MHPA by establishing parity of mental health and substance abuse benefits to include substance abuse disorder benefits as well as mental health benefits; prohibits applying financial requirements or treatment limitations that are more restrictive than the predominant financial requirement or treatment limitations that apply to substantially all medical and surgical benefits.

The Base Plan does not provide parity and has limits on certain services and a maximum dollar limit for mental and substance abuse treatment. These limits do not apply to the Standard Plan which provides mental health and substance abuse disorder benefits as essential health benefits pursuant to PPACA with no maximum dollar limits.

You should consult with your medical provider and the claims administrator to coordinate your care within the benefits offered by the Plan. You may review the mental health and substance abuse disorder benefits provided under the Base and Standard Plans using the Summary of Benefits & Coverage (SBC) for each Plan which is available at: www.southalabama.edu/hr/. A paper copy is also available, free of charge, by contacting the Human Resources department.

MENTAL HEALTH PARITY ACT (MHPA):

The Mental Health Parity Act does not allow plans to establish financial limits on mental health treatment, but does allow plans to establish limits on the number of outpatient office visits, number of inpatient days allowed, coverage of prescription drugs to treat mental health conditions, or elimination of mental health treatment altogether. The Plan provides treatment for mental and nervous conditions as well as substance abuse, with specific limitations.

MICHELLE’S LAW (2008):

Michelle’s Law provides that a group health plan may not terminate coverage of a full-time student due to a medically necessary leave of absence. The ACA requires coverage of a dependent to extend to age 26 regardless of full-time student status. The USA Health & Dental Plan complies with the ACA and extends coverage to all dependent children to age 26 regardless of student status.
AVAILABILITY OF SUMMARY HEALTH INFORMATION

As an employee of the University of South Alabama, the health benefits available to you represent a significant component of your compensation package. These health benefits also provide important protection for you and your family in cases of illnesses or injuries. To assist you in understanding your health coverage, the USA Health & Dental Plan makes available a Summary of Benefits and Coverage (SBC). The SBC summarizes important information about your health coverage in a standard format.

The SBC is available on the web at: www.southalabama.edu/hr/. A paper copy is also available, free of charge, by contacting the Human Resources department.

WOMEN’S HEALTH & CANCER RIGHTS ACT:

The Plan complies with the Women’s Health and Cancer Rights Act, providing the following benefit: The USA Health & Dental Plan provides medical benefits for mastectomies for treatment of breast cancer including reconstructive surgery of the breast on which the mastectomy was performed, and of the other breast to produce a symmetrical appearance; prosthesis and coverage of physical complications resulting from all stages of the mastectomy, including lymphedema. Coverage of prostheses includes initial placement of prostheses and replacements as determined to be medically necessary. Coverage of prostheses also includes the brassiere required to hold the prostheses, limited to a Plan year maximum benefit of four (4) brassieres.

GRANDFATHERED STATUS

The USA Health & Dental Base Plan is a “grandfathered plan” under the Patient Protection and Affordable Care Act (PPACA). As permitted by the Act, a grandfathered plan may preserve certain basic health coverage that was already in effect when that law was enacted. As a grandfathered health plan, the Plan may not include certain consumer protections of the Act that apply to other plans; for example, the requirement for the provision of preventive health services without any cost sharing.

The USA Health & Dental Standard Plan is not a grandfathered plan under PPACA and must comply with all the Act’s provisions including expanded preventive wellness benefits, quality of care reporting, coverage for clinical trials, third-party appeal procedure, and cost sharing limitations.

Questions regarding which protections may or may not apply to a grandfathered health plan and what might cause a plan to change its status can be directed to the Human Resources department. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at: 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

NOTICE OF A SPECIAL ENROLLMENT PERIOD FOR A CHANGE-IN-STATUS EVENT

If you or any of your family members declined coverage in the Plan when first eligible for coverage (or during the annual Open Enrollment Period), you may enroll in the Plan or enroll your eligible dependents when certain events cause a change-in-status event. Some change-in-status events result in termination of coverage for a dependent. To make an enrollment change due to a change-in-status event, you must contact the Human Resources department within 30 days (unless otherwise noted) of the event. Change-in-status events include:

1. A change in your marital status (marriage, divorce, or death of your spouse).
2. A change in the number of your dependents (birth or adoption of a child, death of a child, obtaining legal custody of a child, or obtaining legal guardianship of a child by court action).
3. A change in your employment status (starting/ending employment, changing from part-time to full-time or vice versa, taking or returning from an approved leave).
4. A change in your spouse’s employment status (starting/ending employment, changing from part-time to full-time or vice versa, a strike or lockout, or your spouse taking or returning from an unpaid leave or leave under the Family and Medical Leave Act or USERRA).
5. Exhaustion of your coverage period under a previous employer’s COBRA continuation.
6. A significant change in the costs of or coverage provided by your spouse’s employer-sponsored health plan.
7. A significant change in the costs of or coverage provided by this Plan.
8. A change in the eligibility status of a dependent child, such as the child reaching age 26, the maximum age for coverage under the Plan.
9. An end to the disability of a disabled child enrolled as your dependent under the Plan.
10. A change in your residence or work site, or that of a spouse or dependent, which affects ability to access benefits under this or another employer-sponsored health plan.
11. A required change due to a court order.
12. You or your dependent(s) becoming entitled to Medicare or Medicaid.
13. You or your dependent(s) lose coverage under Medicaid or a State Children’s Health Insurance Plan (SCHIP) because of loss of eligibility. Enrollment request must be made within 60 days of the termination of coverage.
14. You or your dependent(s) become eligible for premium assistance under Medicaid or SCHIP. Enrollment request must be made within 60 days of becoming eligible for the premium assistance.
PRIVACY NOTICE
The USA Health & Dental Plan and its associates, like Blue Cross Blue Shield of Alabama, adhere to and comply with the Privacy Act. The Plan and its associates have adopted practices and procedures to protect the privacy of your medical information. The Plan’s privacy policy in its entirety is available from the Human Resources department and is included in your USA Health & Dental Plan Member Handbook. Blue Cross Blue Shield of Alabama also states its privacy policy on the company website: www.bcbsal.org.

SOUTHFLEX HEALTH & DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)
The annual enrollment and re-enrollment in the SouthFlex Health & Dependent Care Flexible Spending Accounts must be made during open enrollment (November) to be effective January 1, 2015. The Patient Protection and Affordable Care Act (PPACA) places an annual limit of $2,550 on employee salary reduction contributions to the Health FSA. Unused employee contributions to the Health FSA for the 2014 plan year that are carried over into the grace period for that plan year will not count toward the $2,550 limit for the 2015 plan year. Please note that over-the-counter drugs are no longer eligible for reimbursement without a doctor’s prescription pursuant to PPACA. PPACA does not affect the annual maximum employee salary reduction contribution for the Dependent Care FSA, which remains at $5,000, or $2,500 for married taxpayers filing separate returns.

IMPORTANT NOTICE
You should read the USA Health & Dental Plan Member Handbook and share it with your dependents. This booklet provides valuable information about your responsibility under the Plan, eligibility, benefits, and your rights as a participant, including the right to appeal the denial of a benefit. If you do not have a copy of this booklet, you should contact the Human Resources department and one will be sent to you free of charge.

SECTION 125 PREMIUM CONVERSION PLAN
The Section 125 Premium Conversion Plan allows you to pay your employee contribution for the USA Health & Dental Plan with pre-tax dollars through salary reduction rather than regular pay. The employee contribution is deducted from your paycheck before taxes are withheld. This allows you to increase your spendable income by reducing your taxes (your Social Security retirement benefit may be slightly reduced). All eligible employees are automatically enrolled in the Section 125 Premium Conversion Plan. You may change your election for pre-tax premiums during the Open Enrollment period held in November, or during the Plan year if you incur a change-in-status event.

NO WAITING PERIOD FOR PRE-EXISTING MEDICAL CONDITION
Beginning in 2014, the Patient Protection and Affordable Care Act (PPACA) prohibited pre-existing condition waiting periods. In compliance with PPACA, effective January 1, 2014, the USA Health & Dental Plan no longer utilizes a pre-existing condition waiting period.

Departing employees and dependents no longer eligible will be provided a Certificate of Creditable Coverage from Blue Cross Blue Shield of Alabama that can be submitted to possibly offset the waiting period for coverage of pre-existing conditions under a new health plan which may not be subject to PPACA mandates. Departing employees and dependents no longer eligible for coverage may be entitled to COBRA continuation coverage.

PATIENT PROTECTION
The Plan does not restrict coverage to any specific physician and the individual may designate any primary care, pediatrician, obstetric, gynecological, or specialty care provider in the network. A list of covered physicians, hospitals, and other medical providers may be obtained from Blue Cross Blue Shield of Alabama and is provided on its web site: www.bcbsal.org.
USA HEALTH & DENTAL PLAN ELIGIBILITY POLICY
EFFECTIVE JANUARY 1, 2015

OVERVIEW
Effective January 1, 2015, employees of the University of South Alabama and USA HealthCare Management, LLC, are eligible for participation in the USA Health & Dental Plan (the Plan) based solely on hours of service. The Affordable Care Act requires an offer of coverage to employees credited with 30 hours of service per week or 130 hours of service per month on average. The law refers to such an employee as “full-time.” The term “full-time” has a different meaning in other areas of your employment. This Policy only applies to eligibility for an offer of coverage under the USA Health & Dental Plan. The Plan may defer the offer of coverage if the employee is determined as having “variable hours” in which case benefits-eligible status will be determined using a 12-month measurement period with a corresponding 12-month coverage period in compliance with the Affordable Care Act.

Eligible Employees include:
1) An employee with an employment start date prior to January 1, 2013, and a specific appointment with no termination date, occupying a permanently budgeted position, and working a minimum of 20 hours per week on a regular basis.
2) An employee with an employment start date on or after January 1, 2013, who is credited with 30 hours of service per week or 130 hours of service per month on average.

Eligible Employees may also enroll their legal spouse of the opposite sex and children under age 26. Coverage with the Plan will begin on the first day of the month following the first day of employment, contingent upon timely application to the Human Resources department and payment of any required employee contribution.

PARTICIPATION
Eligible Employees and their Eligible Dependents may enroll in the Plan. An Eligible Employee declining coverage under the Plan is required to submit a written declination of coverage.

Eligible Employees include:
1) An employee with an employment start date (first day of active employment) prior to January 1, 2013, and a specific appointment with no termination date, occupying a permanently budgeted position, and working a minimum of 20 hours per week on a regular basis.
2) An employee with an employment start date (first day of active employment) on and after January 1, 2013, who is a benefits-eligible employee. A benefits-eligible employee is defined as one who is credited with 30 hours of service per week or 130 hours of service per month on average.

HOUR OF SERVICE
An hour of service is defined as each hour for which an employee is paid, or entitled to payment, for the performance of duties, and each hour for which an employee is paid, or entitled to payment, for a period of time during which no duties are performed due to approved paid time off (PTO), vacation, sick leave, holiday, jury duty, military duty or eligible leave of absence.

ELIGIBLE DEPENDENTS
An eligible dependent is defined as your legal spouse of the opposite sex and your child. The Plan defines “child” to include:
1. Your natural-born child under the age of 26;
2. Your stepchild under the age of 26;
3. Your legally adopted child under age 26, including a legally adopted child living with you as the adopting parent during a period of probation;
4. A child under age 26 over whom you have legal custody by court appointment (physical custody alone is not sufficient);
5. A child under age 26 over whom you have legal guardian status by court appointment;
6. A child under age 26 for whom you are legally required to provide health insurance pursuant to a Qualified Medical Child Support Order; and,
7. Your disabled child of any age provided the disability commenced prior to age 19. Coverage under the Plan continues without interruption for the duration of the disability so long as the employee maintains dependent coverage. Disability is a defined term in your USA Health & Dental Plan Member handbook or you may contact the USA Human Resources department for detailed information.

WHEN COVERAGE STARTS
Coverage under the Plan will begin on the first day of the month following the first day of employment, or the first of the month if the employee’s start date is the first of the month, contingent upon timely application to the Human Resources department. This Eligibility Policy defines which employees may be offered coverage under the Plan. Coverage is contingent upon proper and timely application with payment of any required employee contribution towards the cost of single or family coverage.

DETERMINING BENEFITS-ELIGIBLE STATUS FOR NEW AND ONGOING EMPLOYEES
Most employees will be determined to be benefits-eligible upon employment. In cases where the employer cannot determine whether an employee will be benefits-eligible based on the facts and circumstances at the employee’s start date, the University will determine benefits-eligible status using the look back measurement method.

The following classifications are used to determine eligibility for the Plan:
1. Benefits-Eligible Employee: Employee who earns at least 30 hours of service per week or 130 hours of service per month on average. A benefits-eligible employee is eligible to participate in the Plan.
2. Non Benefits-Eligible Employee: A non benefits-eligible employee is not eligible for participation in the Plan. A non benefits-eligible employee is defined as follows:
   a) Variable Hour Employee: An employee is considered a variable employee if, based on the facts and circumstances at the employee’s start date, it cannot be determined that the employee is reasonably expected to work on average at least 30 hours per week.
NEW EMPLOYEES
The initial measurement period for a new variable hour employee is 12 months in length and begins the first of the month following the employee’s start date. If during the initial measurement period the employee is determined to be a benefits-eligible employee, then coverage under the Plan is offered during the corresponding 12–month stability period. Coverage must start no later than the last day of the month following the initial measurement period (not to exceed 13 months), so long as the employee has submitted the required application and authorization for the employee contribution toward the cost of coverage and any required documentation of dependent eligibility. Coverage will continue for the 12–month stability period regardless of the number of hours worked or until the employee fails to timely pay the employee contribution or terminates employment.

The chart below illustrates the look back measurement method for new employees.

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<tr>
<th>INITIAL MEASUREMENT PERIOD</th>
<th>ADMINISTRATIVE PERIOD</th>
<th>STABILITY PERIOD</th>
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<tr>
<td>12-month period starts the first of the month after the employee’s start date</td>
<td>30 days to determine the average number of hours earned during the measurement period for coverage to start the first of the month following.</td>
<td>12 months</td>
</tr>
<tr>
<td>30 hours of service per week or 130 hours of service per month on average determines benefits-eligible status.</td>
<td>Coverage continues for 12 months regardless of future hours worked except for a failure to make employee contribution or upon termination of employment.</td>
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ONGOING EMPLOYEES
An ongoing employee is one who has been employed the length of one standard measurement period, or 12 months. An ongoing employee will have benefits-eligible status determined during the standard measurement period, September 1st through August 31st with an administrative period from September 1st through October 31st to provide time for eligibility determination, and the preparation and distribution of material for open enrollment in November. If during the standard measurement period the employee is determined to be a benefits-eligible employee, then coverage under the Plan is offered during the corresponding 12–month stability period. Coverage will continue for the 12–month stability period regardless of the number of hours worked or until the employee fails to timely pay the employee contribution or terminates employment. An employee determined not to be benefits-eligible will again have his/her status reviewed during the next standard measurement period.

1 Pursuant to the Affordable Care Act, the University will use a standard measurement period which is shorter than the corresponding stability period to determine benefits-eligible status of employees for eligibility to participate in the Plan as of January 1, 2015. Eligibility for January 1, 2015, is based on a 6–month standard measurement period, from July 1, 2014, through December 31, 2014, with a corresponding stability period of 12 months, from January 1, 2015, through December 31, 2015. Effective January 1, 2015, the University will use a 12–month standard measurement period to determine benefits-eligible status and eligibility to participate in the Plan as of January 1, 2016.

USA HUMAN RESOURCES DEPARTMENT STREAMLINES MASS COMMUNICATIONS
To increase efficiency, beginning in 2015, the Human Resources (HR) Department will use employees’ University of South Alabama issued email addresses as the primary way to communicate HR-related information directly to employees. This service improvement will enhance HR’s ability to provide all employees with helpful and important information in a more timely and consistent manner. Employees will be responsible for routinely checking their work email accounts to access important announcements and documents, such as the annual employee benefits brochures, newsletters, policy and procedural changes and updates of the Staff Employee Handbook. Paper copies will only be distributed by regular mail when required by applicable laws.

Computers are available at each Human Resources office for employees to access work-related information and websites.

Employees in the USA General Division who do not currently have a USA employee email address may activate their email account by clicking the JagMail icon located on the University of South Alabama’s Home Page, www.southalabama.edu, or by going directly to http://jagmail.southalabama.edu and following the appropriate activation steps. Employees in the Health System Division should consult with their supervisors regarding which email system is used by their department and proceed accordingly.

As needed, employees may also contact their Human Resources office to request paper copies of HR information communicated by email or available on the HR website at www.southalabama.edu/hr/.
HR ADVANTAGE

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