PETERSBURG
ALASKA

EMPLOYEE BENEFITS GUIDE
July 1, 2025 - June 30, 2026

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.
Please see page 27 for more details.

Inside the Guide

Welcome

At Petersburg Borough we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each employee makes to our accomplishments and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access and affordable for all our employees. This brochure will help you choose the type of plan and level of coverage that is right for you.

Sincerely,

Tiffany Glass, HR

Eligibility

Eligible Employees:

You may enroll in the Petersburg Borough Employee Benefits Program if you are a full-time employee who is actively working 30 or more hours per week, or a part-time employee working over 20 hours and under 30 hours a week.

Eligible Dependents:

If you are eligible for our benefits, then your dependents are too. In general, eligible dependents include your spouse and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Children may include natural, adopted, stepchildren and children obtained through court-appointed legal guardianship. Domestic Partners are not eligible for coverage.

When Coverage Begins:

The effective date for your benefits is July 1, 2025. Newly hired employees and dependents will be effective in Petersburg Borough's benefits programs on the first day of the month following thirty (30) days. Returning Permanent Seasonal employees will be effective on the first day following the date of return to duty. All elections are in effect for the entire plan year and can only be changed during Open Enrollment, unless you experience a family status event.

Family Status Change:

A change in family status is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some family status changes include:

- Change of legal marital status (i.e. marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (i.e. birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status (spouse loses job, etc.)

If such a change occurs, you must make changes to your benefits within 31 days of the event date. Documentation may be required to verify your change of status. Failure to request a change of status within 31 days of the event may result in your having to wait until the next open enrollment period to make your change. Please contact HR to make these changes.

Medical

Petersburg Borough is pleased to provide a choice between two (2) medical plans through Moda Health. You can choose between the Moda Health Endeavor Select PPO 1500 or the Moda Health Endeavor Select PPO 3000. Highlights of the medical plans are listed on the following page. Please refer to your Booklet or Summary of Benefits for full details.

Medical Comparison

	Moda Health Plan, Inc. Medical PPO- 1500 10019493		Moda Health Plan, Inc. Medical PPO- 3000 10019493	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Annual Deductible				
Individual	$1,500	$3,000	$3,000	$6,000
Family	$3,000	$6,000	$6,000	$12,000
Embedded or Aggregate	Embedded	Embedded	Embedded	Embedded
Coinsurance	80%	50%	80%	50%
Maximum Out-of-Pocket				
Individual	$4,500	$45,000	$6,000	$45,000
Family	$9,000	$90,000	$12,000	$90,000
Physician Office Visit				
Primary Care	$25 copay	50% after deductible	$30 copay	50% after deductible
Specialty Care	$25 copay	50% after deductible	$30 copay	50% after deductible
Preventive Care				
Adult Periodic Exams	100%	50% after deductible	100%	50% after deductible
Well-Child Care	100%	50% after deductible	100%	50% after deductible
Diagnostic Services				
X-ray and Lab Tests	80%	50% after deductible	80%	50% after deductible
Complex Radiology	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Urgent Care Facility	$25 copay	50% after deductible	$30 copay	50% after deductible
Emergency Room Facility Charges	$100 copay then 80% after deductible	$100 copay then 80% after deductible	$100 copay then 80% after deductible	$100 copay then 80% after deductible
Inpatient Facility Charges	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Outpatient Facility and Surgical Charges	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Mental Health				
Inpatient	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Outpatient	$25 copay	50% after deductible	80% after deductible	50% after deductible
Substance Abuse				
Inpatient	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Outpatient	$25 copay	50% after deductible	80% after deductible	50% after deductible

	Moda Health Plan, Inc. Medical PPO- 1500 10019493		Moda Health Plan, Inc. Medical PPO- 3000 10019493	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Other Services				
Chiropractic	$25 copay; 24 visits per year	50% after deductible; 24 visits per year	$30 copay; 24 visits per year	50% after deductible; 24 visits per year
Retail Pharmacy (30 Day Supply)				
Value	$0 copay	$0 copay	$0 copay	$0 copay
Select	$15 copay	$15 copay	$15 copay	$15 copay
Preferred	$45 copay	$45 copay	$45 copay	$45 copay
Non-Preferred	$75 copay	$75 copay	$75 copay	$75 copay
Mail Order Pharmacy (90 Day Supply)				
Value	$0 copay	$0 copay	$0 copay	$0 copay
Select	$45 copay	$45 copay	$45 copay	$45 copay
Preferred	$135 copay	$135 copay	$135 copay	$135 copay
Non-Preferred	$225 copay	$225 copay	$225 copay	$225 copay
Specialty (30 Day Supply)				
Select Specialty	$15 copay	Not covered	$15 copay	Not covered
Preferred Specialty	$225 copay	Not covered	$225 copay	Not covered
Non-Preferred Specialty	30% Coinsurance	Not covered	30% Coinsurance	Not covered

Directly above is a brief overview of what you can expect to pay for a prescription drug, depending on which "tier" category it falls under in the preferred drug list for your plan when using an In-Network Pharmacy.

If you have a maintenance drug, one you take every day, week, or month, take advantage of the mail order programs with your medical plan. See the Booklet, Carrier Benefit Summary or go online for details.

Preventive Care

You and your family have access to a wide range of preventive services under the Affordable Care Act. These services are 100% covered by your medical plan when using in-network providers. For more details about the services covered please visit **www.healthcare.gov/coverage/preventive-care-benefits.**

Common Prevetive Care services include routine physicals (age 18+) or pediatric exams (birth to age 17), age and gender appropriate screenings blood pressure screening for adults and children, and immunizations for adults and children.

Moda Member Dashboard

You and your family have a personalized Member Dashboard that puts the information you need at your fingertips. The Member Dashboard is a one-stop resource for all you need to get the most out of your plan, including:

- ID cards
- Claim status
- Healthcare cost estimator
- Provider search
- Explanation of Benefits (EOBs)
- Customer service contact information
- Benefits overview

If you don't have a Member Dashboard account, creating one is easy. Go to modahealth.com and enter your information. Be sure to have your member ID card handy. Access the Member Dashboard on your smartphone by following these simple steps:

On an iPhone

1. Open the browser on your phone and go to **modahealth.com/memberdashboard**
2. From the login screen, tap the Share icon in the menu at the bottom of the screen
3. From the Share menu (scroll right to see more options), choose "Add to Home Screen"
4. Tap "Add" to confirm

Your phone will now have an icon that says "Login|Member Dashboard."

On an Android device:

1. On your phone, go to **modahealth.com/memberdashboard**
2. Using the menu (three vertical dots) at the top of the screen, choose "Add to Home screen"
3. Tap "Add" to confirm
4. On the next screen, choose "ADD AUTOMATICALLY" so the icon will be placed on your phone

Your phone will now have an icon that says "Login|Member Dashboard."

Moda CirrusMD

CirrusMD gives you access to a doctor 24 hours a day, 7 days a week.

moda HEALTH CIRRUS MD

Use CirrusMD for:

- Coughs, fevers, sore throat
- Earaches, stomach pain, diarrhea
- Rashes, allergic reactions, animal/insect bites
- Back/abdominal pain
- Sports injuries, burns, heat-related illness
- Urinary tract infections
- General health questions

Download the CirrusMD app or connect online at modahealth.com/cirrusmd and see how easy it is to connect to a doctor in seconds!

Download on the App Store

GET IT ON Google Play

Dental Insurance

Petersburg Borough will continue to offer a combined Dental PPO and Vision plan. This year Petersburg Borough is offering a Base and Buy-Up Dental plan to choose from.

The Dental plans are administered through Delta Dental Insurance Company for all employees. With the Dental PPO plan, you can obtain dental care services from the dentist of your choice (contracted or not).

The Dental plan provides a higher level of benefits if you choose to use an in-network provider. To find an in-network provider, select a Delta Dental PPO dentist from the directory on the website **www.DeltaDentalAK.com.**

The Buy-Up plan offers Orthodontia for both you and your dependents as well as a higher annual maximum.
Please Note: It is recommended that when a course of treatment is expected to cost $300 or more, and is of a non-emergency nature, your dentist should submit a treatment plan before he/she begins. This enables you to see what your out-of-pocket expenses will be so you are not surprised and can budget accordingly. There is also a possibility that suggested procedures may be denied, and alternative procedures approved based upon X-rays and supporting documentation.

Please refer to the summary plan description for complete plan details.

Dental Comparison

	Delta Dental Insurance Company Base Dental Plan	Delta Dental Insurance Company Buy-Up Dental Plan
	In-Network Benefits	In-Network Benefits
Annual Deductible		
Individual	$25 PPO Provider $50 Premier Provider	$25 PPO Provider $50 Premier Provider
Family	$75 PPO Provider $150 Premier Provider	$75 PPO Provider $150 Premier Provider
Waived for Preventive Care?	Yes	Yes
Annual Maximum		
Per Person / Family	$1,600 PPO Provider $1,500 Premier Provider	$2,600 PPO Provider $2,500 Premier Provider
Preventive	100%	100%
Basic	80%	80%
Major	50%	50%
Orthodontia		
Benefit Percentage	Not covered	50%
Adults and Children	Not covered	Adult and children covered
Lifetime Maximum	N/A	$2,000
Benefit Waiting Periods	N/A	N/A

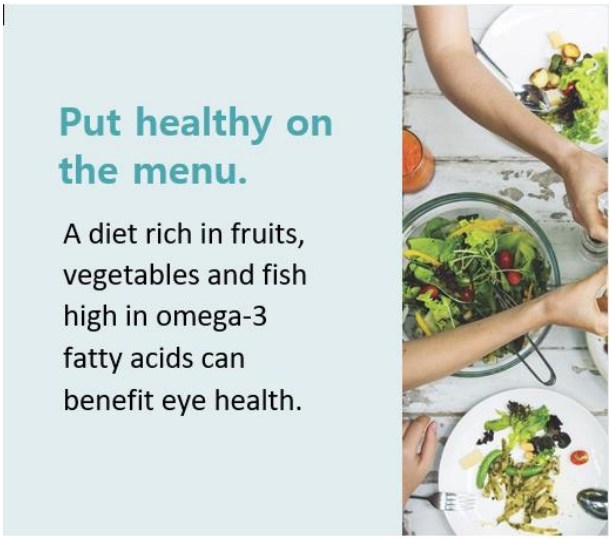
Vision

Your Vision benefit is combined with the Dental Benefit.

Sight, it's a beautiful thing and not to be taken for granted. Whether you want to be incognito and wear contact lenses or stand out in the crowd with the latest stylish frames, this vision plan has you covered.

The Vision plan is combined with the Dental Plan. Moda Health Plan, Inc., has a large network of Eye Care Providers. By seeing a preferred provider, you maximize your benefits.

There is no deductible for covered vision services or supplies. Vision exams and hardware benefits are all subject to the calendar year benefit maximum. Please refer to your Booklet or Summary of Benefits for full details.



	Moda Health Plan, Inc. Vision
Benefit Coverage	
Calendar Year Maximum	$300
Eye Examination (including refraction; PCY*)	100% up to maximum
Vision Materials	
Lenses	100% up to $300
Contacts Covered in lieu of frames. (Medically necessary contacts may be covered at a higher level)	100% up to $300
Frames	100% up to $300
Pediatric Hardware	100%

*PCY = Per Calendar Year

Health Reimbursement Arrangement (HRA)

Petersburg Borough offers a Health Reimbursement Arrangement in conjunction with the Moda Endeavor Select 3000 and Endeavor Select 1500 Medical plans.

The HRA will reimburse funds you have used towards your deductible, coinsurance, copay, and prescription drug expenses as indicated below for both Medical plans:

- The HRA will reimburse $1,000 for employees and dependents enrolled in one of the Medical Plans, with a maximum reimbursement of $2,000 for employees plus dependent coverage.
- Employees must first meet $1,000 of medical expenses before the HRA coverage starts.
- Employees with dependents must first meet $2,000 of medical expenses before the additional HRA coverage up to $2,000 will be distributed.

How the HRA Works

Once you've received treatment from a provider, the provider will bill your medical insurance. You will receive an Explanation of Benefits (EOB) from your insurance carrier showing how your benefits were applied. If the EOB shows that the service was applied to the deductible, you may submit the EOB and a completed claim form to Navia for reimbursement. You can then use the reimbursement to pay the provider. Rx drugs may be submitted in the form of an itemized statement from the pharmacy/provider. The statement must include the date of service, type of service and cost.

- Unused HRA dollars do not roll over from year to year

Claim Submission

1. Complete a claim form, itemize your expenses and list the total amount you are claiming.
2. Attach an Explanation of Benefits (EOB) from your insurance carrier. If you have secondary insurance coverage, you must submit the EOB from both insurance carriers.
3. Submit the claim form and EOB to Navia. The most efficient way to submit a claim is by using the online claim submission tool or the MyNavia smartphone app for Android or iPhone. You may also submit claims via email, fax or mail. Please use only one method per submission. Allow 2 full business days for your claim to be reviewed and processed once it has been received.
4. Reimbursements are processed weekly on Wednesday. Reimbursements will be directly deposited into your bank account or a check mailed to your home. Direct deposits may take 1-2 days to post to your bank account.
5. You will have 90 days to submit claims after the end of the plan year. If your employment is terminated, or you lose HRA coverage, you will have 90 days after your date of termination to submit claims for expenses incurred while you were covered under the plan. You may have the ability to continue coverage under COBRA (see your employer for details).

Life and AD&D

Petersburg Borough provides Basic Life and Accidental Death and Dismemberment (AD&D) insurance to eligible employees through UNUM Life Insurance Company of America. The Life insurance benefit will be paid to your designated beneficiary in the event of death while covered under the plan. The AD&D benefit will be paid in the event of a loss of life or limb by accident while covered under the plan.

Unum Life Insurance Company of America Life and AD&D	
You	
Benefit Maximum	$10,000
Guaranteed Issue	$10,000
Your Spouse	
Benefit Maximum	Not covered
Guaranteed Issue	Not covered
Your Child	
Benefit Maximum	Not covered
Guaranteed Issue	Not covered

The above benefits will reduce to 65% at age 65 and to 50% at age 70.

Important reminder! Be sure to assign a beneficiary or living trust to ensure your assets are distributed according to your wishes

Voluntary Offerings

In addition to the employer paid Basic Life and AD&D coverage, you have the option to purchase voluntary life insurance to cover any gaps in your existing coverage that may be a result of age reduction schedules, cost of living, existing financial obligations, etc. Your election, however, could be subject to medical questions and evidence of insurability.

Voluntary Life and AD&D Insurance

You may purchase additional Life/AD&D insurance with Unum Life Insurance Company of America if you want more coverage. Your contributions will depend on your age and the amount of coverage you elect.

	Unum Voluntary Life and AD&D
Employee	
Benefit Amount	Increments of $10,000
Overall Maximum	5x Annual Salary to $500,000
Guarantee Issue Amount	$100,000
Spouse	
Benefit Amount	Increments of $5,000
Overall Maximum	The lesser of 100% of Employee Amount or $250,000
Guarantee Issue Amount	$25,000
Child(ren) (up to age 19, 26 if full-time student)	
Benefit Amount	14 days to 6 months $1,000; over 6 months increments of $2,000
Overall Maximum	Children 14 days to 6 months: $1,000 Children 6 months and older: $10,000
Guaranteed Issue Amount	Children 14 days to 6 months: $1,000 Children 6 months and older: $10,000

The above benefits will reduce to 65% at age 65 and 50% at age 70.

If you would like to purchase Voluntary Life insurance for your dependents, you must also be enrolled.

The Guarantee issue amount of coverage is guaranteed without having to complete Evidence of Insurability (EOI). Evidence of Insurability will need to be completed for any amount elected over the guarantee issue amount and is subject to carrier medical underwriting approval.

Important reminder! Be sure to assign a beneficiary or living trust to ensure your assets are distributed according to your wishes

Employee Assistance Plan (EAP)

Life does not always go smoothly. All of us experience times when a personal problem or crisis affects the way we function at work or home. Your Employee Assistance Program (EAP) is a problem-solving resource available to you and your household members. A professional counselor will assist you in assessing your situation, finding options, making choices or locating further help.

It's free… Your employer covers the cost of initial assessment, additional problem-solving sessions and referral services. If there is a need for further counseling or treatment, your counselor will help you explore various options.

It's confidential… Your EAP has been set up with ComPsych Corporation, an outside counseling resource to assure confidentiality. No one at work will know you have chosen to seek help unless you choose to tell them. Nothing concerning your use of EAP will appear in your personnel file.

Phone Number	Website	Web ID
877-616-0508	Guidanceresources.com	CN3906K

App Store Google Play

COMPSYCH®
GuidanceResources® Worldwide

Worksite Products

You have the option to purchase additional voluntary benefits through Aflac. Benefits you may purchase include:

- Accident Insurance
- Cancer Protection Assurance
- Critical Illness
- Disability Insurance
- Hospital Indemnity Insurance

Accident & Injury

No one plans to have an accident. But, it can happen at any moment throughout the day, whether at work or at play. Most major medical insurance plans only pay a portion of the bills. Our policy can help pick up where other insurance leaves off and provide cash to cover the expenses. Our accident coverage helps offer peace of mind when an accidental injury occurs.

Cancer Protection Assurance

We believe if faced with a cancer diagnosis, you need real solutions that help you face the financial, physical, and emotional challenges often experienced by cancer patients and their families. This benefit pays cash directly to you when you need it most.

Critical Illness

The signs pointing to a critical illness are not always clear and may not be preventable, but our coverage can help offer financial protection in the event you are diagnosed. Unum Life Insurance Company of America group voluntary critical illness coverage provides a lump-sum cash benefit to help you cover the out-of-pocket expenses associated with a critical illness

Disability Insurance

When disabled, you may not only lose the ability to earn a living, but you may also lose savings or retirement funds. Disability insurance plays an integral and important role in your financial planning. Aflac provides benefits for both total and partial disability.

Hospital Indemnity Insurance

Hospital Insurance helps covered employees and their families cope with the financial impacts of hospitalization. Aflac pays you cash to help with the expenses not covered by health insurance, so you can worry less about making ends meet when you're left with unexpected medical bills.

Visit **https://www.aflacenrollment.com/PetersburgBorough/U98383926688** to view your current coverage, make changes to your information, or file a claim. Your local agent is Travis Carlile who is available for questions at (402) 203-4414 or at **travis_carlile@us.aflac.com**.

Changes in Benefit Elections

Open Enrollment:

With few exceptions, Open Enrollment is the only time of year when you can make changes to your benefits plan. All elections and changes take effect on the first day of the plan year. During Open Enrollment, you can:

- Add, change, or delete coverage
- Add, or drop dependents from coverage
- Enroll, or re-enroll in dependent or health care flexible spending accounts. To continue your FSA benefits, you must re-enroll each plan year.

Please complete enrollment forms during this year's open enrollment period to ensure you and your dependents have the coverage you need.

During open enrollment if you are eligible for benefits you may elect Dental and Vision only, or Medical, Dental, and Vision combined.

Please contact Human Resources to complete any changes to your benefits that are not related to your initial or annual enrollment.

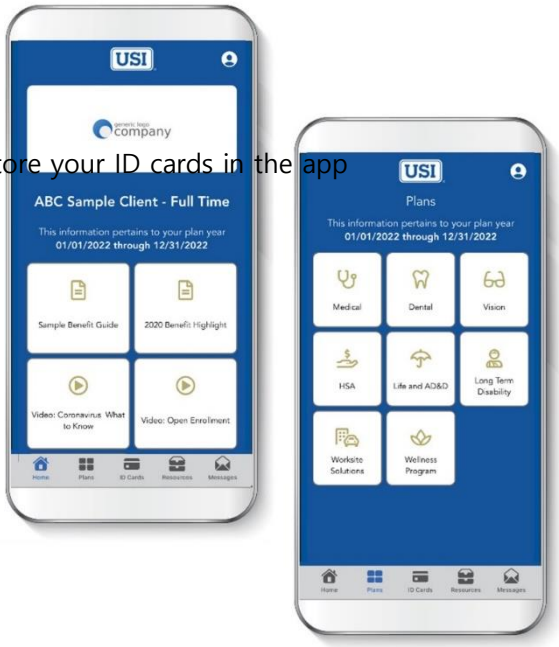
USI Mobile App

USI Mobile App – MyBenefits2GO

Petersburg Borough is pleased to offer on-the-go access to key benefit information through the USI Mobile App, MyBenefits2GO. Download in the App Store or Google Play Store and enter code **S91092** in the app to access your benefit highlights.

Highlights of the MyBenefits2GO App

- Access benefits information on the go
- Convenient contact information for Carriers and HR
- Organized plan information in one place
- View the most updated plan information
- Store your ID cards in the app



USI – Benefit Resource Center

Have Questions? Need Help?

Petersburg Borough is excited to offer access to the USI Benefit Resource Center (BRC), which is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals, and their primary responsibility is to assist you.

BRCWest@usi.com
Monday - Friday
Monday through Friday
8:00am to 5:00pm
Mountain, Pacific and Alaska Standard Time

866-468-7272
24 hours a day, 7 days a week

Carrier Customer Service Contacts

	CARRIER	PHONE NUMBER	Group Number
Medical, Vision, Prescription	Moda Health Plan, Inc.	1-888-217-2363	10019493
Dental PPO	Moda Health / Delta Dental	1-888-374-8906	10019493
Health Reimbursement Arrangement (HRA)	Navia Benefit Solutions	1-866-897-1996	PBB
Life and AD&D, Voluntary Life and AD&D	Unum Life Insurance Company of America	1-866-679-3054	N/A
Employee Assistance Program (EAP)	ComPsych Corporation	1-877-616-0508	CN3906K
Worksite Voluntary Benefits	Aflac	1-402-203-4414	N/A

PETERSBURG
ALASKA

Petersburg Borough
P.O. Box 329
Petersburg, Alaska 99833
(907) 772-5404

This brochure summarizes the benefit plans that are available to Petersburg Borough eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.

REQUIRED NOTIFICATIONS

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH 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. Therefore, the following deductibles and coinsurance apply:

Moda Medical PPO 3000: Deductible $3,000 Individual / $6,000 Family; 80% Coinsurance
Moda Medical PPO 1500: Deductible $1,500 Individual / $3,000 Family; 80% Coinsurance

NEWBORNS ACT DISCLOSURE – FEDERAL

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).

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).

In addition, 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.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 30 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan reviewed and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Tiffany Glass
P.O. Box 329
Petersburg, Alaska United States 99833
907-772-5404
tiffany.glass@petersburgak.gov

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully****.*
Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases, we never share your information unless you give us written permission:
  Marketing purposes
  Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization
- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- July 1, 2025
- Tiffany Glass, Deputy Borough Clerk, (907) 772-5404

MODEL INDIVIDUAL **CREDITABLE COVERAGE** DISCLOSURE NOTICE LANGUAGE FOR USE ON OR AFTER APRIL 1, 2011

If you are receiving a copy of this notice electronically, you are responsible for providing a copy of it to any Part-D eligible dependents covered under the group health plan.

Important Notice from Petersburg Borough 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 Petersburg Borough 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. Petersburg Borough has determined that the prescription drug coverage offered by Moda Health for the plan year 2025 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, the following options may apply:

- You may stay in the Petersburg Borough plan and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
    - During the Medicare prescription drug annual enrollment period, or
    - If you lose Petersburg Borough creditable coverage.
- You may stay in the Petersburg Borough plan and also enroll in a Medicare prescription drug plan. The Petersburg Borough plan will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the Petersburg Borough plan and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the Petersburg Borough plan you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

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 Petersburg Borough 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.

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 Petersburg Borough 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:	July 1, 2025
Name/Entity of Sender:	Petersburg Borough
Contact Position/Office:	Tiffany Glass / Deputy Borough Clerk
Address:	12 South Nordic Drive; P.O. Box 329, Petersburg, AK 99833
Phone Number:	(907) 772-5404

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

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
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
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
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+)

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

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

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

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website:
Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

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: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid

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

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsphttps://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

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

Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
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 July 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)
Option 4, Ext. 61565

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

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)

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

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%[1] 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.[2]

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 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 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

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

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 through your employment, please check your health plan's summary plan description or contact:

Name of Entity/Sender:	Petersburg Borough
Contact--Position/Office:	Tiffany Glass – Deputy Borough Clerk
Address:	12 South Nordic Drive; P.O. Box 329, Petersburg, AK 99833
Phone Number:	(907) 772-5404

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 – Petersburg Borough		4. Employer Identification Number (EIN) – 92-6000142
5. Employer address- PO Box 329		6. Employer phone number – (907) 772-5405
7. City – Petersburg	8. State – AK	9. ZIP code - 99833
10. Who can we contact about employee health coverage at this job? – Becky Regula		
11. Phone number (if different from above)	12. Email address – bregula@petersburgak.gov	

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:

    You may enroll in the Petersburg Borough Employee Benefits Program if you are an active employee working at least 20 hours per week.

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    If you are eligible for our benefits, then your dependents are too. In general, eligible dependents include your spouse and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Children may include natural, adopted, stepchildren and children obtained through court-appointed legal guardianship. Domestic Partners are not eligible for coverage.

  - ☐ We do not offer coverage.

☒ 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.

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly