

A graphic of interlocking puzzle pieces in shades of green, blue, and purple, set against a dark purple background. The puzzle pieces are arranged in a grid-like pattern, with some pieces missing or shifted, creating a sense of assembly or completion. The background is split diagonally from the top-left to the bottom-right, with the top-left portion being dark purple and the bottom-right portion being a lighter, lime green color.

Open Enrollment Guide

Nonbargaining Employees

**July 1, 2024
through
June 30, 2025
Plan Year**

Table of Contents

Welcome.....	3
Alliant Insurance.....	4
Benefit Premium Update	5
Health Plan Summary	6-9
Medical.....	6-7
Vision.....	8
VEBA.....	8
Dental Plan Comparison.....	9
Group Life and Long-term Disability Insurance.....	10
Supplemental Voluntary Benefits	11-12
Standard Voluntary Life Insurance	11
Colonial Short-term Disability.....	12
AFLAC	12
Employee Assistance Programs.....	13
PERS Retirement	14
Deferred Compensation Plans.....	15
FAQ and Reminders	16
Annual Notices.....	17-43

The text contained in this guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your guide, contact Human Resources at hr@cityofalbany.net.

Welcome to Open Enrollment

Your needs may have changed in the past year, now is your chance to update your benefit selections.

Are you interested in switching between Delta Dental and Willamette Dental? Did you have a baby and want to add supplemental life insurance to cover yourself and the new baby? Are you interested in learning what AFLAC is all about? Now is the time to make changes.

The annual open enrollment period for the July 1, 2025, to June 30, 2025, plan year will begin on Wednesday, May 15, 2024, and end at 5:00 p.m. on Friday, May 31, 2024. New elections and changes will become effective July 1, 2024.

Don't need to make any changes? You do not need to do anything.

Your current choices will remain in place for the new plan year (July 1, 2024, through June 30, 2025).



This guide includes helpful information for evaluating your benefits options.

Have questions?

Should you have any questions about any of the plan options or need assistance related to the open enrollment process, our benefit team at Aldrich is eager to assist you (their contact information is on page 4). As always, you can reach out directly to us in Human Resources with any questions as well.

For the 2024-2025 plan year we are holding open enrollment entirely online. Visit www.cityofalbany.net/openenrollment to view videos on plan offerings or to find the forms that you need.

Contact HR:

Email: hr@cityofalbany.net

Phone: 541-917-7529

Have questions about your benefits?

The team at Alliant Insurance is here to help!

I'm Tracey Davis, the benefits consultant at Alliant Insurance working for the City of Albany. The City has hired us to coordinate most of your employee benefits package, including medical, dental, disability and life insurance.

Our team has years of experience in the industry, including 30+ years working directly with the City. We are here to help you with any insurance issues that confront you, including questions about your benefits or any claims issues you may be experiencing. We are the first to admit that navigating your benefit plans can be confusing and we are happy to help! Please feel free to reach out to us! We pride ourselves on getting back to you quickly, usually within one business day.

The Health Insurance Portability and Accountability Act (HIPAA) protects the privacy of your personally identifiable health information. As a result of this legislation, the City of Albany human resources staff is not able to assist you in resolving claims issues or answering any insurance related claims questions that would lead them to have knowledge of any medical condition you have, especially if the condition is of a sensitive nature. If you have claims issues or benefit questions which would make it necessary for you to discuss a medical condition, please contact us directly. We can assist you with most of all your claims questions and all your information is kept confidential.

I look forward to serving your employee benefit needs!

Sincerely,

Tracey Davis
Area Vice President, Employee Benefits Consultant

Tracey Davis
Area Vice President

Toll Free: 877-588-0002
Direct Dial: 503-485-2482

Email: tracey.davis@alliant.com

Trina Berry
Account Executive

Toll Free: 877-588-0002
Direct Dial: 503-716-9329

Email: trina.berry@alliant.com

Karlee Gomez
Account Manager

Toll Free: 877-588-0002
Direct Dial: 971-414-6237

Email: karlee.gomez@alliant.com

Premium Costs Effective July 1, 2024

The following premium increase will take effect with the June 15, 2024, paycheck for coverage effective July 1, 2024.

Premium Changes

PacificSource (Medical)	+9.0%	MODA-Vision	0% (No change)
MODA-Delta Dental	2.1% (No change)	Willamette Dental	0% (No change)

View the new employee/employer premium rates at hr.cityofalbany.net/benefits.



Part-time Employee Premium:

Part-time employees scheduled to work the following full-time equivalent (FTE) will make the following insurance premium benefit contributions:

0.75 FTE to 0.999 FTE (30-39 hours per week) – Equivalent to full-time employee benefits

0.50 FTE to 0.749 FTE (20-29 hours per week) – City pays 75% / Employee pays 25%

Who is eligible to participate?

If you are a regular status employee working 20 or more hours per week, you are eligible to enroll in the benefits described in this open enrollment guide. All regular, full-time employees are required to enroll themselves, their spouse, and their eligible dependent children in health insurance (medical, dental, vision) coverage.

Medical Coverage & Prescription Drugs

The City will continue to offer a high-deductible preferred-provider (PPO) plan through **PacificSource** from July 1, 2024, through June 30, 2025. This PPO plan allows you to use both in-network and out-of-network providers.

Medical summary

Annual Deductible	Per Person, Per Calendar Year	Per Family, Per Calendar Year
Participating Providers	\$2,000	\$4,000
Nonparticipating	\$3,500	\$7,000
Out-of-Pocket Limit	Per Person, Per Calendar Year	Per Family, Per Calendar Year
Participating Providers	\$2,000	\$4,000
Nonparticipating	\$5,000	\$10,000

Prescription drug benefit

	Tier 1: Generic	Tier 2: Preferred	Tier 3: Non-preferred
Participating Retail Pharmacy			
Up to a 30-day	\$20 copay*	\$40 copay*	\$60 copay*
Participating Mail Order Pharmacy			
Up to a 90-day	\$20 copay*	\$40 copay*	\$60 copay*
Nonparticipating Pharmacy			
30-day max fill, no more than three fills allowed per year:	50% coinsurance*		

* Not subject to annual medical deductible.

Note: PacificSource Summary of Benefits and Coverage effective July 1, 2024, through June 30, 2025. For full plan information: [Click Here](#)

Medical Coverage Continued

PacificSource offers a number of programs to help you and your dependents in your health and wellness journey. Review the [PacificSource Member Guide](#) for more details!

We want to be sure that you're aware of the Teladoc resource.

Through your PacificSource plan, Teladoc is available to all covered members. Teladoc is great for one-time acute needs, but also **provides Mental/Behavioral health visits**. Check out the short [video](#) from Teladoc and review the attached discussion guide for more information.

Instructions for downloading and setting up the Teladoc app are available on the Teladoc [website](#). The best time to download the app and register for Teladoc is now rather than waiting until you need care.



Vision Coverage & VEBA Information

MODA Vision

You have vision benefits through MODA Health Plans. This includes services for vision exams, prescription lenses, prescription contact lenses, and frames. In order to be a covered benefit, services must be provided by a licensed eye care provider, ophthalmologist, or optometrist.

Reminder: Each calendar year (January 1) your benefit allowance starts over.

Services	Benefit Amount
Adult Eye Examination	100% after \$20 copay
Lenses: Single vision (per pair) Bifocal (per pair) Trifocal (per pair) Contacts	\$400 limit

Limitations: This contract provides for only **one supply** of contact lenses **or** one pair of glasses (lenses and frames) per insured individual up to the allowable amount every 12 months.

Voluntary Employee Benefits Association (VEBA Trust)

The City continues to provide an annual contribution to your [VEBA Trust](#) account. These funds can be used to reimburse your out-of-pocket health care expenses.

VEBA Contribution	Calendar Year January 1, 2023	Calendar Year January 1, 2024	Rollover Per Calendar Year
Employee Only	\$1,000	\$1,000	100% (or account balance)
Employee + 1 or more	\$2,000	\$2,000	100% (or account balance)

Dental Coverage

Dental Plan Comparison

The City offers two dental plans: Willamette Dental and MODA/Delta Dental. Switching your dental plan is one of the choices that you have during open enrollment.

MODA/Delta Dental allows you to seek treatment from the dentist of your choice. Willamette Dental requires that you seek treatment at a Willamette Dental office. Below is a summary of the differences between the two plans. For more information, please visit our [website](#).

Summary	Willamette Dental Group (WDG)	MODA Delta Dental
Calendar Year Deductible	None	\$50/\$150
Visit Charge	\$5 Regular Office Visit copay \$30 Specialty Office Visit copay \$50 Emergency Office Visit copay	n/a
Choice of Providers	All Services Provided by WDG	Any Licensed Provider
Calendar Year Maximum Benefit	No Maximum Benefit	\$2,000 Per Individual
Service	Member Responsibility (you pay)	
Periodic (routine) Exams	Covered with the Office Visit copay	0%
Prophylaxis (cleaning)	Covered with the Office Visit copay	0%
Fillings	Covered with the Office Visit copay	20%
X-Rays	Covered with the Office Visit copay	0%
Crown or Inlay	\$100 copay	50%
Bridges	\$100 copay (per tooth)	50%
Periodontal Charting/Evaluation	Covered with the Office Visit copay	20%
Nitrous Oxide	\$40 copay	Not Covered
Dentures	\$200 copay (complete upper or lower)	50%
Surgical Tooth Extractions	Covered with the Office Visit copay	20%
Orthodontia	\$1,800 copay (Additional \$150 copay for pre-orthodontia treatment credited if treatment plan accepted) No age limit for benefit.	50% \$1,500 Max. Benefit For Eligible Dependents, treatment must start prior to 17th birthday.

Group Life & Long-term Disability

Basic Life Insurance

Nonbargaining employees are provided life insurance through Standard Insurance Company equal to two times the employee's annual salary, not to exceed \$150,000. This insurance is fully paid by the City. You fill out the enrollment form as a new hire. Have you had any life changes since then? You may need to [update your beneficiary](#).

Long-term Disability Income Benefits

The City of Albany provides employees with long-term disability income benefits through Standard Insurance Company and pays the full cost of this coverage.

In the event you become disabled from a non-work-related injury or sickness and are off work for more than 90 days, 66 2/3 percent of your salary in disability income benefits are provided as a source of income.



Supplemental Benefits

These are benefits that you can choose to newly elect or change at Open Enrollment. These benefits are paid by the employee through payroll deduction.



Voluntary Life Insurance

Employees who want to supplement their group life insurance benefits may purchase additional coverage through Standard. When you enroll yourself, your spouse, and/or dependents in this benefit, you pay the full cost through monthly payroll deductions. You can purchase coverage in \$10,000 increments with the following restrictions:



	Minimum Coverage	Maximum Coverage
Employee	\$10,000	5x Annual Salary up to \$500,000
Spouse or Domestic Partner	\$10,000	\$250,000
Dependent Children up to age 23 if still a full-time student	\$10,000	\$10,000

Not sure how much life insurance you may need? Visit www.standard.com/life/needs to complete a helpful estimate form.

The monthly cost of insurance for you and your spouse will depend on your age and the amount of insurance you wish to purchase. The cost of insurance increases with the age of the insured.

Ready to enroll? Complete the [Enrollment Form](#) and submit to Human Resources.

Supplemental Benefits Continued

Colonial Short-Term Disability

It's important to be financially prepared for the future. That's why you have insurance for your house, your car, and your health. If an accident or illness prevented you from earning an income, how would you pay for your everyday expenses? You never know how long a disability could last, so it's important to have a backup plan. Colonial Life's disability insurance can help protect your way of life by providing a monthly benefit for a covered disability.

This is a payroll-deducted employee-paid benefit through Colonial Insurance that provides replacement income after 7 days of disability for up to 90 days. This benefit provides up to 60 percent of your salary. For more information, [click here](#). To contact our representative Don Brink at 503-808-9133 or service@colonialpd.com.

AFLAC

These policies provide additional medical insurance (premiums after tax) including: Accident Protection; Cancer Indemnity; Specific Event including intensive care for sickness and injury, critical illness such as heart attack, stroke, coma, paralysis, end stage renal failure, third degree burns, coronary bypass surgery and angioplasty; and Hospital Protection coverage.

For more information, [click here](#). To contact our representative Deonna Solano at 503-881-9059 or deonna_solano@us.aflac.com.



Employee Assistance Program (EAP)

Standard Insurance Company

There are times when you might need a little help coping or figuring out what to do. Take advantage of the free, confidential Employee Assistance Program which includes WorkLife Services and is available to you, your dependents (including children up to age 26), and all household members through your Standard group life insurance

You can contact master's-degreed clinicians 24/7 by phone, online, live chat, email, and text. There's even a mobile EAP app. Receive referrals to support groups, a network counselor, community resources, or your health plan. If necessary, you'll be connected to emergency services. This program includes up to three face-to-face assessment and counseling sessions per issue. For more information, visit www.workhealthlife.com.



Additional EAP Services Coming Soon!

In the meantime, Calapooia will continue to see patients until June 2024. Clients who begin sessions by the end of June will have until August 1, 2024, to complete their allotted five sessions free of charge.

Calapooia Employee Assistance

[Calapooia Employee Assistance \(albanyoregon.gov\)](http://albanyoregon.gov) can be reached at:

Phone: 541-974-7541 (voice or text, 7 days a week, calls returned 8 a.m. to 8 p.m.)

Email: caleap@hushmail.com (emails answered Monday-Friday during business hours)

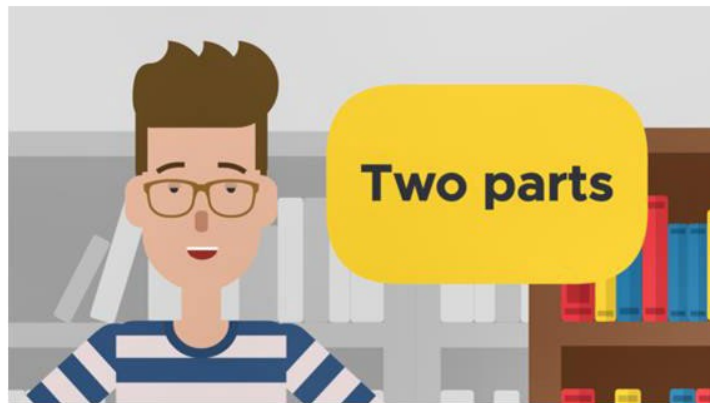
Public Employees Retirement System (PERS)

The City contributes to the PERS retirement system for employees. For more information visit [PERS Home](#).

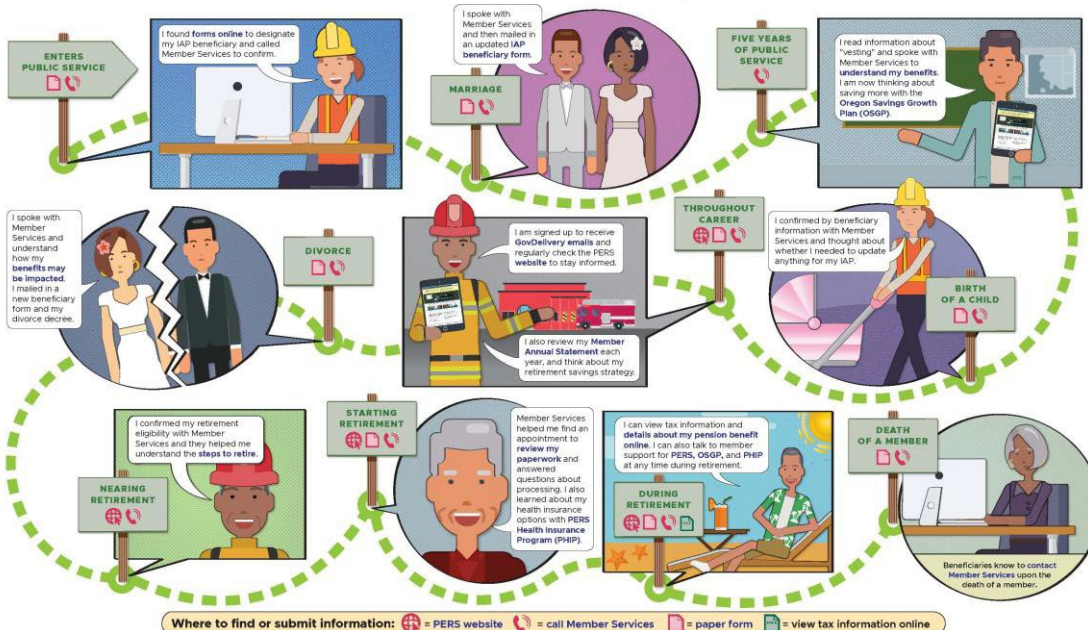
There are two parts to your future PERS retirement: your pension and the IAP.

Watch this short video from PERS for a quick overview.

1. The two parts to your future PERS retirement: your **pension** and your **IAP**



PERS Member Journey: Key moments in your career and life to engage with PERS



Have questions or need help? PERS Member Services representatives are available Monday through Friday, from 8:30 a.m. until 5 p.m., Pacific Time, [via phone and email](#).

What's your plan for retirement?

457 Deferred Compensation Plans

Nonbargaining employees receive a City-paid contribution of two percent (2.0%) of their regular base into a 457 pre-tax deferred compensation plan with either ICMA-RC or Nationwide Retirement Solutions (NRS). It is at your election which company this contribution goes to.

Employees are also eligible to participate with employee contributions into a pre-tax or after tax (Roth) 457 deferred compensation plan with MissionSquare and/or Nationwide Retirement Solutions.

An employee can make changes to their deferred compensation deferral at any time during the year. [Forms are available online.](#)

Meet with a plan representative:

ICMA-RC is now

MissionSquare
RETIREMENT



DeLana Hansen

Retirement Plans Specialist

[Click here to schedule an appointment with DeLana](#)

Phone: 888-803-2726

Email: dhansen@missionsq.org

Website: www.missionsq.org

Olivia Anastasi, CRC

Retirement Specialist

[Click here to schedule an appointment with Olivia](#)

Phone: 614-395-2476

Email: olivia.anastasi@nationwide.com

Website: <https://www.nationwide.com/>

Remember, it's never too early to begin planning for retirement.

**All Open Enrollment Forms Due
5:00 p.m., Friday, May 31, 2024.**

Open Enrollment FAQ & Reminders

I don't want to make any changes. What do I need to do?

Nothing! All of your current selections will continue into the next plan year.

How do I tell what I'm enrolled in?

Login into Munis Employee Self-Service (ESS), navigate to your paycheck and review the items listed under the benefits section.

What changes can I make right now?

- Change dental plans
- Enroll or terminate individual and/or dependent coverage in the medical/dental plans
- Add or make changes to the Voluntary Life and AD&D plan (Standard), the Colonial Short-Term Disability Plan and AFLAC Insurance Plans
- Add, change, or terminate your employee contributions with ICMA or Nationwide Retirement Solutions

Can I change or enroll in a Flexible Spending Account right now?

Open Enrollment for the January 1, 2024, to December 31, 2025, plan year will occur in November 2024. To access your benefit information online, visit [PacificSource Administrators](#).

Who do I contact with specific questions? Human Resources at hr@cityofalbany.net.

Aldrich Benefits works on your behalf to negotiate insurance contracts and resolve FSA claim issues. If you have questions, you can reach Alliant Insurance directly at 877-588-0002 or alb-maybenefits@alliant.com

Annual Benefit Notices

City of Albany

333 Broadalbin Street SW
Albany, Oregon 97321
(541) 917-7506

Created on: 05/08/2024

Employer's Children Health Insurance Program (CHIP) Notice

COBRA General Notice

General FMLA Notice

Genetic Information Nondiscrimination Act (GINA) Disclosures

Health Insurance Exchange Notice

Medicare Part D Creditable Coverage Notice

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

Newborns' and Mothers' Health Protection Act Notice

No Surprise Billing

Notice of Patient Protections

Special Enrollment Rights Notice

Uniformed Services Employment and Reemployment Rights Act (USERRA) Notice

WHCRA Notice

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 January 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid

<p>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</p>	<p>Website: https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html Phone: 1-877-357-3268</p>
---	---

GEORGIA – Medicaid	INDIANA – Medicaid
<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>Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584</p>
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
<p>Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562</p>	<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
<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/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
MINNESOTA – Medicaid	MISSOURI – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	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. 5218
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669

VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	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
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, 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.

OMB Control Number 1210-0137 (expires 1/31/2026)

General Notice of COBRA Rights

(For use by single-employer group health plans)

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get 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 and other members of your family when group health coverage would otherwise end. 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.

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 it would otherwise end because of a life event. This is also called 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. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- 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 entitled to Medicare benefits (under Part A, Part B, or both); or

- You become divorced or legally separated from your spouse.

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

- 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 entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation 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. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

**Holly Roten
333 Broadalbin Street SW
Albany, Oregon 97321**

How is COBRA continuation coverage provided?

Once the Plan Administrator receives 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 that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a 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 COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 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 the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, [Children's Health Insurance Program \(CHIP\)](#), 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 period¹ 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.

¹ <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.

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 contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep your Plan informed of address changes

To protect your family’s rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

2024 - 2025 Plan Year

Holly Roten

Human Resources

333 Broadalbin Street SW

Albany, Oregon 97321

(541) 917-7506

Holly.roten@cityofalbany.net

General FMLA Notice

EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT

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 1 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 servicemember'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 servicemember 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.

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

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

Genetic Information Nondiscrimination Act (GINA) Disclosures

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 (“GINA”) protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic information,” as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Health Insurance Exchange Notice

For Employers Who Offer a Health Plan to Some or All Employees

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace (“Marketplace”). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn’t meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%² of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee’s cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee’s household income.¹³

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if

² Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

³ An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

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
333 Broadalbin Street SW
Albany, Oregon 97321

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit 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 Albany	4. Employer Identification Number (EIN) 93-6002114	
5. Employer address 333 Broadalbin Street	6. Employer phone number (541) 917-7506	
7. City Albany	8. State Oregon	9. ZIP code 97321
10. Who can we contact about employee health coverage at this job? Holly Roten		
11. Phone number (541) 917-7506	12. Email address Holly.roten@cityofalbany.net	

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

- As your employer, we offer a health plan to:
 - Some employees. Eligible employees are: All full time/part-time eligible employees on the first of the month following the waiting period.
- With respect to dependents:
 - We do offer coverage. Eligible dependents are: Legal spouses, domestic partners, and all dependents until age 26.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Note: 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.

Medicare Part D Creditable Coverage Notice

Important Notice from City of Albany 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 City of Albany 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. City of Albany has determined that the prescription drug coverage offered by the City of Albany Plan 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 to 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 City of Albany coverage may be affected. Plan participants may be able to keep their prescription drug coverage under the group health plan if they select Medicare Part D prescription drug coverage. If they select Medicare Part D prescription drug coverage, the group health plan prescription drug coverage may coordinate with the Medicare Part D prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your current City of Albany coverage, be aware that you and your dependents may not be able to get this coverage back.

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 Albany 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.

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact the person listed below for further information call Holly Roten at (541) 917-7506. 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 City of Albany 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).

Date: 5/08/2024

Name of Entity/Sender: City of Albany

Contact--Position/Office: Holly Roten, Human Resources Director

Address: 333 Broadalbin Street SW Albany, Oregon 97321

Phone Number: (541) 917-7506

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at (541) 917-7506.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain [out-of-pocket costs](#), like a [copayment](#), [coinsurance](#), or [deductible](#). You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-

of-network care. You can choose a provider or facility in your plan’s network.

When balance billing isn’t allowed, you also have these protections:

- You’re only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - Cover emergency services without requiring you to get approval for services in advance (also known as “prior authorization”).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you’ve been wrongly billed, contact the No Surprises Help Desk, operated by the U.S. Department of Health and Human Services, at 1-800-985-3059.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Notice of Patient Protections

The City of Albany Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact:

Holly Roten

333 Broadalbin Street SW

Albany, Oregon 97321

For children, you may designate a pediatrician as the primary care provider.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependent(s) lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of CHIP or Medicaid coverage.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.

To request special enrollment or obtain more information, contact:

Holly Roten

333 Broadalbin Street SW

Albany, Oregon 97321

USERRA Notice

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right to Be Free from Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
 - Initial employment;
 - Reemployment;
 - Retention in employment;
 - Promotion; or
 - Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at <http://www.dol.gov/vets>. An interactive online USERRA Advisor can be viewed at <http://www.dol.gov/elaws/userra.htm>.

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: <http://www.dol.gov/vets/programs/userra/poster.htm>. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

Women's Health and Cancer Rights Act (WHCRA) Notices

Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Refer to your plan documents for detailed information about the in-network and out-of-network cost and co-insurance amounts. If you would like more information on WHCRA benefits, call your plan administrator at (541) 917-7506.

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at (503) 971-7506 for more information.

