BENEFITS

Open Enrollment Guide

AFSCME Employees

Plan Year: July 1, 2020 – June 30, 2021

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Welcome to Open Enrollment

Dear City of Albany Colleagues:

The annual open enrollment period for the July 1, 2020, to June 30, 2021, plan year will begin on Monday, May 4, 2020. Open enrollment is the time of year when all eligible City employees can re-evaluate their benefit needs and review current plan elections to ensure they continue to meet their needs and those of their families.

Now is the time to make changes to current elections or enroll for the first time for the new benefit year. Any new elections and all changes will become effective July 1, 2020, and continue through June 30, 2021. This guide includes helpful information for evaluating your benefits options. If you do not wish to make any changes to your current benefit elections, you do not need to do anything. Your current choices will remain in place for the July 1, 2020, through June 30, 2021, plan year.

Due to the current pandemic, we are holding open enrollment entirely online this year. Please visit www.cityofalbany.net/openenrollment to view videos on plan offerings or to find the forms that you need.

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. As always, you can reach out directly to us in HR with any questions as well.

Please be sure to enter into our Adventure Challenge! Details on our Open Enrollment website. There will be prizes and fun!

Sincerely,

Your Human Resources Team

Email: hr@cityofalbany.net
Phone: 541-917-7512

What do I need to do?

The City of Albany offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

Who is eligible?

If you are an 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.

How to make changes or enroll

Review your semi-monthly paystub for details on what benefits you're currently enrolled in. Verify your personal information and make any benefit changes by picking up change forms at an open enrollment meeting. Once you have made your insurance changes, you will not be able to change them until the next open enrollment period unless you have a qualified change in status.

When to enroll

Your benefits will remain the same unless you make changes during open enrollment. Open enrollment change forms are **due by 5:00 p.m., Friday, May 29, 2020**. Changes you elect to make during open enrollment will take effect July 1, 2020.

No changes to your current elections?

If you do not want to make any changes to your current benefit elections, you do not need to do anything. Your 2019 elections for these benefit plans will automatically continue for the July 1, 2020, through June 30, 2021, plan year.

How to make changes during the plan year

You can make changes with a qualified change in status during the plan year. Qualified changes in status include: marriage; divorce; legal separation; domestic partnership status change; birth or adoption of a child; change in child's dependent status; death of spouse, child, or other qualified dependent; change in residence due to an employment transfer for you, your spouse, or domestic partner; commencement or termination of adoption proceedings; or change in spouse's or domestic partner's benefits or employment status.

It is your responsibility to notify Human Resources within 30 days of any and all changes that affect your insurance benefits and benefit records or other changes that affect payroll deductions. (Employees who do not comply with this requirement and for whom the City pays insurance premiums for ineligible dependents may be required to reimburse the City for those expenditures per Human Resources Policy HR-BC-09-005).

Have questions about your benefits?

The team at Aldrich Benefits is here to help!

I'm Tracey Davis, the benefits consultant at Aldrich Benefits 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 a number of 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 of your information is kept confidential.

I look forward to serving your employee benefit needs!

Sincerely,

Tracey Davis
Partner, Employee Benefits Consultant

Tracey Davis
Employee Benefits Consultant

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

Email: tdavis@aldrichadvisors.com

Trina Berry
Account Manager

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

Email: tberry@aldrichadvisors.com

Todd Eide
Member Claims Advocate

Toll Free: 877-588-0002
Direct Dial: 360-787-0654

Email: mybenefits@aldrichadvisors.com

Premium Cost Effective July 1, 2020

The following premium increase will take effect on the June 15, 2020, paycheck for coverage effective July 1, 2020.

View the new employee/employer premium rates https://www.cityofalbany.net/hr/openenrollment

Premium Change:	Pacific Source (Medical)	6.2%	MODA Vision	-6.0%
	MODA- Delta Dental	0%	Willamette Dental	4.0%

Part-time Employee Premium:

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

0.50 FTE to 0.749 FTE (20-29 hours per week)	City pays 75% / Employee pays 25% premium contribution
0.75 FTE to 0.999 FTE (30-39 hours per week)	Equivalent to full-time employee benefits (95% / 5%)

PacificSource and MODA (Vision/Dental)

Monthly Health Insurance Premium Rates

Status	PacificSource Medical	MODA Vision	MODA Dental (Delta Dental)	Employee-paid Portion	City-paid Portion	Total Premium
Employee	$743.43	$24.54	$63.19	$41.54	$789.62	$ 831.16
Employee + Child (ren)	$1,313.01	$46.56	$131.46	$74.52	$1416.51	$1,491.03
Employee + Spouse	$1,601.01	$43.58	$111.85	$87.80	$1,668.64	$1,756.44
Employee + Family	$2,155.49	$65.56	$180.15	$120.04	$2,281.16	$2,401.20

PacificSource, MODA Vision, & Willamette Dental

Monthly Health Insurance Premium Rates

Status	PacificSource Medical	MODA Vision	Willamette Dental	Employee-paid Portion	City-paid Portion	Total Premium
Employee	$743.43	$24.54	$44.54	$40.60	$771.91	$ 812.51
Employee + Child (ren)	$1,313.01	$46.56	$78.80	$71.90	$1,366.47	$1,438.37
Employee + Spouse	$1,601.01	$43.58	$96.28	$87.02	$1,653.85	$1,740.87
Employee + Family	$2,155.49	$65.56	$129.67	$117.52	$2,233.20	$2,350.72

Health Plan Summary

Medical coverage and prescription drugs

The City will continue to offer a high-deductible preferred-provider (PPO) plan through PacificSource from July 1, 2020 through June 30, 2021. This PPO plan allows you to use both in- and out-of-network providers.

In-network change: PacificSource Network (PSN) will be changing to Voyager. You will receive new member cards in the mail.

Medical coverage summary:

Annual Deductible	Per Person, Per Calendar Year	Per Family, Per Calendar Year
Participating Providers	$2,000	$4,000
Nonparticipating Providers	$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 Providers	$5,000	$10,000

Prescription drug benefit summary:

	Tier 1: Generic	Tier 2: Preferred	Tier 3: Non-preferred
Participating Retail Pharmacy			
Up to a 30-day supply:	$20 copay*	$40 copay*	$60 copay*
Participating Mail Order Pharmacy			
Up to a 90-day supply:	$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: Please see the PacificSource Summary of Benefits and Coverage effective July 1, 2020, through June 30, 2021, available online at **hr.cityofalbany.net** for full plan information. Please contact **HR@cityofalbany.net** to request a paper copy.

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 will start over.

Services	Benefit Amount
Eye Examination (complete, including refraction):	100% after $20 copay
Lenses: Single vision (per pair) Bifocal (per pair) Trifocal (per pair) Contacts (per pair)	$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.

Health Plan Summary

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, 2021	Rollover Per Calendar Year
Employee Only	$1,500	100% (or account balance)
Employee + 1 or more	$3,000	100% (or account balance)

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 co-pay	50%
Bridges	$100 Copay (per tooth)	50%
Periodontal Charting/Evaluation	Covered with the Office Visit copay	20%
Nitrous Oxide	$40 co-pay	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 Maximum Benefit For Eligible Dependents, treatment must start prior to 17th birthday

Group Life and Long-term Disability

Basic Life Insurance

Employees are provided $75,000 of life insurance through Standard Insurance Company. This insurance is fully paid by the City. Contact Human Resources to update your beneficiary.

Disability Income Benefits

Long-Term Disability: 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 CIGNA. 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? Use the Cigna provided worksheet for an estimate. 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.

Cigna Informational Brochure

Questions?

Cigna Group Insurance customer service representatives can assist you with the completion of your enrollment form by calling 1-800-732-1603 toll-free anytime from Monday through Friday, 8 a.m. to 6 p.m. Eastern time. For specific benefit/account questions on what is available under your plan, please contact Human Resources.

Supplemental Benefits Continued

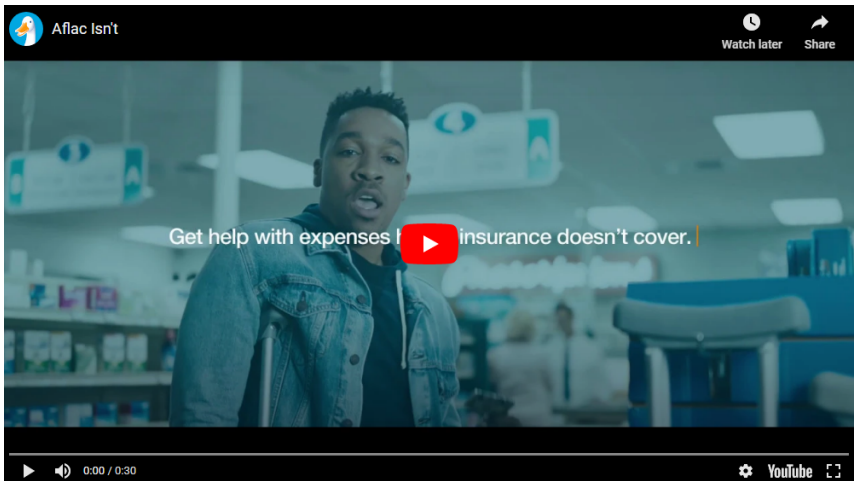
Colonial Short-Term Disability

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. Complete an interest form to learn more. A Colonial representative will contact you directly.

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. Complete an interest form to learn more. An AFLAC representative will contact you directly.



Employee Assistance Program

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.

www.workhealthlife.com

Calapooia Employee Assistance (CALEA)

All of us are faced with changes; some changes we choose, and others are not voluntary. We all have various levels of stress due to these changes in our lives. At some point or another, most of us could benefit from some professional assistance, support, or guidance during our more difficult times.

This is an independent EAP service based in Albany. CALEA was established for the specific purpose of linking local employees and their families with local mental health professionals so that employer, employees, and community all benefit. There is no charge to you for this service.

Call 541-967-8345 and identify yourself as an employee or family member asking about the EAP. You may call any time, day or night, seven days a week, 365 days a year. If you reach a voicemail, please leave a message that you would like the EAP counselor to return your call.

What's your plan for retirement?

Oregon Public Employees Retirement System (PERS)

The City contributes to the PERS retirement system for employees. For more information visit www.oregon.gov/pers.

July 1, 2020, changes to PERS

Oregon PERS has created new, animated videos to help explain some of the upcoming changes due to Senate Bill (SB) 1049. A portion of your employer paid 6% Individual Account Program (IAP) contribution will be redirected to a new "Employee Pension Stability Account."

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

2. What is changing with your **IAP** under SB 1049, starting July 1, 2020

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.

Deferred Compensation Plans

457 Deferred Compensation & City Match

Employees are eligible to participate with employee contributions into a pre-tax or after tax (Roth) 457 deferred compensation plan with ICMA-RC and/or Nationwide Retirement Solutions; the City will match up to 0.5% (one-half of one percent) based on an employee's base salary.

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

Nationwide and ICMA have knowledgeable plan representatives available to meet with you individually.

Nationwide	Web/Phone Meetings Available
Contact: Andy Segrist a.segrist@nationwide.com 503-702-3769 OFFICE	
ICMA	Web/Phone Meetings Available
Contact: DeLana Hansen dhansen@icmarc.org 888-803-2726 OFFICE 202-731-0134 CELL	

Annual Notices

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2019. Contact your State for more information on eligibility –

ALASKA – Medicaid	**WASHINGTON** – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
OREGON – Medicaid and CHIP	
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/indexes.html Phone: 1-800-699-9075	

To see if any other states have added a premium assistance program since January 31, 2020, 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

Annual Notices

Women's Health and Cancer Rights Act of 1998 ("WHCRA")

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. For more information regarding these notices contact Human Resources.

Newborns' and Mothers' Protection Act

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).

Patient Protection Disclosure

The group health plan listed in this guide 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 children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the group health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a preapproved treatment plan, or procedures for making referrals.

For information on how to select a primary care provider, for a list of the participating primary care providers or participating health care professionals who specialize in obstetrics or gynecology, contact your plan administrator.

Annual Notices

Important Notice from PacificSource Health Plans about Your Prescription Drug Coverage and Medicare

May 1, 2020

Re: Your Prescription Drug Coverage Is Creditable for Medicare Part D

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

- 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.
- PacificSource Health Plans has determined that the prescription drug coverage offered by your employer's health 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 15 to December 7. 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 PacificSource Health Plans coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. You will still be eligible to receive all of your current health and prescription benefits if you choose to enroll in a Medicare prescription drug plan. The two plans combined will never pay more than 100 percent of your prescription drug costs.

You should compare your current coverage with Medicare prescription drug coverage in your area. The cost of the plans and which drugs are covered should be taken into consideration. If you do decide to join a Medicare drug plan and drop your current PacificSource Health Plans coverage, be aware that you and your dependents will 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 PacificSource Health Plans 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 percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

Annual Notices

Medicare Part D Notice Continued

For more information about this notice or your current prescription drug coverage, contact your group plan administrator as indicated below.

Name of Plan Sponsor (employer):	City of Albany
Name of Group Health Plan:	PacificSource Health Plans
Name of Group Administrator:	Katie Forsman
Address:	333 Broadalbin Street SW, Albany, OR 97321
Phone Number:	541-917-7500

NOTE: You'll receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan, and if this coverage through PacificSource Health Plans 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 available in the *Medicare and You* handbook. Medicare will mail a copy of the handbook to you. They may also contact you directly regarding their prescription drug plans.

For more information about Medicare Prescription Drug Coverage
Visit the Medicare website at Medicare.gov.
Call your state Health Insurance Assistance Program. (See the inside back cover of *Medicare and You* handbook for their telephone number.)
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 online at 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).

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.

Reminders

All Open Enrollment Forms Due by
5:00 p.m., Friday, May 29, 2020.

Reach out to Aldrich Benefits or our other benefit representatives: Ask supplemental insurance questions, pick up plan summaries and enrollment/change forms.

Changes that you can make during open enrollment to be effective July 1, 2020:

- Change dental plans (i.e., MODA- Delta Dental or Willamette Dental)
- 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 (CIGNA/LINA Insurance), the Colonial Short-Term Disability Plan and AFLAC Insurance Plans
- Add or terminate your City Match Program with ICMA or Nationwide Retirement Solutions

Review your beneficiaries: Life changes? Be sure to review your designated beneficiaries for your Standard Life Insurance, CIGNA Life Insurance, Deferred Compensation and PERS/OPSRP. Required forms are available online https://www.cityofalbany.net/hr/benefits/supplemental-benefits or https://www.cityofalbany.net/hr/benefits/retirement-benefits.

Benefit Summary: Review your semi-monthly paystub for details on what benefits you are currently enrolled in!

Flexible Spending Account (FSA): Open Enrollment will be in November for the January 1, 2021, to December 31, 2021, plan year. Remember only $500 rolls over into the next plan year for your unreimbursed health-related expenses account. Setup a MyFlex account to access your benefit information online https://psa.pacificsource.com/MyFlex.aspx.

Who do I contact?

Contact Human Resources with any questions or for enrollment/change forms.
Email HR@cityofalbany.net.

- Melissa Humphries 541-791-0072
- Amy Steele 541-917-7512

Aldrich Benefits works on your behalf to negotiate insurance contracts and resolve claim issues. If you have questions, you can reach Aldrich Benefits directly at 877-588-0002.

- Tracey Davis, Consultant
- Trina Berry, Account Manager
- Todd Eide, Employee Advocate/Claims Analyst

Aldrich
FORMERLY AKT

PacificSource HEALTH PLANS

G0020038 City of Albany- Oregon Fully Insured Health Coverage

Notice of Change to Your Medical Benefits

Your Plan may change in 2020 to comply with the Affordable Care Act (ACA), state legislation or PacificSource best practices. The following outline summarizes the changes and the reasons they are occurring. Please seek legal counsel if you have questions about how these changes apply to your organization.

Terminology Changes

Document	Summary of Change	Why are these changes occurring?
Plan Summary and Member Handbook	Product names will be changing in 2020. PSN will be replaced with Voyager. Please check our online provider directory for in-network providers in your area.	Core benefit change.

Group Contract Changes

Document	Summary of Change	Why are these changes occurring?
Eligibility	Included information regarding how and when to notify PacificSource of an employee's termination.	Updated for clarity.

Member Handbook Changes

Section	Summary of Change	Why are these changes occurring?
Coordination of Benefits	Added language to further clarify the coordination with Medicare Part A and B for employers with fewer than 19 enrolled employees.	Updated for clarity and administration.
Using the Provider Network – Termination of Provider Contracts	If a provider's contract is terminated and you have had a claim with that provider in the last six months, previously three months, PacificSource will use best efforts to notify you.	Updated to meet state requirements.

Medical Benefit Changes

Section	Summary of Change	Why are these changes occurring?
Excluded Services	Removed exclusion for narcosynthesis. These services require medical review.	Core benefit change.
Other Covered Services, Supplies, and Treatments – Cochlear Implants	Added language that coverage includes both programming and reprogramming of cochlear implants.	Updated for clarity and administration.
Durable Medical Equipment	Adding clarification language regarding age and benefit limits for hearing aids, hearing assistance technology systems, and ear molds.	Updated for clarity and administration.

Pharmacy Benefit Changes

Section	Summary of Change	Why are these changes occurring?
Plan Summary and Member Handbook	Compound drugs will follow the drug tier breakdown referencing up to 30 day supply, 31- 60 day supply, and 61-90 day supply as opposed to up to 30 day supply only.	Updated for consistency.

Prescription Drugs – Diabetic Supplies, Member Handbook	Included third party co-payment program assistance language stating that when a generic equivalent is available members will not receive credit towards their deductible or out-of-pocket limit when a manufacturer coupon or rebate is used.	Updated for clarity.

Renewing Your Plan

The changes in this notice will occur automatically. Due to potential eligibility changes, however, it is important that you complete the attached **Renewal Confirmation Form**. To allow time to process your changes and, if needed, get new ID cards to covered members prior to the effective date, please return the completed form and attach a copy of the **final rates** to PacificSource at least 30 days prior to your renewal date.

Member Materials

After your renewal changes have been processed, **new ID cards will be mailed to your covered employees and their dependents only if there is a change that impacts ID cards.** Your employees and their covered family members will have 24/7 access to their new benefit handbook document through InTouch for Members at PacificSource.com, as well as access to our **provider directory** and other information.

Employer Materials

An electronic copy of your new benefit handbook and contract will be emailed to you, and a single printed office reference copy will be mailed or delivered to you. You can also access your group policy information online. You can access your benefit materials, enroll new members, update existing member information, pay your bill, print temporary ID cards, and view your current census information and enrollment totals through InTouch for Employers at https://intouch.pacificsource.com/ITE/Login.

We're here to help.

As always, PacificSource is here to assist you. If you have questions, your agent or PacificSource Account Manager, Solange' Mainard, is happy to help.

DELTA DENTAL

City of Albany
Oregon Dental Plan Changes for Large Group Plans (51+)
Renewing July 1, 2020

The following is a summary of the significant changes that will be made to the Delta Dental group policy and member handbook when your group renews in 2020. The summary is provided for your convenience and shall not be binding upon the parties. The language in the group policy and member handbook is controlling in all cases. Minor changes, including grammatical, cosmetic or formatting changes or moving sections around for ease of use are not included in this summary.

FEDERAL REGULATORY CHANGES		
Reference	**Former Benefit**	**Change/Rationale/Exceptions**
ACA	Delta Dental will monitor for any changes to the ACA.	To be determined

STATE REGULATORY CHANGES		
Reference	**Former Benefit**	**Change/Rationale/Exceptions**
SB 421	When a third party is responsible for an injury, the Plan may recover claims costs.	Changes to the subrogation process may affect the Plan's ability to recover claims costs.

DELTA DENTAL BENEFIT CHANGES			
Reference	**Former Benefit**	**New Benefit**	**Explanation**
Benefits and Limitations Consultation	Consultation was covered regardless of whether the related services were covered.	Consultation in conjunction with non-covered services is denied.	Align consultations with covered services.
Benefits and Limitations Periodic or comprehensive exams	Problem focused, detailed, extensive oral evaluations were covered twice per year separate from periodic / comprehensive exams.	Problem focused, detailed, extensive oral evaluations are covered as a periodic / comprehensive exam.	Problem focused detailed extensive oral evaluations are a comprehensive service.

DELTA DENTAL BENEFIT CHANGES			
Reference	**Former Benefit**	**New Benefit**	**Explanation**
Benefits and Limitations Space maintainer	The Plan allowed once per space. Space maintainers for primary anterior teeth or missing permanent teeth or for members age 14 or over are not covered.	The Plan allows once per space per quadrant as a lifetime benefit. Space maintainers for primary anterior teeth or missing permanent teeth or for members age 14 or over are not covered.	Change based on evidence based practice.
Benefits and Limitations Interim caries arresting medicament	Not covered.	Interim caries arresting medicament application is covered twice per tooth per benefit year. Restorations within 3 months of interim caries arresting medicaments are not covered.	A new service for the treatment of tooth decay.
Benefits and Limitations Repair to crown, inlay and onlay	The Plan reviewed for necessity if the repair was made to a crown, inlay or onlay within 24 months by a different dentist.	Repair made to a crown, inlay or onlay within 24 months is denied.	Repair is included in the charge for the original care.
Benefits and Limitations Endodontic services	Retrograde fillings were covered.	Retrograde fillings by the same dentists within a 2-year period of the initial retrograde filling is not covered.	Retreatment is included in the charge for the original care.
Benefits and Limitations Oral surgical services	Osseous surgery was covered subject to consultant review.	Osseous surgery is limited to 2 quadrants per date of service.	Based on evidence based dentistry.
Benefits and Limitations Oral surgical services	Bone replacement graft was covered subject to consultant review.	Bone replacement grafts are limited to once per single tooth or multiple teeth within a quadrant in any 3-year period.	Based on evidence based dentistry.

DELTA DENTAL BENEFIT CHANGES			
Reference	**Former Benefit**	**New Benefit**	**Explanation**
Benefits and Limitations Oral surgical services	Post-operative care for oral surgery was covered subject to consultant review within 30 days of the surgical service.	A separate charge for post-operative care done within the 30 days following of the surgery is not covered.	Post-operative care within 30 days is included in the surgery charge.
Benefits and Limitations Prosthodontic services	Re-cement or re-bond implant/abutment supported crown or fixed partial denture was covered.	Re-cement or re-bond implant/abutment supported crown or fixed partial denture is limited to once in any 12-month period.	Additional re-cement or re-bond is likely due to underlying issues with the implant or abutment.

DIRECTOPTION BENEFIT CHANGES			
Reference	**Former Benefit**	**New Benefit**	**Explanation**
Dental Implant Surgery Surgical placement of endosteal implant	Not covered	Surgical placement of an endosteal implant is covered once per calendar year to a maximum of $1,500.	Members are responsible for costs above $1,500.

DELTA DENTAL ADMINISTRATIVE CHANGES		
Reference	**Change/Rationale/Exceptions**	**Details**
Benefits and Limitations Diagnostic & Preventive	Added language stating limited exam and re-evaluation are covered up to 2 exams per plan year.	Clarifying the existing frequency for these benefits.
Benefits and Limitations Diagnostic & Preventive	Added language to explain that adult prophylaxis is only allowed for age 12 and over.	Members under 12 receive child prophylaxis.
Benefits and Limitations Restorative services - Basic	Added language that the plan denies post and core in addition to a crown unless less than half the coronal tooth structure remains.	Clarify existing limitation on post and core.
Benefits and Limitations Endodontic services	Add language that pulpotomy in conjunction with a root canal is not covered.	The pulpotomy is included in the charge for the root canal.
Benefits and Limitations Periodontal services	Added language to clarify periodontal surgical procedures by the same dentist within a 3-year period of the initial surgery is not covered.	Additional services should be included in the cost of the initial procedure.

DELTA DENTAL ADMINISTRATIVE CHANGES		
Reference	**Change/Rationale/Exceptions**	**Details**
Benefits and Limitations Surgical Stent **Exclusions** Maxillofacial prosthetics	Added language to clarify surgical stent is covered in conjunction with covered surgical procedures. All other maxillofacial prosthetics are not covered.	Clarifying existing coverage for members.
Benefits and Limitations Implants	Added language to describe scaling and debridement of an implant is limited to once per implant in a 2-year period.	Language added to clarify the current process.
Benefits and Limitations Other services Orthodontia	Added language to explain that orthodontia is covered when an in-person clinical exam of the patient is performed to establish the need for orthodontics.	Clarify that self-administered orthodontics are not covered.
Benefits and Limitations Other services Teledentistry	Teledentistry is not covered as a separate benefit.	Teledentistry is included in the fees for overall patient management.
Benefits and Limitations Other services Translation	Translation or sign language service is not covered as a separate benefit.	Translation or sign language service are included in the fees for overall patient management.
Exclusions Behavior management	Added language to exclude behavior management.	Additional charges for extra time or services to manage behavioral issues are not covered.
Exclusions Copy of records	Copying a patient's records is not covered.	Dental office administrative processes are not covered.
Exclusions Coping	Coping, a thin covering of the coronal portion of a tooth, is not covered.	Specialized procedures are not covered.
Exclusion Tobacco counseling	Added exclusion except if members are qualified under the Health through Oral Wellness program.	Members with enhanced benefits based on a high risk of oral cancer are eligible for tobacco cessation counseling.
Exclusions Treatment of closed fractures	Added exclusion for treatment of closed fractures.	Clarification of the current administration.

DIRECTOPTION ADMINISTRATIVE CHANGES		
Reference	**Change/Rationale/Exceptions**	**Details**
Schedule of Covered Services	CDT codes and procedures have been changed to reflect the most current codes and practices.	This includes updates such as using CDT codes that differentiate between denture repair between the upper and lower arches.

DELTA DENTAL AND DIRECTOPTION ADMINISTRATIVE CHANGES		
Reference	**Change/Rationale/Exceptions**	**Details**
Overall	Minor changes for improved readability.	This includes separating 1 sentence into 2 and replacing some words with simpler synonyms.
Enrollment Loss of Eligibility by Dependent	Added language clarifying that dependent coverage based legal guardianship ends when the subscriber is no longer the legal guardian.	Grandchildren are eligible when the subscriber is the legal guardian. When the guardian relationship legally ends earlier than age 26, the grandchild's coverage also ends.
Claims Administration & Payment Order of Benefit Determination	The plan will now coordinate benefits with Medicare.	The new Medicare COB process will comply with the Oregon and Federal rules.

POLICY CHANGES		
Reference	**Change/Rationale/Exceptions**	**Details**
Group Size Changes	New section	Describer group's responsibility to inform Delta Dental of group size changes.

Additional changes may be required at any time as a result of new federal rules or regulations; changes to existing ACA rules or regulations or State law. Delta Dental will provide written notice of any additional changes including any modification to premium rates or administrative fees, and will administer such changes accordingly.

Services are provided by Oregon Dental Service doing business as Delta Dental Plan of Oregon (Delta Dental). Delta Dental is part of the Moda organization.