Crook County
Benefits Resource Guide

PLAN YEAR | **2021 / 2022**

YOUR SERVICE TEAM
BENEFITS

It is our desire to work with you and your personnel to establish direct, efficient communications with our office. We are committed to serving your insurance and risk management needs with excellence.

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CONTACT

LOCAL OFFICE	TOLL FREE	FAX	ADDRESS
(541) 342-4441	(800) 852-6140	(541) 484-5434	2930 CHAD DRIVE EUGENE, OR 97408

Contact Information

Refer to this list when you need to contact one of your benefit vendors. For general information contact Human Resources.

MEDICAL: _____ page 9
PacificSource Health Plans
(800) 624-6052
www.pacificsource.com

DENTAL: _____ page 39
Moda
(888) 217-2365
www.modahealth.com

VISION: _____ page 51
PacificSource Health Plans
(800) 624-6052
www.pacificsource.com

HEALTH REIMBURSEMENT ARRANGEMENT (HRA VEBA): _____ page 53
BPAS
(855) 404-8322
www.bpas.com

HEALTH SPENDING ACCOUNTS (HSA): _____ page 54
BPAS
(855) 404-8322
www.bpas.com

FLEXIBLE SPENDING ACCOUNTS (FSA): _____ page 59
PacificSource Administrators
(800) 442-7038
www.psa.pacificsource.com

LIFE & ACCIDENTAL DEATH & DISMEMBERMENT: _____ page 65
United Heritage
(800) 657-6351
www.unitedheritage.com

VOLUNTARY LIFE & ACCIDENTAL DEATH & DISMEMBERMENT: _____ page 66
United Heritage
(800) 657-6351
www.unitedheritage.com

EMPLOYEE ASSISTANCE PROGRAM (EAP): _____ page 68
Guidance Resources
(866) 511-3361
www.guidanceresources.com

TRAVEL ASSISTANCE: _____ page 69

AFLAC: _____ page 71

EMERGENCY MEDICAL TRANSPORT: _____ page 72

Eligibilty Information

Who is Eligible and When:

All full-time employees are eligible for benefits the first of the month following 30 days of employment.

Employer Pays:

Crook County pays 90% of the medical, dental, vision premiums for employees and their dependents. As well as 100% of the Life and Disability premium. You will be responsible for the premiums for any voluntary life insurance elected

If you waive the medical coverage because you have coverage elsewhere, you will receive a stipend of $62.50 per paycheck.

Crook County
Plan Comparison - County & Road
July 1, 2021

	Voyager $1500 Deductible		Voyager $3000 Deductible	
	$1500 Deductible		$3000 Deductible	
Medical & Prescription Benefits	**In-Network - Voyager**		**In-Network - Voyager**	
Individual Deductible	$1,500		$3,000	
Family Deductible	$3,000		$6,000	
Individual OOP Max	**$3,500**		**$5,000**	
Family OOP Max	**$7,000**		**$10,000**	
OOP Max includes Deductible	***YES***		***YES***	
OOP Max includes Copays	***YES; Including Prescription Copays***		***YES; Including Prescription Copays***	
Preventative Office Visit	Covered in Full		Covered in Full	
Office Visit	**$25 Copay, Ded. Waived**		**$25 Copay, Ded. Waived**	
Urgent Care Visit	**$25 Copay, Ded. Waived**		**$25 Copay, Ded. Waived**	
Specialist Office Visit	**$25 Copay, Ded. Waived**		**$25 Copay, Ded. Waived**	
Maternity - Delivery and Postnatal	$250 per delivery, Ded. Waived		$250 per delivery, Ded. Waived	
Maternity Hospital Stay	20%		20%	
Hospital Services	20%		20%	
Outpatient Services	20%		20%	
Diagnostic Lab/X-Ray	20%, Ded. Waived		20%, Ded. Waived	
CT, PET, MRI & MRA Lab	20%, Ded. Waived		20%, Ded. Waived	
Emergency Room Services	$250 Copay, Ded. Waived		$250 Copay, Ded. Waived	
Ambulance Services (Ground)	20%		20%	
Physical Therapy	$25 Copay, Ded. Waived *30 visits per calendar year*		$25 Copay, Ded. Waived *30 visits per calendar year*	
Durable Medical Equipment	20%		20%	
Allergy Injections	20%		20%	
Prescription	**30 Day**	**90 Day**	**30 Day**	**90 Day**
Deductible	N/A		N/A	
Preferred Generic	$15	$30	$15	$30
Generic				
Preferred Brand	$45	$90	$45	$90
Brand	$45	$90	$45	$90
Compounded	50%		50%	
Alternative Care	**Acup., Chiro, Naturopath**		**Acup., Chiro, Naturopath**	
Copay	$25 Copay, Ded. Waived		$25 Copay, Ded. Waived	
Benefit Maximum	$1500 per person		$1500 per person	
Vision - PacificSource				
Exam	$10 Copay		$10 Copay	
Hardware Allowance	Under age 19: No Charge Over age 19: No Charge up to $300		Under age 19: No Charge Over age 19: No Charge up to $300	
Dental - Moda				
Deductible	None		None	
Preventative	Covered in Full		Covered in Full	
Basic - Restorative	Covered in Full		Covered in Full	
Basic - Complicated	Covered in Full		Covered in Full	
Major	50%		50%	
Annual Maximum	$1500		$1500	
Orthodontia	50% to $1500 lifetime maximum		50% to $1500 lifetime maximum	

	Monthly Employee Contribution	Annual Employee Contribution	Monthly Employee Contribution	Annual Employee Contribution
Employee Only	87.38	$1,048.60	22.73	$272.80
Employee + Spouse	189.89	$2,278.62	48.63	$583.50
Employee + Family	218.46	$2,621.54	60.38	$724.58
Employee + Child(ren)	149.21	$1,790.52	41.23	$494.76

	Total Premium	Employer Contribution	Total Premium	Employer Contribution
Employee Only	$873.83	$786.45	$809.18	$786.45
Employee + Spouse	$1,898.85	$1,708.97	$1,757.59	$1,708.97
Employee + Family	$2,184.62	$1,966.16	$2,026.54	$1,966.16
Employee + Child(ren)	$1,492.10	$1,342.89	$1,384.12	$1,342.89

Navigator $3000 Deductible	Navigator HSA $2000 Deductible
$3000 Deductible	**$2000 Deductible**
In-Network - Navigator	**In-Network - Navigator**
$3,000	$2,000
$6,000	$4,000
$5,000	**$4,000**
$10,000	**$8,000**
YES	***YES***
YES; Including Prescription Copays	***YES; Including Prescription Copays***
Covered in Full	Covered in Full
$25 Copay, Ded. Waived	**20%**
$25 Copay, Ded. Waived	**20%**
$25 Copay, Ded. Waived	**20%**
$250 per delivery, Ded. Waived	20%
20%	20%
20%	20%
20%	20%
20%, Ded. Waived	20%
20%, Ded. Waived	20%
$250 Copay, Ded. Waived	20%
20%	20%
$25 Copay, Ded. Waived *30 visits per calendar year*	20%
20%	20%
20%	20%

30 Day	90 Day	30 Day	90 Day Mail
N/A		Medical Deductible	
$15	$30	20%	20%
$45	$90	20%	20%
$45	$90	20%	20%
50%		20%	
Acup., Chiro, Naturopath		**Acup., Chiro, Naturopath**	
$25 Copay, Ded. Waived		$25 Copay	
$1500 per person		$1500 per person	
$10 Copay		$10 Copay	
Under age 19: No Charge Over age 19: No Charge up to $300		Under age 19: No Charge Over age 19: No Charge up to $300	
None		None	
Covered in Full		Covered in Full	
Covered in Full		Covered in Full	
Covered in Full		Covered in Full	
50%		50%	
$1500		$1500	
50% to $1500 lifetime maximum		50% to $1500 lifetime maximum	

Monthly VEBA Contribution	Annual VEBA Contribution	Monthly HSA Contribution	Annual HSA Contribution
-30.54	-$366.44	-64.13	-$769.52
-67.75	-$813.06	-141.15	-$1,693.74
-69.86	-$838.30	-151.99	-$1,823.86
-47.74	-$572.88	-103.84	-$1,246.08

Total Premium	Employer Contribution	Total Premium	Employer Contribution
$755.91	$786.45	$722.32	$786.45
$1,641.21	$1,708.97	$1,567.82	$1,708.97
$1,896.30	$1,966.16	$1,814.17	$1,966.16
$1,295.15	$1,342.89	$1,239.05	$1,342.89

Medical Insurance
PacificSource Health Plans

PacificSource HEALTH PLANS

Crook County

Medical Benefit Summary
Voyager 1500+25_20 S3

Provider Network: **Voyager**

Deductible Per Calendar Year	In-network and Out-of-network
Individual/Family	$1,500/$3,000
Out-of-Pocket Limit Per Calendar Year	**In-network and Out-of-network**
Individual/Family	$3,500/$7,000

Note: Your actual costs for services provided by an out-of-network provider may exceed this plan's out-of-pocket limit for out-of-network services. In addition, out-of-network providers can bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company, and this amount is not counted toward the out-of-network out-of-pocket limit. Please see allowable fee in the Definitions section of your member handbook.

The member is responsible for any amounts shown above, in addition to the following amounts:

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Preventive Care		
Well baby/Well child care	No deductible, 0%	No deductible, 40%
Preventive physicals	No deductible, 0%	No deductible, 40%
Well woman visits	No deductible, 0%	No deductible, 40%
Preventive mammograms	No deductible, 0%	After deductible, 40%
Immunizations	No deductible, 0%	No deductible, 40%
Preventive colonoscopy	No deductible, 0%	After deductible, 40%
Prostate cancer screening	No deductible, 0%	After deductible, 40%
Professional Services		
Office and home visits	No deductible, $25	No deductible, 40%
Naturopath office visits	No deductible, $25	No deductible, 40%
Specialist office and home visits	No deductible, $25	No deductible, 40%
Telemedicine visits	No deductible, $10	No deductible, 40%
Office procedures and supplies	After deductible, 20%	After deductible, 40%
Surgery	After deductible, 20%	After deductible, 40%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Outpatient rehabilitation and habilitation services	No deductible, $25	After deductible, 40%
Chiropractic manipulations and acupuncture ($1,500 per benefit year.)	No deductible, $25	No deductible, 40%
Hospital Services		
Inpatient room and board	After deductible, 20%	After deductible, 40%
Inpatient rehabilitation and habilitation services	After deductible, 20%	After deductible, 40%
Skilled nursing facility care	After deductible, 20%	After deductible, 40%
Outpatient Services		
Outpatient surgery/services	After deductible, 20%	After deductible, 40%
Advanced diagnostic imaging	No deductible, 20%	After deductible, 40%
Diagnostic and therapeutic radiology/lab and dialysis	No deductible, 20%	After deductible, 40%
Urgent and Emergency Services		
Urgent care center visits	No deductible, $25	No deductible, 40%
Emergency room visits – medical emergency	No deductible, $250^	No deductible, $250^
Emergency room visits – non-emergency	No deductible, $250^	After deductible, 40%
Ambulance, ground	After deductible, 20%	After deductible, 20%
Ambulance, air	After deductible, 20%	After deductible, 20%+
Maternity Services**		
Physician/Provider services (global charge)	No deductible, $250 per pregnancy	After deductible, 40%
Hospital/Facility services	After deductible, 20%	After deductible, 40%
Mental Health and Substance Use Disorder Services		
Office visits	No deductible, $25	No deductible, 40%
Inpatient care	After deductible, 20%	After deductible, 40%
Residential programs	After deductible, 20%	After deductible, 40%
Other Covered Services		
Allergy injections	After deductible, 20%	After deductible, 40%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Durable medical equipment	After deductible, 20%	After deductible, 40%
Home health services	After deductible, 20%	After deductible, 40%
Transplants	After deductible, 0%	After deductible, 40%
Temporomandibular joint	After deductible, 50%	Not covered

This is a brief summary of benefits. Refer to your member handbook for additional information or a further explanation of benefits, limitations, and exclusions.

^ Co-pay applies to ER physician and facility charges only. Co-pay waived if admitted into hospital.

** Medically necessary services, medication, and supplies to manage diabetes during pregnancy from conception through six weeks postpartum will not be subject to a deductible, co-payment, or co-insurance.

+ Out-of-network air ambulance coverage is covered at 200 percent of the Medicare allowance. You may be held responsible for the amount billed in excess. Please see your member handbook for additional information or contact our Customer Service team with questions.

Additional information

What is the deductible?

Your plan's deductible is the amount of money that you pay first, before your plan starts to pay. You'll see that many services, especially preventive care, are covered by the plan without you needing to meet the deductible. The individual deductible applies if you enroll without dependents. If you and one or more dependents enroll, the individual deductible applies for each member only until the family deductible has been met. Deductible expense is applied to the out-of-pocket limit.

In-network expense and out-of-network expense apply together toward your deductible.

What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for covered expenses during the plan year. Once the out-of-pocket limit has been met, the plan will pay 100 percent of allowed amounts for covered services for the rest of that year. The individual out-of-pocket limit applies only if you enroll without dependents. If you and one or more dependents enroll, the individual out-of-pocket limit applies for each member only until the family out-of-pocket limit has been met. Be sure to check your member handbook, as there are some charges, such as non-essential health benefits, penalties, and balance billed amounts that do not count toward the out-of-pocket limit.

In-network expense and out-of-network expense apply together toward your out-of-pocket limits.

Payments to providers

Payment to providers is based on the prevailing or contracted PacificSource fee allowance for covered services. In-network providers accept the fee allowance as payment in full. Out-of-network providers are allowed to balance bill any remaining balance that your plan did not cover. Services of out-of-network providers could result in out-of-pocket expense in addition to the percentage indicated.

Preauthorization

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called preauthorization. Preauthorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. Preauthorization does not change your out-of-pocket expense for in-network and out-of-network providers. You'll find the most current preauthorization list on our website, PacificSource.com/member/preauthorization.aspx.

Provider Network: **Voyager**

Deductible Per Calendar Year	In-network and Out-of-network
Individual/Family	$3,000/$6,000
Out-of-Pocket Limit Per Calendar Year	**In-network and Out-of-network**
Individual/Family	$5,000/$10,000

Note: Your actual costs for services provided by an out-of-network provider may exceed this plan's out-of-pocket limit for out-of-network services. In addition, out-of-network providers can bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company, and this amount is not counted toward the out-of-network out-of-pocket limit. Please see allowable fee in the Definitions section of your member handbook.

The member is responsible for any amounts shown above, in addition to the following amounts:

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Preventive Care		
Well baby/Well child care	No deductible, 0%	No deductible, 40%
Preventive physicals	No deductible, 0%	No deductible, 40%
Well woman visits	No deductible, 0%	No deductible, 40%
Preventive mammograms	No deductible, 0%	After deductible, 40%
Immunizations	No deductible, 0%	No deductible, 40%
Preventive colonoscopy	No deductible, 0%	After deductible, 40%
Prostate cancer screening	No deductible, 0%	After deductible, 40%
Professional Services		
Office and home visits	No deductible, $25	No deductible, 40%
Naturopath office visits	No deductible, $25	No deductible, 40%
Specialist office and home visits	No deductible, $25	No deductible, 40%
Telemedicine visits	No deductible, $10	No deductible, 40%
Office procedures and supplies	After deductible, 20%	After deductible, 40%
Surgery	After deductible, 20%	After deductible, 40%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Outpatient rehabilitation and habilitation services	No deductible, $25	After deductible, 40%
Chiropractic manipulations and acupuncture ($1,500 per benefit year.)	No deductible, $25	No deductible, 40%
Hospital Services		
Inpatient room and board	After deductible, 20%	After deductible, 40%
Inpatient rehabilitation and habilitation services	After deductible, 20%	After deductible, 40%
Skilled nursing facility care	After deductible, 20%	After deductible, 40%
Outpatient Services		
Outpatient surgery/services	After deductible, 20%	After deductible, 40%
Advanced diagnostic imaging	No deductible, 20%	After deductible, 40%
Diagnostic and therapeutic radiology/lab and dialysis	No deductible, 20%	After deductible, 40%
Urgent and Emergency Services		
Urgent care center visits	No deductible, $25	No deductible, 40%
Emergency room visits – medical emergency	No deductible, $250^	No deductible, $250^
Emergency room visits – non-emergency	No deductible, $250^	After deductible, 40%
Ambulance, ground	After deductible, 20%	After deductible, 20%
Ambulance, air	After deductible, 20%	After deductible, 20%+
Maternity Services**		
Physician/Provider services (global charge)	No deductible, $250 per pregnancy	After deductible, 40%
Hospital/Facility services	After deductible, 20%	After deductible, 40%
Mental Health and Substance Use Disorder Services		
Office visits	No deductible, $25	No deductible, 40%
Inpatient care	After deductible, 20%	After deductible, 40%
Residential programs	After deductible, 20%	After deductible, 40%
Other Covered Services		
Allergy injections	After deductible, 20%	After deductible, 40%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Durable medical equipment	After deductible, 20%	After deductible, 40%
Home health services	After deductible, 20%	After deductible, 40%
Transplants	After deductible, 0%	After deductible, 40%
Temporomandibular joint	After deductible, 50%	Not covered

This is a brief summary of benefits. Refer to your member handbook for additional information or a further explanation of benefits, limitations, and exclusions.

^ Co-pay applies to ER physician and facility charges only. Co-pay waived if admitted into hospital.

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+ Out-of-network air ambulance coverage is covered at 200 percent of the Medicare allowance. You may be held responsible for the amount billed in excess. Please see your member handbook for additional information or contact our Customer Service team with questions.

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The out-of-pocket limit is the most you'll pay for covered expenses during the plan year. Once the out-of-pocket limit has been met, the plan will pay 100 percent of allowed amounts for covered services for the rest of that year. The individual out-of-pocket limit applies only if you enroll without dependents. If you and one or more dependents enroll, the individual out-of-pocket limit applies for each member only until the family out-of-pocket limit has been met. Be sure to check your member handbook, as there are some charges, such as non-essential health benefits, penalties, and balance billed amounts that do not count toward the out-of-pocket limit.

In-network expense and out-of-network expense apply together toward your out-of-pocket limits.

Payments to providers

Payment to providers is based on the prevailing or contracted PacificSource fee allowance for covered services. In-network providers accept the fee allowance as payment in full. Out-of-network providers are allowed to balance bill any remaining balance that your plan did not cover. Services of out-of-network providers could result in out-of-pocket expense in addition to the percentage indicated.

Preauthorization

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called preauthorization. Preauthorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. Preauthorization does not change your out-of-pocket expense for in-network and out-of-network providers. You'll find the most current preauthorization list on our website, PacificSource.com/member/preauthorization.aspx.

Deductible Per Calendar Year	In-network and Out-of-network
Individual/Family	$3,000/$6,000
Out-of-Pocket Limit Per Calendar Year	**In-network and Out-of-network**
Individual/Family	$5,000/$10,000

Note: Your actual costs for services provided by an out-of-network provider may exceed this plan's out-of-pocket limit for out-of-network services. In addition, out-of-network providers can bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company, and this amount is not counted toward the out-of-network out-of-pocket limit. Please see allowable fee in the Definitions section of your member handbook.

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Service/Supply	In-network Member Pays	Out-of-network Member Pays
Preventive Care		
Well baby/Well child care	No deductible, 0%	No deductible, 40%
Preventive physicals	No deductible, 0%	No deductible, 40%
Well woman visits	No deductible, 0%	No deductible, 40%
Preventive mammograms	No deductible, 0%	After deductible, 40%
Immunizations	No deductible, 0%	No deductible, 40%
Preventive colonoscopy	No deductible, 0%	After deductible, 40%
Prostate cancer screening	No deductible, 0%	After deductible, 40%
Professional Services		
Primary care provider (PCP) Office and home visits	No deductible, $25	No deductible, 40%
Naturopath office visits	No deductible, $25	No deductible, 40%
Specialist office and home visits	No deductible, $25	No deductible, 40%
Telemedicine visits	No deductible, $10	No deductible, 40%
Office procedures and supplies	After deductible, 20%	After deductible, 40%
Surgery	After deductible, 20%	After deductible, 40%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Outpatient rehabilitation and habilitation services	No deductible, $25	After deductible, 40%
Chiropractic manipulations and acupuncture ($1,500 per benefit year.)	No deductible, $25	No deductible, 40%
Hospital Services		
Inpatient room and board	After deductible, 20%	After deductible, 40%
Inpatient rehabilitation and habilitation services	After deductible, 20%	After deductible, 40%
Skilled nursing facility care	After deductible, 20%	After deductible, 40%
Outpatient Services		
Outpatient surgery/services	After deductible, 20%	After deductible, 40%
Advanced diagnostic imaging	No deductible, 20%	After deductible, 40%
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Urgent care center visits	No deductible, $25	No deductible, 40%
Emergency room visits – medical emergency	No deductible, $250^	No deductible, $250^
Emergency room visits – non-emergency	No deductible, $250^	After deductible, 40%
Ambulance, ground	After deductible, 20%	After deductible, 20%
Ambulance, air	After deductible, 20%	After deductible, 20%+
Maternity Services**		
Physician/Provider services (global charge)	No deductible, $250 per pregnancy	After deductible, 40%
Hospital/Facility services	After deductible, 20%	After deductible, 40%
Mental Health and Substance Use Disorder Services		
Office visits	No deductible, $25	No deductible, 40%
Inpatient care	After deductible, 20%	After deductible, 40%
Residential programs	After deductible, 20%	After deductible, 40%
Other Covered Services		
Allergy injections	After deductible, 20%	After deductible, 40%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Durable medical equipment	After deductible, 20%	After deductible, 40%
Home health services	After deductible, 20%	After deductible, 40%
Transplants	After deductible, 0%	After deductible, 40%
Temporomandibular joint	After deductible, 50%	Not covered

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In-network expense and out-of-network expense apply together toward your out-of-pocket limits.

Primary care physician or primary care provider (PCP)

You are highly encouraged to select a PCP from the plan's provider directory. The PCP will coordinate healthcare resources to best meet your needs. Referrals are not required.

Payments to providers

Payment to providers is based on the prevailing or contracted PacificSource fee allowance for covered services. In-network providers accept the fee allowance as payment in full. Out-of-network providers are allowed to balance bill any remaining balance that your plan did not cover. Services of out-of-network providers could result in out-of-pocket expense in addition to the percentage indicated.

Preauthorization

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called preauthorization. Preauthorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. Preauthorization does not change your out-of-pocket expense for in-network and out-of-network providers. You'll find the most current preauthorization list on our website, PacificSource.com/member/preauthorization.aspx.

Formulary Oregon Drug List (ODL)

This PacificSource health plan includes coverage for prescription drugs and certain other pharmaceuticals, subject to the information below. This plan complies with federal healthcare reform. To check which tier your prescription falls under, call our Customer Service team or visit PacificSource.com/drug-list.

The amount you pay for covered prescriptions at in-network and out-of-network pharmacies applies toward your plan's in-network medical out-of-pocket limit, which is shown on the Medical Benefit Summary. The co-payment and/or co-insurance for prescription drugs obtained from an in-network or out-of-network pharmacy are waived during the remainder of the calendar year in which you have satisfied the medical out-of-pocket limit.

Affordable Care Act Standard Preventive No-cost Drug List

Your prescription benefit includes certain outpatient drugs as a preventive benefit at no deductible, $0. This includes specific drugs that are taken regularly to prevent a disease or to keep a specific disease or condition from progressing. You can get a list of covered preventive drugs by contacting our Customer Service team or visit PacificSource.com/drug-list.

Each time a covered prescription is dispensed, you are responsible for any amounts shown above, in addition to the following amounts:

Service/ Supply	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays	Tier 4 Member Pays
In-network Retail Pharmacy				
Up to a 30 day supply:	No deductible, $15	No deductible, $45	No deductible, $45	No deductible, $45
31 - 60 day supply:	No deductible, $30	No deductible, $90	No deductible, $90	No deductible, $90
61 - 90 day supply:	No deductible, $45	No deductible, $135	No deductible, $135	No deductible, $135
In-network Mail Order Pharmacy				
Up to a 30 day supply:	No deductible, $15	No deductible, $45	No deductible, $45	No deductible, $45
31 - 90 day supply:	No deductible, $30	No deductible, $90	No deductible, $90	No deductible, $90
Compound Drugs**				
Up to a 90 day supply:	No deductible, 50%			
Out-of-network Pharmacy				
30 day max fill, no more than three fills allowed per year:	No deductible, 90%			

**Compounded medications are subject to a preauthorization process. Compounds are generally covered only when all commercially available formulary products have been exhausted and all the ingredients in the compounded medications are on the applicable formulary.

Specialty Medications must be filled through an in-network specialty pharmacy and are limited to a 30 day supply.

MAC B - Unless the prescribing provider requires the use of a brand name drug, the prescription will automatically be filled with a generic drug when available and permissible by state law. If you receive a brand name drug when a generic is available, you will be responsible for the brand name drug's co-payment and/or co-insurance plus the difference in cost between the brand name drug and its generic equivalent. If your prescribing provider requires the use of a brand name drug, the prescription will be filled with the brand name drug and you will be responsible for the brand name drug's co-payment and/or co-insurance. The cost difference between the brand name and generic drug does not apply toward the medical plan's out-of-pocket limit. Does not apply to preventive bowel prep kit medications covered under USPSTF guidelines.

If your provider prescribes a brand name contraceptive due to medical necessity it may be subject to preauthorization for coverage at no charge.

See your member handbook for important information about your prescription drug benefit, including which drugs are covered, limitations, and more.

HSA Plan

PacificSource HEALTH PLANS
Crook County

Medical Benefit Summary
Navigator HSA 2000_20+Rx Non-embedded S3

Provider Network: **Navigator**

Deductible Per Calendar Year	In-network	Out-of-network
Individual/Family	$2,000/$4,000	$7,500/$15,000
Out-of-Pocket Limit Per Calendar Year	**In-network**	**Out-of-network**
Individual/Family	$4,000/$8,000	$15,000/$30,000

Note: In-network deductible and out-of-pocket limit accumulate separately from the out-of-network deductible and out-of-pocket limit. Even though you may have the same benefit for in-network and out-of-network, your actual costs for services provided by an out-of-network provider may exceed this plan's out-of-pocket limit for out-of-network services. In addition, out-of-network providers can bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company, and this amount is not counted toward the out-of-network out-of-pocket limit. Please see allowable fee in the Definitions section of your member handbook.

The member is responsible for any amounts shown above, in addition to the following amounts:

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Preventive Care		
Well baby/Well child care	No deductible, 0%	After deductible, 50%
Preventive physicals	No deductible, 0%	After deductible, 50%
Well woman visits	No deductible, 0%	After deductible, 50%
Preventive mammograms	No deductible, 0%	After deductible, 50%
Immunizations	No deductible, 0%	After deductible, 50%
Preventive colonoscopy	No deductible, 0%	After deductible, 50%
Prostate cancer screening	No deductible, 0%	After deductible, 50%
Professional Services		
Primary care provider (PCP) Office and home visits	After deductible, 20%	After deductible, 50%
Naturopath office visits	After deductible, 20%	After deductible, 50%
Specialist office and home visits	After deductible, 20%	After deductible, 50%
Telemedicine visits	After deductible, 20%	After deductible, 50%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Office procedures and supplies	After deductible, 20%	After deductible, 50%
Surgery	After deductible, 20%	After deductible, 50%
Outpatient rehabilitation and habilitation services	After deductible, 20%	After deductible, 50%
Chiropractic manipulations and acupuncture ($1,500 per benefit year.)	After deductible, 20%	After deductible, 50%
Hospital Services		
Inpatient room and board	After deductible, 20%	After deductible, 50%
Inpatient rehabilitation and habilitation services	After deductible, 20%	After deductible, 50%
Skilled nursing facility care	After deductible, 20%	After deductible, 50%
Outpatient Services		
Outpatient surgery/services	After deductible, 20%	After deductible, 50%
Advanced diagnostic imaging	After deductible, 20%	After deductible, 50%
Diagnostic and therapeutic radiology/lab and dialysis	After deductible, 20%	After deductible, 50%
Urgent and Emergency Services		
Urgent care center visits	After deductible, 20%	After deductible, 50%
Emergency room visits – medical emergency	After deductible, 20%	After deductible, 20%
Emergency room visits – non-emergency	After deductible, 20%	After deductible, 50%
Ambulance, ground	After deductible, 20%	After deductible, 20%
Ambulance, air	After deductible, 20%	After deductible, 20%+
Maternity Services**		
Physician/Provider services (global charge)	After deductible, 20%	After deductible, 50%
Hospital/Facility services	After deductible, 20%	After deductible, 50%
Mental Health and Substance Use Disorder Services		
Office visits	After deductible, 20%	After deductible, 50%
Inpatient care	After deductible, 20%	After deductible, 50%
Residential programs	After deductible, 20%	After deductible, 50%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Other Covered Services		
Allergy injections	After deductible, 20%	After deductible, 50%
Durable medical equipment	After deductible, 20%	After deductible, 50%
Home health services	After deductible, 20%	After deductible, 50%
Transplants	No deductible, 0%	After deductible, 50%
Temporomandibular joint	After deductible, 50%	Not covered

This is a brief summary of benefits. Refer to your member handbook for additional information or a further explanation of benefits, limitations, and exclusions.

** Medically necessary services, medication, and supplies to manage diabetes during pregnancy from conception through six weeks postpartum will not be subject to a deductible, co-payment, or co-insurance.

+ Out-of-network air ambulance coverage is covered at 200 percent of the Medicare allowance. You may be held responsible for the amount billed in excess. Please see your member handbook for additional information or contact our Customer Service team with questions.

Additional information

What is the deductible?

Your plan's deductible is the amount of money that you pay first, before your plan starts to pay. You'll see that many services, especially preventive care, are covered by the plan without you needing to meet the deductible. The individual deductible applies if you enroll without dependents. If you and one or more dependents enroll, the deductible applies until the family deductible has been met. Deductible expense is applied to the out-of-pocket limit.

Note that there is a separate category for in-network and out-of-network when it comes to meeting your deductible. Only in-network expense applies to the in-network deductible and only out-of-network expense applies to the out-of-network deductible.

What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for covered expenses during the plan year. Once the out-of-pocket limit has been met, the plan will pay 100 percent of allowed amounts for covered services for the rest of that year. The individual out-of-pocket limit applies only if you enroll without dependents. If you and one or more dependents enroll, the out-of-pocket limit applies until the family out-of-pocket limit has been met. Be sure to check your member handbook, as there are some charges, such as non-essential health benefits, penalties, and balance billed amounts that do not count toward the out-of-pocket limit.

Note that there is a separate category for in-network and out-of-network when it comes to meeting your out-of-pocket limit. Only in-network expense applies to the in-network out-of-pocket limit. Only out-of-network expense applies to the out-of-network out-of-pocket limit.

Primary care physician or primary care provider (PCP)

You are highly encouraged to select a PCP from the plan's provider directory. The PCP will coordinate healthcare resources to best meet your needs. Referrals are not required.

Payments to providers

Payment to providers is based on the prevailing or contracted PacificSource fee allowance for covered services. In-network providers accept the fee allowance as payment in full. Out-of-network providers are allowed to balance bill any remaining balance that your plan did not cover. Services of out-of-network providers could result in out-of-pocket expense in addition to the percentage indicated.

Preauthorization

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called preauthorization. Preauthorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. Preauthorization does not change your out-of-pocket expense for in-network and out-of-network providers. You'll find the most current preauthorization list on our website, PacificSource.com/member/preauthorization.aspx.

Value-added Extras **For Members**

Our extra tools, benefits, and programs are how we add value to members' health plans. These extras help our members make the most of their plan and live a healthier life.

Online Tools and Resources at PacificSource.com

InTouch for Members

Members can access their benefit information by logging on to the secure InTouch area of our website. They can view their claims, the status of preauthorizations and referrals, the accumulated expenses towards their plan's deductible, and more.

CaféWell

CaféWell is a secure online health engagement portal with personalized information and tools to help members make the most of their health.

myPacificSource Mobile App

Members can stay "InTouch" with their PacificSource coverage, no matter where they are, with our free mobile app.

The myPacificSource app is available for both iPhone® and Android™. Visit PacificSource.com/mobile.

Provider Directory

Members can find up-to-date participating provider information based on their location or the provider's name. Members can also make a personalized directory.

Wellness and Care Management Programs

24-Hour NurseLine

Our 24-Hour NurseLine is staffed around the clock, seven days a week. The member toll-free number is (855) 834-6150.

Prenatal Program

Our Prenatal Program helps expectant mothers learn more about their pregnancy and their child's development. Participants get educational materials and toll-free phone access to a nurse consultant.

Prenatal Vitamins

Women between the ages of 15 and 45 with prescription drug coverage are eligible to receive physician-prescribed prenatal vitamins at no cost when filled through an in-network pharmacy. The vitamins covered by this program include O-Cal FA, Vol-Plus, Prenatal 19, or PNV-DHA.

Tobacco Cessation

Our Quit For Life® program, brought to you by Optum and the American Cancer Society, can help tobacco users kick the habit. Members receive phone and online support, as well as a Quit Kit with nicotine replacement therapy patches or gum to help keep them on track. The member toll-free number is (866) 784-8454.

Bend
Direct: (541) 330-8896
Toll-free: (888) 877-7996

Portland
Direct: (503) 699-6561
Toll-free: (866) 540-1191

Medford
Direct: (541) 858-0381
Toll-free: (800) 899-5866

Springfield
Direct: (541) 686-1242
Toll-free: (800) 624-6052

Boise
Direct: (208) 342-3709
Toll-free: (888) 492-2875

Coeur d'Alene
Direct: (208) 333-1557
Toll-free: (888) 492-2875

Idaho Falls
Direct: (208) 522-1360
Toll-free: (888) 492-2875

Helena
Direct: (406) 422-1008
Toll-free: (855) 422-1008

PacificSource.com

PacificSource HEALTH PLANS

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Teladoc™

We've partnered with Teladoc™ as of January 1, 2018 to offer members virtual healthcare visits. Teladoc™ is a national network of U.S.board-certified physicians and pediatricians that members can see on-demand 24/7, via phone or online video consultations. For a virtual visit with Teladoc™, members pay the same as they would a regular office visit.

Hospital-based Education Classes

Members can be reimbursed for up to $150 per member per plan year for hospital-based health and wellness education classes in your area.

Weight Management Programs

Members with medical coverage can:

- Participate in a **Weight Watchers®** program and receive an annual reimbursement of $100 ($40 if an online Weight Watchers participant) for their Weight Watchers membership.
- Receive a **Jenny Craig®** program discount: 50 percent off the enrollment fee (normally $99), plus five percent off all Jenny Craig food.

For full details and eligibility requirements, visit PacificSource.com/weightmanagement.

Discounted Gym Membership

PacificSource members have access to discounted gym memberships with a wide network of gyms through Active&Fit.

Wellness for Kids

Nine- and six-year-olds currently covered by a PacificSource medical plan may be invited by mail to join HealthKicks!, a children's program that promotes healthy behaviors. Contact us for more information.

Condition Support Program

Our Condition Support Program offers support and information to members with asthma and diabetes (including members age 18 and younger), heart failure (HF), chronic obstructive pulmonary disease (COPD), and coronary artery disease (CAD). The program includes personal support to help participants reach their health and wellness goals. Participants may also contact our nurses and registered dietitian.

AccordantCare® Rare Disease Management Program

Our members with certain chronic, rare conditions receive ongoing one-on-one support and care coordination to ensure optimal care, decrease complications, and improve health outcomes.

Chronic Disease Self-Management Program

The Chronic Disease Self-Management Program provides six weekly sessions to help participants establish immediate goals. Members will learn to manage their symptoms and take control of their health.

Caremark® Specialty Pharmacy

Caremark® Specialty Pharmacy Services is our provider for injectable medications and biotech drugs. A pharmacist-led CareTeam provides individual follow-up care and support to our members with certain conditions.

Nurse Case Management

Our Health Services Department provides individual case management for members who require specific help in managing their healthcare needs. Nurse Case Managers work collaboratively with providers and members to improve members' health, financial outcomes, and quality of life.

LifeTrac℠ Transplant Network

We partner with LifeTrac Transplant Network to ensure that our members requiring transplant services have access to nationally recognized centers of excellence. Our Case Managers assist members by coordinating all phases of transplant services.

Travel Program

Assist America® Global Emergency Services

Members with medical coverage who experience a medical emergency when traveling 100 or more miles from home or abroad can call Assist America for help. Services include medical consultation and evaluation, medical referrals, foreign hospital admission guarantee, critical care monitoring, and when medically necessary, evacuation to a facility that can provide treatment. These services are provided at no cost to members when arranged and provided by Assist America.

PacificSource HEALTH PLANS

Mail Order **Pharmacy**

If your PacificSource health plan includes prescription drug coverage, you can use our convenient mail order service for your daily or long-term medications.

Why Use Mail Order for Your Prescriptions?

- Convenience. Ordering is easy, and your medication is delivered right to your mailbox.
- Cost savings. There's never a shipping or handling charge for standard delivery.
- Refills are easy. You can order refills by phone or mail, or order online 24 hours a day!

Order up to a 90-day supply of covered medications, with no standard shipping charge.

Our mail order service partner is CVS Caremark Mail Service Pharmacy. You'll find more information and mail order forms at **PacificSource.com/member/mail-order-rx.** Alternatively, you can use the contact information provided on this flier.

If you have questions, please contact our Customer Service Department toll-free at (888) 977-9299 or email at cs@pacificsource.com.

Mail Order Pharmacy Contact Information

CVS Caremark

Online:
Caremark.com

Phone:
(866) 329-3051, TTY/TDD 711

Mail:
CVS Caremark
PO Box 659541
San Antonio, TX 78265-9541

Idaho
Direct: (208) 333-1596
Toll-free: (800) 688-5008

Montana
Direct: (406) 442-6589
Toll-free: (877) 590-1596

Oregon
Direct: (541) 684-5582
Toll-free: (888) 977-9299

TTY
Toll-free: (800) 735-2900

En Español
Direct: (541) 684-5456
Toll-free: (800) 624-6052 ext. 1009

Email
cs@pacificsource.com

PacificSource.com

PacificSource HEALTH PLANS

CLB286_1018

On-demand access to doctors via phone, video, or mobile app

As a PacificSource member,* you have access to board-certified doctors 24 hours a day, 7 days a week.

Here's how to get started and what you need to know.

1. Set up your Teladoc® account

There are three convenient ways to get started. When asked to enter the name of your employer or insurance carrier, please enter PacificSource.

Online: Log in or register with InTouch for Members through PacificSource.com. You'll find the Teladoc Remote link under Tools. This will provide a direct link for you to set up your Teladoc account.

Mobile app: Visit Teladoc.com/mobile to download the app, then click "Activate account."

By phone: Teladoc can help you register your account over the phone. Call toll-free (855) 201-7488.

2. Provide medical history

Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis.

3. Request a consult

Once your account is set up, request a consult anytime you need care. And talk to a doctor by phone, web, or mobile app.

Talk to a doctor anytime!

Web
Teladoc.com

Phone
(855) 201-7488

Mobile App
Teladoc.com/mobile

See reverse for FAQ >

PacificSource HEALTH PLANS

* Employer group members: check with your employer to see if available on your plan.

CLB604_1218

Frequently Asked Questions

What is Teladoc?

Teladoc is the first and largest provider of telehealth medical consults in the United States, giving you 24/7/365 access to quality medical care through phone and video consults.

Who are the Teladoc doctors?

Teladoc doctors are U.S. board certified in internal medicine, family practice, or pediatrics. They average 20 years practice experience, are licensed in your state, and incorporate Teladoc into their day-to-day practice as a way to provide people with convenient access to quality medical care.

Does Teladoc replace my doctor?

No. Teladoc does not replace your primary care physician. Teladoc should be used when you need immediate care for nonemergent medical issues. It is an affordable, convenient alternative to urgent care and ER visits.

What kind of medical care does Teladoc provide?

Teladoc provides general medical care for adults and children, and behavioral healthcare for adults. Examples of common medical conditions Teladoc can address include: sinus problems, pink eye, bronchitis, allergies, flu, ear infections, urinary tract infections, and upper respiratory infections.

What consult methods are available?

You can talk with a general medical Teladoc doctor via a phone consult, video consult within the secure member portal, or video consult within the Teladoc mobile app. Behavioral health visits are available via video only.

How do I set up my Teladoc account?

You can set up your account through InTouch at PacificSource.com, or through the Teladoc website or mobile app. You can also call Teladoc to get started. If setting up your account online, when asked to enter the name of your employer or insurance carrier, please make sure to enter PacificSource.

How do I request a consult to talk to a doctor?

Visit the Teladoc website, log into your account, and click "Request a Consult." You can also call Teladoc to request a general medical consult by phone. Behavioral health appointments can be scheduled online or through our mobile app.

How do I request a behavioral health visit?

Behavioral health visits are scheduled and occur via the Teladoc website or mobile app. Log into your account, complete a quick assessment, and choose your therapist. Provide three options of times you are available for an appointment. The therapist will reach out to you to schedule the appointment.

How quickly can I talk to the doctor?

The median call back time for a general medical request is just 10 minutes. If you miss the doctor's call, whether you are away from the phone or you have anonymous call blocker on, you will be returned to the bottom of the waiting list. The consult request is cancelled if you miss three calls.

Is there a time limit when talking with a doctor?

There is no time limit for consults.

Can Teladoc doctors write a prescription?

Yes. Teladoc doctors can prescribe short-term medication for a wide range of conditions when medically appropriate. Teladoc doctors do not prescribe substances controlled by the DEA, nontherapeutic, and/or certain other drugs, which may be harmful because of their potential abuse.

How do I pay for a prescription called in by Teladoc?

When you go to your pharmacy of choice to pick up the prescription, you may use your health/prescription insurance card to help pay for the medication. The exact amount you will pay is based on the type of medication and your plan benefits.

Is the consult fee the same price, regardless of the time?

The exact amount you will pay is based on your plan design. This dollar amount is shown on your summary of benefits.

How do I pay for the consult?

You can pay with your HSA (health savings account) card, credit card, prepaid debit card, or by PayPal. Your account will be charged at the time of the visit.

If the Teladoc doctor recommends that I see my primary care physician or a specialist, do I still have to pay the Teladoc consult fee?

Yes. Just like any doctor appointment, you must pay for the consulting doctor's time.

Can I provide consult information to my doctor?

Yes. You have access to your electronic medical record at anytime. Download a copy online from your account or call Teladoc and ask to have your medical record mailed or faxed to you.

PacificSource HEALTH PLANS

Help When You Need It **24-Hour NurseLine**

Most medical situations don't happen during business hours. So what do you do in medical situations where you know it's not life-threatening, but you're not sure whether you should go to urgent care or an emergency room? Call a nurse!

Talk to a Nurse—Anytime

Our 24-Hour NurseLine is staffed around the clock, seven days a week, so you'll never be without a registered nurse to talk to when you have health-related questions.

To talk to a registered nurse, call our 24-Hour NurseLine toll-free at (855) 834-6150.

Need more than the 24-Hour NurseLine?

Not sure where to go for help? Here are some tips that may help you decide when to call our 24-Hour NurseLine, when to seek urgent care, and when to go to the emergency room.

24-Hour NurseLine

- It's after regular business hours, and you have a health-related question.
- You want to speak to a medical professional to figure out if you need to be seen by a doctor.
- You have a question, but you don't think you need to see your doctor.

Urgent Care

- You need care, but it isn't life-threatening.
- You have an illness like a cold, flu, bronchitis, sinus infections, strep throat, ear infections, vomiting, and diarrhea.
- You have an injury such as bumps, bruises, nose bleeds, sports injuries, minor burns, simple fractures, cuts, and dislocations.

You can look up urgent care doctors and locations using our online directory at PacificSource.com/find-a-provider. You may also check with your primary care doctor about after-hours appointment availability.

Emergency Room

- It's life-threatening and nurse lines or urgent care just aren't enough.
- You're experiencing things like trouble breathing, chest pain, choking, severe head injury, seizure, severe burns, ingested poisonous substance, heavy bleeding, and other life-threatening ailments.

If it's a true medical emergency, call 911, or go to the nearest emergency room or appropriate treatment facility.

Idaho
Direct: (208) 333-1596
Toll-free: (800) 688-5008

Montana
Direct: (406) 442-6589
Toll-free: (877) 590-1596

Oregon
Direct: (541) 684-5582
Toll-free: (888) 977-9299

TTY
Toll-free: (800) 735-2900

En Español
Direct: (541) 684-5456
Toll-free: (800) 624-6052 ext. 1009

Email
cs@pacificsource.com

PacificSource.com

PacificSource HEALTH PLANS

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Health Education **Classes**

Health classes can help you optimize your health. As part of your PacificSource medical coverage, you may be able to participate in health education classes and receive reimbursement.

How does this work?

The program will reimburse eligible PacificSource medical members up to a maximum of $150 per member per plan year for health and wellness classes. Covered dependents are also eligible for this program.

Check with your local hospital or organization to see what health and wellness classes they offer.

Our Customer Service Representatives are happy to help you determine if the class you'd like to attend is eligible for reimbursement.

How do I get reimbursed?

After you've taken a class, just complete and mail in our reimbursement request form (on the back of this flier). The reimbursement will be paid directly to you.

Are there any limitations?

You must be an eligible and enrolled PacificSource member at the time of class registration and when the class begins to qualify for class reimbursement.

Reimbursement may include:

- Health education and wellness classes taught by a licensed or certified instructor
- Classes that promote and maintain health and well-being, enhance quality of life, and recognize individual desires to remain active, productive, and independent. These types of classes may include:
  - First aid/CPR
  - Nutrition
  - Prenatal classes
  - Any class that is offered at a hospital
  - Cardiology services education (includes CPR and first aid)
  - Childbirth and parenting education, including baby sitter first aid/ CPR (member only), sibling class, "Caring for your new brother or sister" class
  - Condition management (diabetes, cancer, arthritis, asthma, and more)
  - General health and wellness
  - Weight, health, or nutrition classes
  - Stress management (includes yoga, tai chi, pilates)
  - Health education, wellness, activity classes that do not require a membership to attend

Continued on reverse >

Idaho
Direct: (208) 333-1596
Toll-free: (800) 688-5008

Montana
Direct: (406) 442-6589
Toll-free: (877) 590-1596

Oregon
Direct: (541) 684-5582
Toll-free: (888) 977-9299

TTY
Toll-free: (800) 735-2900

En Español
Direct: (541) 684-5456
Toll-free: (800) 624-6052
ext. 1009

Email
cs@pacificsource.com

PacificSource.com

PacificSource HEALTH PLANS

CLB285_0419

Reimbursement excludes:

- Punch card for drop-in gym time
- Classes that require a gym, health club facility, or parks and recreation membership
- Gym membership fees or health-center membership fees (for example, YMCA, recreation center membership, Curves, Golds Gym, 24 Hour Fitness)
- Advance payment for a class (Reimbursement for classes purchased in advance will not be paid until the month the class is offered.)
- Sports league fees, sports fees
- Employer-required training courses
- Employer reimbursement

Questions?

Contact Customer Service at (888) 977-9299, or email cs@pacificsource.com.

Find information online at PacificSource.com/health-education.

Reimbursement Request Form

Please attach a copy of your class payment receipt. Mail your receipt and this completed form to:

PacificSource
Attn: Claims Department
PO Box 7068
Springfield, OR 97475

Or fax it to:

(541) 225-3632
Attn: Claims Department

Member Information

Member name:	PacificSource ID #:
Date of birth:	Group #:
Home phone #:	Email address:
Mailing address:	

Class Information

Organization name:	
Organization address:	
Class name:	
Class cost:	Class start date:

PacificSource HEALTH PLANS

The Active&Fit Direct™ **Fitness Center Program**

The Active&Fit Direct program provides you with access to a broad network of participating fitness centers and participating YMCAs.

Freedom and flexibility

Active&Fit Direct program gives you access to 9,000+ fitness centers nationwide. You can switch fitness centers to ensure you find the right fit. The program also includes access to the Active&Fit Direct website, which features a fitness center locator and online fitness tracking.

Get started

Visit PacificSource.com/ActiveAndFit for more information. A $25 enrollment fee, $25 for the current month (regardless of the enrollment date within that month), and $25 plus applicable taxes for the next month are due when you enroll ($75 plus applicable taxes). Each month's fee is $25 (plus applicable taxes). After a 3-month commitment, participation is month-to-month. Once enrolled, you may view or print your fitness card and take it to any fitness center/YMCA in the Active&Fit Direct network. Once the fitness center verifies your enrollment in the Active&Fit Direct program, you will sign a standard membership agreement and receive a card or key tag from the fitness center to check in for future visits.

Try out a fitness center

Many fitness centers/YMCAs offer guest passes so you can try out their location. You may request a guest-pass letter through the Active&Fit Direct website to take to the fitness center, where available. Note: You will need to register and sign in to request the guest-pass letter.

The Active&Fit Direct program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Active&Fit Direct is a trademark of ASH and used with permission here.

Idaho
Direct: (208) 333-1596
Toll-free: (800) 688-5008

Montana
Direct: (406) 442-6589
Toll-free: (877) 590-1596

Oregon
Direct: (541) 684-5582
Toll-free: (888) 977-9299

TTY
Toll-free: (800) 735-2900

En Español
Direct: (541) 684-5456
Toll-free: (800) 624-6052
ext. 1009

Email
cs@pacificsource.com

PacificSource.com

PacificSource HEALTH PLANS

CLB419_0118

Getting Started with **CaféWell**

CaféWell is a secure, online health engagement portal that helps you make the most of your health.

Step One: Log Into InTouch

1. Go to PacificSource.com.
2. Under Access Your Benefit Information, click InTouch for Members.
3. Enter your username and password to log in.

New InTouch Users: If you have never used InTouch, follow steps one and two, above. Then, follow the on-screen instructions to sign up. You'll need your member ID to register.

Step Two: Go to CaféWell

From your InTouch home page:

- Select the Benefits menu.
- Click Wellness – CaféWell.
- Follow the on-screen instructions to complete the registration process.

You'll create a new username and password specifically for CaféWell. This will allow you to log in directly from CafeWell.com on your next visit or through the mobile app.

Step Three: Explore these Great Features

Begin using all the great features CaféWell has to offer!

Talk to a Health Coach

Get your health questions answered with one-to-one messages and video coaching.

Join a Community

Connect with family, friends, and others who are focused on similar health goals.

Explore Expert Content

Access helpful tips and articles on health and wellness.

Complete the Health Assessment

Identify your potential health risks and create or revamp a plan to achieve your health goals.

Continued on next page >

Idaho
Direct: (208) 333-1596
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Montana
Direct: (406) 442-6589
Toll-free: (877) 590-1596

Oregon
Direct: (541) 684-5582
Toll-free: (888) 977-9299

TTY
Toll-free: (800) 735-2900

En Español
Direct: (541) 684-5456
Toll-free: (800) 624-6052 ext. 1009

Email
cs@pacificsource.com

PacificSource.com

PacificSource HEALTH PLANS

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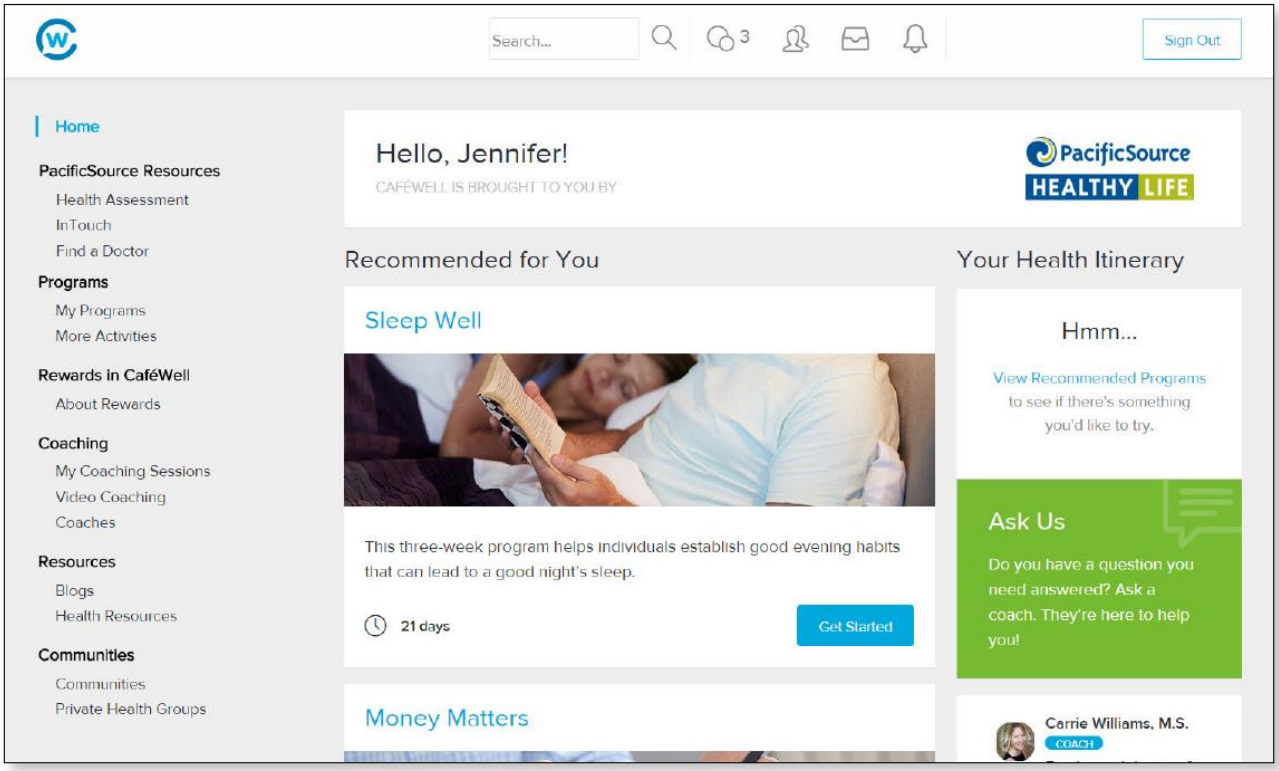
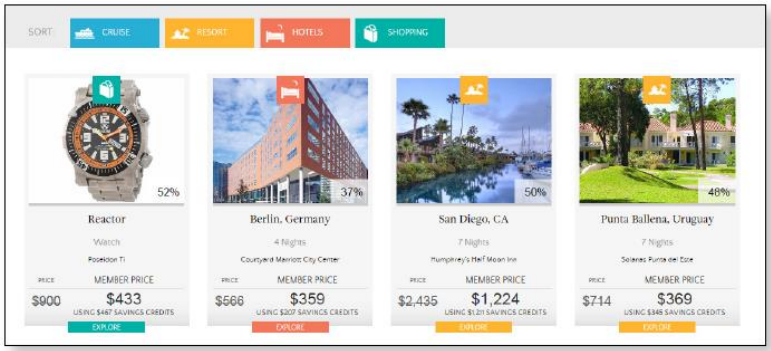


Reward Yourself

With My Choice Rewards, you'll earn points for completing various activities within CaféWell. Redeem these points for discounts on retail goods and travel through the CaféWell rewards store.



PacificSource HEALTH PLANS

Dental Insurance
Moda

2021 Delta Dental PPO Plan Benefit Summary

DELTA DENTAL
Delta Dental of Oregon & Alaska

Crook County | Custom Passive PPO | 100/100/50/1500_PF	PPO provider	Premier provider	Out-of-network non-participating provider
Calendar year costs			
Calendar year maximum, per member		$1,500	
Calendar year deductible, per member		$0	
Calendar year maximum deductible, per family		$0	
Class 1* *(Services do not apply to the calendar year max)*			
Periodic examinations / x-rays	100%	100%	100%
Prophylaxis (cleanings) / periodontal maintenance	100%	100%	100%
Sealants	100%	100%	100%
Space maintainers	100%	100%	100%
Topical application of fluoride	100%	100%	100%
Class 2			
Restorative fillings	100%	100%	100%
Oral surgery (extractions & certain minor surgical procedures)	100%	100%	100%
Endodontics (treatment of teeth with diseased or damaged nerves)	100%	100%	100%
Periodontics (treatment of diseases of the gums and supporting structures of the teeth)	100%	100%	100%
Class 3			
Implants	50%	50%	50%
Crowns and other cast restorations	50%	50%	50%
Dentures and bridges (construction or repair of fixed bridges, partial, and complete dentures)	50%	50%	50%

* Deductible waived for preventive.

This is a benefit summary only. For a more detailed description of benefits, refer to your member handbook.

How to use this dental plan

For In-Network benefits, members select a Delta Dental PPO dentist from our directory which is on our website at www.modahealth.com. Each family member may choose a different dentist. If you receive care from a dental provider not in the Delta Dental PPO Network, Out-of-Network coverage levels apply.

When the member visits:

Delta Dental PPO Dentists:
Benefits are paid at the PPO benefit level. Members are held harmless from balance billing (will not be billed for the difference between the dentist's billed charge and the Delta Dental PPO fee).

Delta Dental Premier Dentist, Non PPO:
Benefits are paid at the Premier benefit level. Members are held harmless from balance billing (will not be billed for the difference between the dentist's billed charge and the Delta Dental negotiated fee).

Non Participating Dentists:
Benefits are paid at the Out of Network benefit level. Members may be held liable for the difference between the dentist's billed charge and the non-participating allowable.

Limitations

If a more expensive treatment than is functionally adequate is performed, Delta Dental Plan of Oregon will pay the applicable percentage of the maximum plan allowance for the least costly treatment.

Preventive (Class 1 Services)

- **Diagnostic** Routine examinations or consultations covered twice in a calendar year. Problem focused exams covered twice in a calendar year. Supplementary bitewing x-rays are covered once in a calendar year. Complete series x-rays or a panoramic film are covered once in any 5-year period.
- **Preventive** Prophylaxis (cleaning) or periodontal maintenance is covered twice in a calendar year. Additional periodontal maintenance is covered for members with periodontal disease, up to a total of 2 additional periodontal maintenances per year. Topical application of fluoride is covered 4 times in a calendar year. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant, per tooth, during any 5-year period.

Basic (Class 2 Services)

- **Oral Surgery** Limited to extractions and other minor surgical procedures.
- **Restorative** Amalgam and composite fillings are covered for all teeth. A separate charge for general anesthesia and/or IV sedation is not covered when used for non-surgical procedures.
- **Periodontic** Scaling and root planing is limited to once per quadrant in any 2-year period.

Major (Class 3 Services)

- **Implants** and implant removal are limited to once per lifetime per tooth space. A crown over an implant is covered once per lifetime of the implant.
- **Restorative** Cast restorations (including pontics) are covered once in 60 months on any tooth.
- **Prosthodontic** A bridge or denture (full or partial, including alternate benefits) will be covered once in 60 months. only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the past 60 months. Specialized or personalized prosthetics are limited to the cost of standard devices.
- **Occlusal Guard** (night guard) covered at 100% once in a five year period, up to $150 maximum. Over-the-counter night guards are excluded.
- **Athletic mouth guard** covered at 50%, once in any 12-month period for members age 15 and under and once in any 24-month period age 16 and over. Over-the-counter athletic mouth guards are excluded.
- **Nitrous oxide** Members under age 19

Exclusions

- Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
- Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis and disturbance of the temporomandibular joint.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth except for occlusal guards.
- Services started prior to the date the individual became eligible for services under the program.
- Hypnosis, prescribed drugs, premedications or analgesia or any other euphoric drugs.
- Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
- General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office.
- Plaque control and oral hygiene or dietary instructions.
- Experimental procedures.
- Missed or broken appointments.
- Precision attachments.
- Orthodontic services (except when an orthodontia rider is included).
- Services for cosmetic reasons.
- Claims submitted more than 12 months after the date of service are not covered.
- All other services or supplies, not specifically covered.

DELTA DENTAL®

MEMBER DASHBOARD

Be in charge of your healthy smile

Get to know your benefits! Your personalized member website, helps you manage your dental plan and find ways to improve and maintain your oral health.

Discover more ways to better oral health

- Click on Find Care to find a dentist near you
- Get in touch with a dental health coach and find answers to your oral health questions
- Use the Dental Optimizer for a cavity risk assessment, treatment cost estimates and dental health tips
- Find dental care while travelling outside the U.S.

Easily see and manage your benefits

- View your benefit eligibility and history
- Receive and view electronic explanations of benefits (EOBs)
- View account information, such as your contact information and dependents
- Download your digital ID card or order a new one
- Check the status of pending claims, view your personal claims history and access claim forms

OVER→

Delta Dental of Oregon & Alaska

DeltaDentalAK.com | DeltaDentalOR.com

DELTA DENTAL®

Log in to your Member Dashboard 24/7

To sign in to your Member Dashboard, visit our website. On the top right side of the home page click the "sign in" button to get started.

If you don't have an account, creating one is easy. You'll love everything you can do on your Member Dashboard, like check your benefits, use interactive health tools, see your Member Handbook and more.

Questions?

We're here to help.
Call us toll-free at
877-277-7280.
TTY users, please call 711.

60146865 (6/20)

DELTA DENTAL®

Health through Oral Wellness®

When it comes to oral health, we know some people need more care than others. Delta Dental of Oregon's Health through Oral Wellness® program offers extra benefits to members who have a greater risk for oral diseases.

The program uses an oral health assessment to find out your risk of tooth decay, gum disease and oral cancer. Based on your risk score, you may qualify for additional cleanings, fluoride treatments, sealants and periodontal maintenance.*

With extra benefits and related care, you can:

- Take charge of your oral health
- Prevent oral health issues before they happen
- Access resources to manage your oral health
- Learn how to achieve and maintain better oral wellness

Ready to get started?

Follow these simple steps to see if you qualify:

1. Visit deltadentalor.com/oralwellness/members to learn more about the program and take a free oral health risk self-assessment. You can choose to share your results with your dentist to start the conversation.
2. Talk to your dentist about the program. If they're not registered, ask them to call our toll-free Health through Oral Wellness provider line at 844-663-4433. Once registered, they can perform an oral health risk exam and can let you know if you qualify.
3. To look for providers registered with the program, go to modahealth.com and choose Find Care. Dental providers registered with Health through Oral Wellness will have a badge icon next to their name.

Registered provider badge icon

Still have questions?

We're here to help. Contact our customer service team toll-free at 888-217-2365. TTY users, please call 711. Or visit deltadentalor.com to learn more.

** All enhanced dental benefits are subject to your plan's annual maximum and other limitations.*

Delta Dental of Oregon and Alaska

moda

Delta Dental is part of the Moda, Inc. family of companies.

Our mission is the same as it was more than 60 years ago — to find a better way to health, every day, for the people and communities we serve.

As a founding member of the Delta Dental Plans Association, we offer affordable, quality dental coverage to people in the Pacific Northwest and beyond.

deltadentalor.com

DENTAL TOOLS

Take your dental game to the next level

Does whitening toothpaste really work? How much will you pay if your kid needs braces? Dental Tools can answer these questions and much more. It's free for Delta Dental members.

Get dental answers and tips

Did you know that you can fight cavities... with lollipops? Have you ever wondered which works better — a manual or electric toothbrush? Dental Tools have lots of surprising tips to keep your teeth and mouth healthy. You can also post any dental-related question, and a dental professional will answer.

Find a great dentist

Search for a top-rated professional near you using the Best Dentist Finder tool. It lets you pick the location, language, evening and weekend hours, and other helpful items.

Check treatment costs

If you think you might need a dental procedure, Dental Tools can help you plan. You can easily check the cost of common procedures and see if there are ways to save money. No more surprises at your dentist's office!

OVER→

Delta Dental of Oregon and Alaska

DeltaDentalOR.com | DeltaDentalAK.com

DELTA DENTAL®

Find dental deals

Want to save money while keeping your mouth healthy? Find savings on dental products in the Dental Store, or check out Dental Deals for special offers in your neighborhood. If you don't have dental coverage, these deals can offer an affordable way to make sure you're taking care of yourself and your family.

Visit now

To get to Dental Tools, log in to your Member Dashboard at DeltaDental.com.

If you don't have an account, it's easy to create one. Just click "Create an account" in the login box and have your member ID card ready.

60146869 (9/19)

DELTA DENTAL NETWORKS

Save money on dental visits

Your dental plan lets you see any licensed dentist you want. But when you see a provider in our Delta Dental networks, you'll save money; and visiting a Delta Dental PPO dentist will give you an even better deal.

Choose Delta Dental providers to keep costs low

Your dental plan gives you access to Delta Dental, the largest network of dentists in the nation. You'll find Delta Dental providers close to home and across the country.

Through Delta Dental PPO and Premier networks, we set limits on what dentists can charge for certain services. It's our way of connecting you with great care at even better rates.

You'll save the most when you visit Delta Dental PPO providers. They agree to accept our lowest contracted rates as full payment.

Both Delta Dental networks protect you from 'balance billing' — the practice of billing you for the difference between your dentist's fees and the rates your dental plan will pay.

OVER→

Delta Dental of Oregon & Alaska

DeltaDentalOR.com | DeltaDentalAK.com

What you pay by network

Here's how your network choice can affect your bill:

Delta Dental PPO dentists

- Lowest costs and the most savings
- No balance billing

Delta Dental Premier dentists

- Slightly higher costs with some savings
- No balance billing

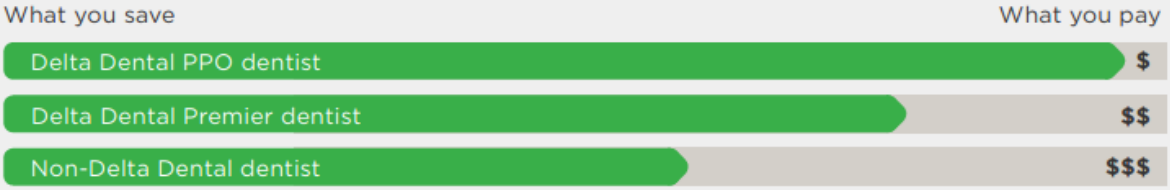
Non-Delta Dental dentists

- Higher costs, since dentists don't set fee agreements
- Balance billing

Find an in-network dentist

To locate a provider near you, log in to your my Member Dashboard and select "Find Care."

Your dentist's network determines your cost



The share of costs shown in this graphic are samples only. Actual dentist fees and other charges will vary.

Questions?

We're here to help. Call us toll-free at 877-277-7280. TTY users, please call 711.

59589853 (9/19) HCS-152

DELTA DENTAL®

DENTAL TOOLS

Manage your dental health easily, in one location

As a Delta Dental member, you have access to dental tools — an online dashboard to help you manage your dental health.

Make the most of your benefits

Use your Benefits Dashboard to get an up-to-date look at your annual maximum balance, savings, deductible and more.

Check treatment costs

If you think you might need a dental procedure, dental tools can help you plan. You can use the Cost Calculator to easily check the cost of common procedures, and see if there are ways to save money. No more surprises at your dentist's office!

See your risks

Activate the Risk Assessments tool to discover your personal risk for tooth decay, cavities and gum disease.

Schedule dental appointments

Schedule, and even cancel dental appointments, without making phone calls. This feature works if your dentist uses online scheduling.

Visit now

Log in to your myModa account at **modahealth.com**. From there, click on the "Dental Tools" tab at the top of the page.

If you do not have a myModa account, you can create one quickly. Just click "Create an account" in the login box and have your member ID card ready.

Delta Dental of Oregon and Alaska

deltadentalOR.com

DELTA DENTAL®

PASSPORT DENTAL℠

Take your smile on the road

No matter where in the world you roam, Passport Dental℠ gives you access to great care through your dental plan.

In the states

Wherever you go, your dental plan benefits go with you. Our network, Delta Dental, lets you access more than 230,000 office locations and three quarters of all dentists across the country. You can choose any licensed dentist, but if you work with a dentist in the network, you'll get great care and better plan benefits.

To find a dentist in the U.S., visit modahealth.com and click Find Care. Then, search for dentists in all other states. Or, you can call AXA Assistance toll-free at 888-558-2705, 24 hours a day, seven days a week. Just say you're a Delta Dental plan member. An operator will connect you with a dentist in a flash.

Beyond borders

Whether you're traveling to Australia or Zimbabwe, AXA Assistance is there to help you find quality care. Call them collect at 312-356-5971 any time and tell them you're a Delta Dental plan member.

Please keep in mind that dentists outside of the U.S. are not considered participating dentists. Nonparticipating coverage limits will apply.

OVER→

Delta Dental of Oregon and Alaska

DeltaDentalOR.com | DeltaDentalAK.com

DELTA DENTAL®

Find a dentist

Inside the U.S.:
Call toll-free at 888-558-2705

Outside the U.S.:
Call collect at 312-356-5971 and tell the operator your are a Delta Dental member.

How do I submit a claim?

When traveling outside the U.S., pay for your treatment and request an itemized receipt. Submit your receipt to us for reimbursement after you get home. For faster payment, make sure you include:

- The dentist's name and address, including country
- Member's name and date of birth
- A description of services performed
- Tooth number(s) and tooth surface(s) treated
- Individual charge for each service, and whether those charges were billed in U.S. dollars or another currency

You'll be paid back according to your plan benefits. Please check your Member Handbook at myModa for benefit details.

Questions?

We're here to help.
Call us toll-free at 877-277-7280. TTY users, please call 711.

60146867 (9/19)

PacificSource HEALTH PLANS

Vision Benefit Summary
Vision 10-300

The following shows the vision benefits available under this plan for enrolled members for all covered vision exams, lenses, and frames when performed or prescribed by a licensed ophthalmologist or licensed optometrist. Coverage for pediatric services will end on the last day of the month in which the enrolled member turns 19. Co-payment and/or co-insurance for covered charges apply to the medical plan's out-of-pocket limit.

If charges for a service or supply are less than the amount allowed, the benefit will be equal to the actual charge. If charges for a service or supply are greater than the amount allowed, the expense above the allowed amount is the member's responsibility and will not apply toward the member's medical plan deductible or out-of-pocket limit.

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Enrolled Members Age 18 and Younger		
Eye exam	No deductible, $10	No deductible up to $40 then 100%
Vision hardware	No deductible, 0% for one pair per year for frames and/or lenses	No deductible, 0% for one pair per year up to $75 then 100% for frames and/or lenses
Enrolled Members Age 19 and Older		
Eye exam	No deductible, $10	No deductible up to $40 then 100%
Vision hardware	No deductible, 0% up to $300	

Benefit Limitations: enrolled members age 18 and younger

One vision exam every calendar year.

Vision hardware includes glasses (lenses and frames) and/or contacts (lenses and fitting) once per calendar year.

Benefit Limitations: enrolled members age 19 and older

One vision exam every calendar year.

Vision hardware includes glasses (lenses and frames) and/or contacts (lenses and fitting). Benefit maximum is per calendar year.

Anti-reflective coatings and scratch resistant coatings are covered.

Exclusions

Charges for services or supplies covered in whole or in part under any medical or vision benefits provided by an employer.

Expenses covered under any workers' compensation law.

Eye exams required as a condition of employment, required by a labor agreement or government body.

Medical or surgical treatment of the eye.

Nonprescription lenses.

Plano contact lenses.

Services or supplies not listed as covered expenses.

Services or supplies received before this plan's coverage begins or after it ends.

Special procedures, such as orthoptics or vision training.

Visual analysis that does not include refraction.

Important information about your vision benefits

Your PacificSource health plan includes coverage for vision services. To make the most of those benefits, it's important to keep in mind the following:

In-network Providers: PacificSource is able to add value to your vision benefits by contracting with a network of vision providers. Those providers offer vision services at discounted rates, which are passed on to you in your benefits.

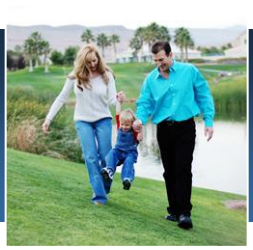
Paying for Services: Our provider contracts require in-network providers to bill us directly whenever you receive covered services and supplies. Providers will verify your vision benefits.

In-network providers should not ask you to pay the full cost in advance. They may only collect your share of the expense up front, such as co-payments and amounts over your plan's maximum benefit. If you are asked to pay the entire amount in advance, tell the provider you understand they have a contract with PacificSource and they should bill PacificSource directly.

Sales and Special Promotions (sales and promotions are not considered insurance): Vision retailers often use coupons and promotions to bring in new business, such as free eye exams, two-for-one glasses, or free lenses with purchase of frames. Because in-network providers already discount their services through their contract with PacificSource, your plan's in-network benefits cannot be combined with any other discounts or coupons. You can use your plan's in-network benefits, or you can use your plan's out-of-network benefits to take advantage of a sale or coupon offer.

If you do take advantage of a special offer, the in-network provider may treat you as an uninsured customer and require full payment in advance. You can then send the claim to PacificSource yourself, and we will reimburse you according to your plan's out-of-network benefits.

HRA VEBA
BPAS



For those enrolled on the $3000 Navigate Network plan only. Please see page 6 for monthly contributions

The HRA VEBA plan is a tax-free health reimbursement arrangement (HRA.) HRAs are account-based health plans. You can use your HRA funds to cover qualified healthcare expenses and premiums for you and your family. Employer contributions, earnings, and withdrawals (claims) are exempt from taxes. In other words, the money goes in tax-free, is invested tax-free, and comes out tax-free.

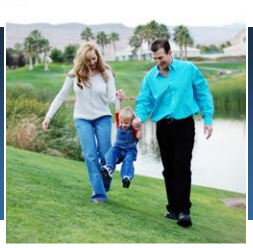
Qualified Healthcare Expenses:

Common qualified out-of-pocket expenses include:

- Deductibles
- Copays
- Coinsurance
- Prescription drugs

For a more complete list of qualified expenses and premiums eligible for reimbursement from your HRA Veba account, please visit www.BPAS.com

Health Saving Account (HSA)
BPAS



For those enrolled on the HSA $2000 Navigate Network plan only. Please see page 6 for monthly contributions

The Health Saving Account (HSA) plan is a tax-free health savings account. You can use your HSA funds to cover qualified healthcare expenses. Contribution made by your and your employer, earnings, and withdrawals (claims) are exempt from taxes. In other words, the money goes in tax-free, is invested tax-free, and comes out tax-free.

In addition to the contributions made by Crook County, you may also make contributions on a pre-tax basis up to the limits listed below.

2021 HSA Contribution limit *(employer and employee)*	Self Only: $3550 Family: $7100
HSA Catch-Up Contribution *(Age 55 or older)*	$1000

Qualified Healthcare Expenses:

Common qualified out-of-pocket expenses include:

- Deductibles
- Copays
- Coinsurance
- Prescription drugs

For a more complete list of qualified expenses and premiums eligible for reimbursement from your HRA Veba account, please visit www.BPAS.com

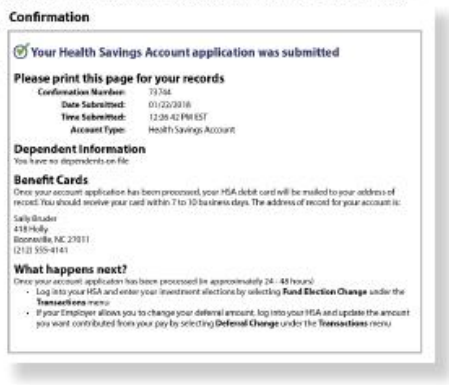
Activate Your BPAS Roadways HSA

To start enjoying the many benefits of your HSA, you must first accept ownership by electronically signing the HSA Agreements regarding the account operation. You may accept ownership and activate your account online in the initial account set-up. Here's how:

1. Visit bpas.com and choose the **Participants** tab
2. In the **Sign into Your Account** box, choose **HSA** for your account type
3. Choose **BPAS Roadways HSA,** then click the login button

   If you have an existing BPAS account for your retirement plan:
   - Enter your User ID and Password
   - Select BPAS Roadways HSA and continue to step 5 below

   If you don't have an existing BPAS account:
   - You'll be prompted to enter a 10-character Plan Code. You'll receive this code in a letter mailed to your home address.
   - After you enter the Plan Code, you'll be prompted to create a User ID, Password, and challenge/security question
4. Select **Transactions**, then **HSA Transactions** from the top menu.
5. Confirm your mailing address. Your HSA Benefit Card will be mailed to this address. Call your employer if your mailing address is incorrect.
6. Choose **Activate HSA** to be guided through a 4-step activation wizard. You must complete all 4 steps to activate your account:
   - Confirm your eligibility for an HSA
   - Answer a series of questions to authenticate your identity
   - Add dependents (if desired)
   - Review and electronically sign your HSA Agreements
7. Click **Submit** and that's it!



Please be sure to print the Confirmation page. If you don't see a Confirmation page, you haven't completed the process! You'll receive your HSA Benefit Card 7 to 10 days after you complete your online account activation.

Frequently Asked Questions about the BPAS Roadways HSA

1. What responsibilities do I have with my Health Savings Account (HSA)?	Much like a savings or checking account, you as the participant "own" this account. Contributions, earnings, and distributions are tax free as long as the distribution is for an eligible expense. It's your responsibility to: • Use funds for qualified expenses; if not, there could be tax consequences and penalties. • Keep receipts for all expenses as the IRS may require documentation. • Notify your HR Department within 30 days if you have a qualifying event that affects your eligibility to contribute to the HSA. For example, if you get married and become a dependent on a spouse's plan, which isn't a high deductible health plan (HDHP), you need to notify your HR Department within 30 days.
2. What can I do online?	The Roadways HSA program provides for a single sign-on web experience and a menu of investment options similar to our 401(k) program. Once you log into your account at BPAS.com, you can: • Activate your account • Order Roadways HSA Benefit Cards (debit cards) • Request a distribution • Manage investment options • Change deferral amounts • Download tax forms • View quarterly statements • View balances (total available balance and debit card available balance) • Add transactions and upload receipts for a current transaction
3. How do I use my HSA funds to pay for expenses?	BPAS offers the following distribution options: • Use your HSA debit card to pay for eligible expenses. It's the fastest way to access your funds, and BPAS does not charge any fees to use your debit card. • Use the debit card at ATMs to withdraw cash for services at places that don't accept the debit card; however, ATM fees may apply. • Request an **online distribution** with direct deposit, free of charge, from your account at BPAS.com. • Complete and submit a Distribution form to BPAS for a manual distribution. To access the form, log into your account at BPAS.com. There is a $10 fee for manual distributions and account liquidations. **To minimize fees assessed to your account, use your HSA debit card or the online distribution option.**
4. How Can I View My HSA Transactions?	To access your HSA transactions or pending transactions, add dependents, or request new/replacement debit cards, simply select the **HSA Transactions** link located directly under your Debit Card Availability in the left navigational menu or in the **Transactions** tab in the top toolbar.
5. How do I designate a beneficiary for my HSA?	It's important that you designate a beneficiary when enrolling. If your spouse is your beneficiary, your HSA will be treated as his/her HSA in the event of your death. To designate your beneficiary, login to your account at BPAS.com. Under your HSA **Account Maintenance** tab, select **Designate Beneficiary**.
6. What types of fees might be charged to my HSA?	Certain fees applicable to your account may be assessed, such as fees for manual distributions, additional debit cards for dependents or spouse, and the monthly custodial fee of approximately .029%. As an example, for a balance of $2,000, the monthly fee would be 58 cents ($2,000 x .029 %= $0.58).

Frequently Asked Questions about the BPAS Roadways HSA

7. What's the difference between my Total Account Balance and my Debit Card Availability?	Because your account is on an investment platform, it's subject to market fluctuation. To ensure you don't overdraw your account because of daily market fluctuation, the Roadways HSA limits Debit Card Availability to 90% of your previous day's total account balance, minus any pending transactions you made prior to 3:30 pm EST. You can view your debit card available balance on the home page of the website once you login. If an expense is more than your available debit card balance, the charge will be declined. If you're using the HSA to fund an anticipated medical expense, consider investing your contributions in a conservative investment option to minimize market fluctuation. If you have an emergency and need access to 100% of your Account Balance, you may request a manual check for the entire balance or the remaining 10% of your Account Balance.
8. It's after my plan effective date, why don't I have access to my HSA funds?	**The most likely reason is that you haven't activated your HSA**. For detailed instructions about activating your HSA, please refer to your Activation Guide. Once you login to your account at BPAS.com, confirm that your address and email address are correct. Then, click on the **Transaction** tab at the top and select **HSA Transactions**. Follow the instructions to complete the four-step account activation process. If you've successfully completed the activation process, you'll receive a **confirmation**. If you don't get the CONFIRMATION page, you haven't completed the process. If you've activated your account but still don't have access to your funds, check your **account balance**. If it's $0 or less than the expense amount, your debit card/distribution request could be declined. Contact BPAS Customer Service at 1-866-401-5272 to review your account if you still have questions.
9. How do I order debit cards?	Once you receive a confirmation that you've activated your account, we'll mail your HSA debit card to your address on record. Please allow two weeks for your card to arrive. You'll receive one debit card. If you elected family coverage, you may order a second debit card at no charge. There's a $5 charge for each additional debit card. To order a debit card for a spouse/dependent, you must add them in step 2 of the account activation process, under **HSA Benefit Card**. Add the spouse/dependent's name. Then you'll see a record for the dependent and a link to issue a card. Enter the dependent's SSN and select "**Issue Card**". You will know the card has been ordered when you see the last 4 digits of the debit card. Repeat this step as many times as needed for each dependent. To order additional cards, log into your account and go to the **Benefit Cards** tab in your **HSA Transactions** screen. If the dependent names are already listed, click on "Issue Card". To add a dependent, enter the dependent name, select "Issue Card", enter the SSN for the dependent, then click "**Issue Card**". To order a **replacement card** for a lost or stolen card, contact Customer Service immediately so that we can review your account for any fraudulent activity before cancelling the existing card and ordering a new card.
10. How do I activate my debit card?	**Activate your new HSA debit card** when it arrives, by calling the toll-free number listed on the sticker of the card. You must call from the telephone number on record for verification purposes. When prompted: • Enter the last four digits of the cardholder's SSN, and select 1 to verify • Enter Expiration Date of card, and select 1 to verify • Enter the last four digits of the cardholder's social security number, and select 1 to verify • Create a PIN, and select 1 to verify If any entries are incorrect, select 2 and then correct the entry when prompted and verify.
11. Why did I receive tax forms for my HSA?	If you made any distributions from your HSA account during the calendar year, BPAS will generate a 1099-SA tax form no later than January 31 of the following year. BPAS will also generate a 5498-SA tax form no later than May 31 of the following year if you've made contributions during the calendar year. You can access these forms in your account on BPAS.com under **Tax Forms** in the **Resource Center**. We'll also mail these forms to your address on record. Be sure to review IRS instructions regarding HSA forms when filing your tax return. Visit IRS.gov for more information.
12. I still have questions, what can I do?	Please contact BPAS Customer Service at 1-866-401-5272 for further information.

Flexible Spending Accounts
PacificSource Administrators

FSAs provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pretax basis. By anticipating your family's health care and dependent care costs for the next year, you can actually lower your taxable income.

Health Care Reimbursement FSA:

This program allows Crook County employees to set aside pre-tax money to pay for medically necessary healthcare expenses that are not covered by a health plan. The annual maximum amount you may contribute to the Health Care FSA is $2,750. Some examples of reimbursable expenses include:

- Insurance deductibles, coinsurance, and copayments
- Hearing services, including hearing aids and batteries
- Vision services, including contact lenses, contact lens solution, eye examinations and eyeglasses
- Dental services and orthodontia
- Chiropractic services
- Acupuncture
- Prescription copays

Note: If you are enrolled in the HSA plan and choose to enroll in the FSA plan, you will be enrolled in a limited purpose FSA. These funds can only be used for dental and vision expenses, no health expenses will be eligible.

Dependent Care FSA:

The Dependent Care FSA lets Crook County employees use pretax dollars toward qualified dependent care such as caring for children under the age 13 or caring for elders. The annual maximum amount you may contribute to the Dependent Care FSA is $5,000 (or $2,500 if married and filing separately) per calendar year. Examples include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

Pay for Qualified Healthcare Expenses with Your Benefit Debit Card

The Basics

The PacificSource Administrators benefit debit card gives you an easy, automatic way to pay for qualified healthcare expenses that aren't paid by your health insurance. When you use your card, the funds are deducted from your health Flexible Spending Account (FSA) or Health Reimbursement Arrangement (HRA) when you pay for eligible healthcare expenses.

Keep your itemized receipts for these purchases, as they may be needed for documentation.

How It Works

Once your benefit debit card is set up with your health FSA, you can use it for eligible expenses for yourself and your dependents. The annual amount you choose to contribute to your account will be available on the first day your plan begins. When you use your card, your purchases are automatically deducted from your account.

If you have an HRA, check with your plan administrator to find out if and when the funds will be available and whose expenses may be reimbursed.

Where You Can Use It

Use your card at the following:

- Physician offices, including medical, dental, and vision care
- Medical facilities, such as hospitals and urgent care clinics
- Pharmacies, grocery stores, and retail stores for eligible healthcare expenses

At Your Provider's Office

- **Copays:** When paying for your healthcare services, the system will automatically approve services that match your group-sponsored insurance copay amounts (not coinsurance) from your benefit plan. Rarely will you need to submit supporting documentation for these services.
- **Reminder about other charges:** Only use your benefit card to pay for services not paid by your health or dental insurance plan, or for any remaining balance after your insurance has paid (such as for a copay or noncovered services).
- **Have the provider charge only the exact amount** that is shown as the "patient balance" on your insurance carrier's explanation of benefits (EOB) statement.
- **If you are paying for multiple office visits,** ask the provider to run the card separately for the exact "patient balance" for each visit. You may need to submit documentation when paying for multiple visits with one card swipe.

Continued >

Email
PSACustomerService@pacificsource.com

Phone

Toll-free
(800) 422-7038
TTY (800) 735-2900

En Español
Sin costo (866) 281-1464

PacificSource.com/PSA

PacificSource ADMINISTRATORS

At Pharmacies, Retail Stores, and Online

Purchase your over-the-counter (OTC) items from pharmacies, retail stores, or online outlets. Some of these businesses can automatically identify as items that are eligible for reimbursement, and you shouldn't need to submit documentation.

If you are also purchasing noneligible items, you will need to use a different card or another form of payment for those items.

Not all retailers are equipped with the automatic inventory system. In those cases, you can use the benefit card, and follow up by providing documentation of the purchase.

Maximize Your Benefits

Remember that you can only use your card at health-related businesses.

Date of service is important! It is assumed the date of service is the day the card is swiped. If you are paying for a prior service, only use your card if the service date is within your current plan year. Prior year services need to be submitted as manual claims for reimbursement.

If you make a purchase for more than your available balance, ask the merchant to charge part to your card (up to your available balance amount), and then use another form of payment for the remainder of your purchase. If the merchant won't allow a partial payment, you will need to use another form of payment and then submit a manual claim for reimbursement.

Ineligible Transactions

You may occasionally receive a notice if your transaction is ineligible or needs additional documentation. When this happens, you have three options:

- Submit the documentation identified in the letter.
- Shift ("offset") the amount from the ineligible transaction to one that is eligible (and hasn't already been reimbursed) by submitting documentation for the other eligible transaction.
- Refund the expense by sending a check or money order for the ineligible amount to PacificSource Administrators.

If the transaction issue hasn't been resolved within the allotted time, the card will be suspended. Amounts for transactions that aren't properly documented or that have been deemed ineligible may be included as wages on your W-2 if not corrected within 150 days after the plan year ends or the card closes.

Benefit Debit Card Tips

Activation

To activate your card, call PacificSource Administrators Customer Service or the number on the back of the card. Card activation requires the last four digits of your PacificSource Administrators ID number (e.g., 0001234567).

Who Should Sign?

While both of the cards you receive are printed with the participant's name, your spouse or dependent should sign their own name on the card that they will use.

About Your Card

There is no cost for the initial set of two cards. You should retain your card until expiration, even if you do not re-enroll during that time. If you are enrolled in an eligible plan, you will automatically receive a new set of cards upon expiration (five years) for no additional fee.

Additional and Replacement Cards

You may request additional cards for eligible dependents. When additional cards are requested, you will automatically receive two cards for a fee of $10 per set. This fee is deducted from your FSA or HRA account.

Manage Your Account Online

Sign into your account at **PSA.Consumer.PacificSource.com/Login**. Here, you can view your eligible expenses, check your current balance and transaction history, submit claims, or provide documentation for transactions.

Visit **PSA.PacificSource.com/fsa-hra-benefits** for more information.

Save Your Receipts!

It is important to keep your paperwork, such as your insurance carrier's explanation of benefits (EOB) statement or an itemized receipt that shows the item name or description. When we're not able to verify purchases automatically, we'll request documentation to confirm that the products or services are eligible.

Where to Send Documentation

Send your documentation the same way you submit a manual claim. This can be via mail, fax, or online.

Fax: **(866) 446-6090**
Online: **PSA.Consumer.PacificSource.com/Login**
Mail: PacificSource Administrators
PO Box 2797, Portland OR 97208-2797

PacificSource Administrators Website
Online Account Access for Participants

Manage your FSA account from the convenience of your home or office

At PacificSource Administrators (PSA), we're committed to providing you with flexible, personalized service. One way we do that is through the PSA website, which includes a secure consumer web portal. By logging in you can access information about your accounts 24 hours a day. Whether you have a flexible spending account (FSA) or health reimbursement arrangement (HRA), you can find everything you need at **PacificSource.com/PSA**.

Visit our website at PacificSource.com/PSA

- **Learn more** about your benefits debit card.
- **Download forms and materials** including claim forms, direct deposit forms, and more.
- **Review eligible expenses**.
- **Find answers** to frequently asked questions.

Logging into the Web Portal

1. **To begin, simply visit our website, psa.pacificsource.com**, and click the "FSA/HRA Benefits" button.
2. **Click the FSA/HRA login at the top of the page.** All participants are automatically assigned a username and password by PSA.
3. **Enter your username** and click the "Login" button.
   a. If you have previously participated and changed your username or password, please log in using your existing information.
   b. If this is your first time logging in, enter your member ID number in the username field. Your member ID number is provided in your Welcome Letter (sent in the mail when you first enrolled). If you cannot locate your ID, call Customer Service at **(800) 422-7038** to request it.
   c. Follow the on-screen instructions.
   d. Once you are logged in, you will be prompted to enter or confirm your information and create security questions.

Continued >

Email
PSACustomerService@pacificsource.com

Phone

Toll-free
(800) 422-7038
TTY (800) 735-2900

En Español
Sin costo (866) 281-1464

PacificSource.com/PSA

PacificSource ADMINISTRATORS

Site Overview

The website is organized as follows:

Home page

- Overview
- View balances, recent transactions, and more
- File a claim or manage your expenses

Accounts menu

- Account Summary
- Account Activity
- Dashboard
- Claims
- Payments
- Statements
- Profile Summary
- Banking/Cards
- Payment Method
- Login Information

Tools & Support menu

- Documents and forms
- How-to

Message Center link

- Click to see messages about recent activity

Tips

- Access the consumer web portal directly at **PSA.Consumer.PacificSource.com**
- Access additional information, forms, and materials at **PacificSource.com/PSA**

Questions and Answers

How can I be sure my personal information is secure?

Our FSA/HRA consumer website is secure. All information you send to us via this site will be encrypted.

Can I change my password?

Yes, you can change your password at any time. To do so, select "Login Information" from the Accounts menu. Click on "Change Username" and follow the on-screen instructions.

Can I change my address through the site?

Yes, just select "Profile Summary" from the Accounts menu. Click on "Update Profile" and make your changes. Once you save your change, it will be routed to Customer Service for updating. You can monitor the submitted change on your home page. Keep in mind that you will still need to notify your employer of the change.

Does the site provide information about my Transportation Benefit?

Yes, if you have a Transportation account with PacificSource Administrators, the site allows you to view your transportation claims, payments, and balances.

How do I submit a claim?

To request reimbursement online, click "File A Claim" on the Home page and follow the on-screen instructions.

I get an error message when I click my browser back button. How do I fix this?

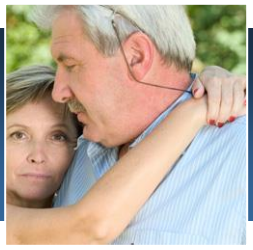
If you get an error message, try refreshing your screen. Use the site menu to navigate instead of your browser back button.

Who should I contact if I have technical problems?

If you have any difficulties with logging in or the site, call Customer Service. We'll look into it and follow up with you right away.

PacificSource ADMINISTRATORS

Life and Long-Term Disability
United Heritage



Crook County

Summary of Benefits

Group Term Life and Accidental Death & Dismemberment Benefit

Class 1 – All full-time employees excluding County Commissioners working a minimum of 30 hours per week.

Employee Life and Accidental Death & Dismemberment Benefit:	**$ 10,000**
Dependent Life Benefit:	
Spouse	**$ 2,000**
Child(ren) 15 days to 6 months	**$ 100**
Child(ren) 6 months to 26* years of age	**$ 2,000**
*If unmarried and financially dependent upon you.	

Conversion Privilege – An Insured Employee and Dependent(s) may convert Group Life Insurance coverage, without evidence of insurability, to an Individual Life Insurance policy during the 31 day period following termination of employment.

Waiver of Premium - If an Insured Employee becomes totally disabled prior to attainment of age 60 and if disability lasts 9 months or more, no further premiums will be required for the Employee during the continuance of total disability.

Accidental Death & Dismemberment Insurance – Payable when an Insured Employee suffers a loss* as a result of an accidental bodily injury or death sustained in an accident.
*A table outlining the description of Loss and payable benefit can be found in the group's complete certificate of coverage.

Long Term Disability

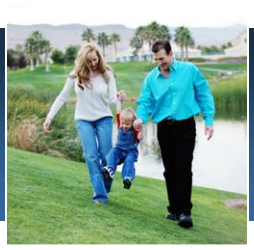
A *monthly* benefit payable to an insured employee in the event they become disabled due to sickness or injury and are unable to perform one or more of the essential duties of his/her regular occupation for **24 months**. The insured employee must be earning less than 80% of his/her pre-disability earnings.

This benefit will pay the insured employee **60%** of their pre-disability gross monthly earnings to a maximum benefit of **$6,000 per month**. **The duration of payments is based on the insured's age when disability occurs.** For a complete table of your benefit duration period, please refer to the certificate of coverage.

Elimination Period
An elimination period of **180 days** after disability begins must be met before benefits are payable.

This Benefit Summary is not part of your group's policy or the Certificate of Coverage you have been provided. The policy may contain certain Limitations and Exclusions not stated here. Please see the Certificate of Coverage for specific policy information.

Voluntary Life and AD&D
United Heritage



Crook County

Summary of Benefits

Group Term Supplemental Life Insurance

Classification	*Supplemental Life Benefit*
All Full-Time Employees	Up to $500,000, in $10,000 increments, not to exceed 5 X Basic Annual Earnings, whichever is less
Guarantee Issue – $100,000	

Classification	*Supplemental Life Benefit**
Spouse	Up to $250,000, in $5,000 increments, not to exceed 50% of the Employee's Supplemental Life Benefit Election
Children 15 days to 6 months of age	$ 250
Children 6 months to 26 years of age (Unmarried and financially dependent upon you)	Up to $10,000, in $2,000 increments
Spouse Guarantee Issue – Up to $30,000; **Children Guarantee Issue** – Up to $10,000	

Age	Employee & Spouse Supplemental Life Rate per $1000
0 - 24	$ .07
25 – 29	$ .07
30 – 34	$ .07
35 – 39	$ .10
40 – 44	$ .16
45 – 49	$ .25
50 – 54	$ .50
55 – 59	$ .79
60 – 64	$ .93
65 – 69	$1.06
70 - 74	$1.57
75 & Over	$3.79
Child(ren) Unit Per $1000	$ .20

Supplemental Spouse rates and premiums are based on the Employee's age, not the Spouse's age.

Conversion Privilege – An Insured Employee and Dependent(s) may convert Group Supplemental Life Insurance coverage, without evidence of insurability, to an Individual Life Insurance policy during the 31 day period following termination of employment.

Waiver of Premium - If an Insured Employee becomes totally disabled prior to attainment of age 60 and if disability lasts 9 months or more, no further premiums will be required for the Employee during the continuance of total disability.

United Heritage Supplemental Life Insurance Premiums-Guaranteed Issue Monthly Rates

Age	Rate/$1,000	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
0-24	$ 0.07	$ 0.70	$ 1.40	$ 2.10	$ 2.80	$ 3.50	$ 4.20	$ 4.90	$ 5.60	$ 6.30	$ 7.00
25-29	$ 0.07	$ 0.70	$ 1.40	$ 2.10	$ 2.80	$ 3.50	$ 4.20	$ 4.90	$ 5.60	$ 6.30	$ 7.00
30-34	$ 0.07	$ 0.70	$ 1.40	$ 2.10	$ 2.80	$ 3.50	$ 4.20	$ 4.90	$ 5.60	$ 6.30	$ 7.00
35-39	$ 0.10	$ 1.00	$ 2.00	$ 3.00	$ 4.00	$ 5.00	$ 6.00	$ 7.00	$ 8.00	$ 9.00	$ 10.00
40-44	$ 0.16	$ 1.60	$ 3.20	$ 4.80	$ 6.40	$ 8.00	$ 9.60	$ 11.20	$ 12.80	$ 14.40	$ 16.00
45-49	$ 0.25	$ 2.50	$ 5.00	$ 7.50	$ 10.00	$ 12.50	$ 15.00	$ 17.50	$ 20.00	$ 22.50	$ 25.00
50-54	$ 0.50	$ 5.00	$ 10.00	$ 15.00	$ 20.00	$ 25.00	$ 30.00	$ 35.00	$ 40.00	$ 45.00	$ 50.00
55-59	$ 0.79	$ 7.90	$ 15.80	$ 23.70	$ 31.60	$ 39.50	$ 47.40	$ 55.30	$ 63.20	$ 71.10	$ 79.00
60-64	$ 0.93	$ 9.30	$ 18.60	$ 27.90	$ 37.20	$ 46.50	$ 55.80	$ 65.10	$ 74.40	$ 83.70	$ 93.00
65-69	$ 1.06	$ 10.60	$ 21.20	$ 31.80	$ 42.40	$ 53.00	$ 63.60	$ 74.20	$ 84.80	$ 95.40	$ 106.00
70-74	$ 1.57	$ 15.70	$ 31.40	$ 47.10	$ 62.80	$ 78.50	$ 94.20	$ 109.90	$ 125.60	$ 141.30	$ 157.00
75+	$ 3.79	$ 37.90	$ 75.80	$ 113.70	$ 151.60	$ 189.50	$ 227.40	$ 265.30	$ 303.20	$ 341.10	$ 379.00

*** Spouse premium is based of the employee's age

Employee Assistance Program
Guidance Resources

Call ComPsych® DisabilityGuidance℠ anytime for confidential assistance.

Call: **866.511.3361**
Go online: **guidanceresources.com**
TDD: **800.697.0353**
Your company Web ID: **EAP4UH**

Personal issues, planning for life events or simply managing daily life can affect your work, health and family. ComPsych® DisabilityGuidance℠ provides support, resources and information for personal and work-life issues. DisabilityGuidance is company-sponsored, confidential and provided at no charge to you and your dependents. This flyer explains how DisabilityGuidance can help you and your family deal with everyday challenges.

Confidential Counseling

Someone to talk to.

This no-cost counseling service helps you address stress, relationship and other personal issues you and your family may face. It is staffed by GuidanceConsultants℠—highly trained master's and doctoral level clinicians who will listen to your concerns and quickly refer you to in-person counseling and other resources for:

- Stress, anxiety and depression
- Relationship/marital conflicts
- Problems with children
- Job pressures
- Grief and loss
- Substance abuse

Financial Information and Resources

Discover your best options.

Speak by phone with our Certified Public Accountants and Certified Financial Planners on a wide range of financial issues, including:

- Getting out of debt
- Credit card or loan problems
- Tax questions
- Retirement planning
- Estate planning
- Saving for college

Legal Support and Resources

Expert info when you need it.

Talk to our attorneys by phone. If you require representation, we'll refer you to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter. Call about:

- Divorce and family law
- Debt and bankruptcy
- Landlord/tenant issues
- Real estate transactions
- Civil and criminal actions
- Contracts

GuidanceResources® Online

Knowledge at your fingertips.

GuidanceResources Online is your one stop for expert information on the issues that matter most to you... relationships, work, school, children, wellness, legal, financial, free time and more.

- Timely articles, HelpSheets℠, tutorials, streaming videos and self-assessments
- "Ask the Expert" personal responses to your questions
- Child care, elder care, attorney and financial planner searches

Just call or click to access your services.

Note: Before a disability claim, DisabilityGuidance offers insured Policyholders up to five sessions per calendar year. Following an approved LTD Claim, claimants are also entitled to five additional sessions. The sessions may be used with a counselor, financial planner or lawyer or split among the three types of professionals.

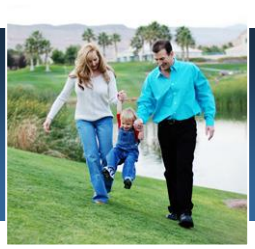
UNITED HERITAGE Insurance

UNITED HERITAGE LIFE INSURANCE COMPANY
P.O. BOX 7777 • MERIDIAN, ID 83680
800-657-6351 • unitedheritage.com

Your ComPsych® DisabilityGuidance Program

CALL ANYTIME
Call: **866.511.3361**
TDD: 800.697.0353
Online: **guidanceresources.com**
Your company Web ID: **EAP4UH**

Travel Assistance
Assist America



Coverage No Matter **Where You Travel**

There's nothing more reassuring when you're away from home than knowing there's someone available to help in an emergency. That's why we provide global emergency services from Assist America® as a value-added program with medical policies.

Help When It's Needed Most

Should a member experience a medical emergency when traveling 100 or more miles from home or in a foreign country, a simple phone call to Assist America will help them get the care they need. Assist America's operations center is staffed 24 hours a day, 365 days a year with trained, multilingual and medical personnel, including doctors and nurses, who are ready to help.

Assist America's services can be accessed for:

- Business and pleasure travel
- All members including spouses and dependents enrolled in a PacificSource medical plan, whether traveling together or independently
- Travel periods of 90 days or less (members traveling for longer durations may purchase expatriate coverage directly from Assist America if desired)

No Unexpected Cost to Member or Employer

Assist America completely arranges and pays for all of the assistance services it provides, without limits on the covered cost. This alleviates many of the obstacles and potential expenses that can be caused by medical emergencies away from home.

Key Services

Medical Consultation, Evaluation and Referral

Calls to Assist America's Operations Center are evaluated by medical personnel and referred to English-speaking, Western-trained doctors and hospitals.

Hospital Admission Guarantee

Assist America will guarantee hospital admission outside the United States by validating the member's health coverage or by advancing funds to the hospital.

Emergency Medical Evacuation

If adequate medical facilities are not available locally, Assist America will use whatever mode of transport, equipment, and personnel necessary to evacuate the member to the nearest facility capable of providing a high standard of care.

Critical Care Monitoring

Assist America's medical personnel will maintain regular communication with the member's attending physician and hospital and relay information to the family.

Medical Repatriation

If medical assistance is required after being discharged from a hospital, Assist America will repatriate the member home or to a

Bend
Direct: (541) 330-8896
Toll-free: (888) 877-7996

Portland
Direct: (503) 699-6561
Toll-free: (866) 540-1191

Medford
Direct: (541) 858-0381
Toll-free: (800) 899-5866

Springfield
Direct: (541) 686-1242
Toll-free: (800) 624-6052

Boise
Direct: (208) 342-3709
Toll-free: (888) 492-2875

Coeur d'Alene
Direct: (208) 665-7976
Toll-free: (800) 688-5008

Idaho Falls
Direct: (208) 522-1360
Toll-free: (800) 688-5008

Helena
Direct: (406) 422-1008
Toll-free: (855) 422-1008

PacificSource.com

PacificSource HEALTH PLANS

rehabilitation facility with a medical or non-medical escort, as necessary.

Prescription Assistance

If the member needs a replacement prescription while traveling, Assist America will help fill that prescription.

Emergency Messages

Assist America will receive and send emergency messages as needed.

Compassionate Visit

If a member is traveling alone and will be hospitalized for more than seven days, Assist America will provide economy, round-trip, common carrier transportation to the place of hospitalization for a designated family member or friend.

Care of Minor Children

Assist America will arrange for the care of children left unattended as the result of a medical emergency and pay for any transportation costs involved in such arrangements.

Return of Mortal Remains

In the event of a member's death, Assist America will render every possible assistance. This service includes arranging preparation of the remains for transport, procuring required documentation, providing the necessary shipping container, and paying for transport.

Emergency Trauma Counseling

Assist America will provide initial telephone-based counseling and referrals to qualified counselors as needed or requested.

Lost Luggage or Document Assistance

Members can call Assist America for assistance in locating lost luggage, documents, or personal belongings.

Interpreter and Legal Referrals

Assist America will refer members to interpreters and legal personnel as necessary.

Pre-trip Information

Web-based country profiles that include visa requirements, immunization and inoculation recommendations, and security advisories for any travel destination are available from Assist America.

Services that Compliment Health Coverage

Assist America's services compliment rather than replace PacificSource coverage. Once a member is under the care of a physician or medical facility, the PacificSource policy's terms and conditions apply. Assist America's services ensure that in an emergency, members get access to the care they need, when they're traveling 100 or more miles from home or in a foreign country.

About Assist America

Formed in 1990, Assist America, Inc. is the nation's largest provider of global emergency services. The company, headquartered in Princeton, New Jersey, serves more than 300,000 enterprises through benefit programs from the country's most prominent insurance providers.

Questions?

If you need more information about Assist America, or any of our products or services, please contact us.

AFLAC

Your Lifestyle.
Your Coverage.

Aflac has policies to help protect any lifestyle – From helping protect your paycheck due to out-of-pocket medical expenses, to cash for groceries and getaways. And because we pay you directly*, it's up to you how you spend it.

Here are some of the insurance policies we offer.

ACCIDENT
Helps with costs associated with covered accidental injuries.

HOSPITAL
Helps with expenses that may not be covered by major medical insurance, like deductibles and other expenses related to hospital stays.

LIFE
We're not just here to help protect your lifestyle, but the lifestyle of your family as well.

SHORT-TERM DISABILITY
Helps ease financial stress when you're out of work due to a covered illness or injury.

CANCER
We're here to help you and your family better cope financially–and emotionally–if a positive diagnosis of cancer ever occurs.

CRITICAL ILLNESS
Helps with treatment costs of covered life-changing illnesses and health events, so you can recover and do the things you love.

NAME _____

DATE OF BIRTH _____

PHONE (CELL) _____

PHONE (WORK) _____

HIRE DATE _____

Kate Thomas
541.382.4451
Kate_Thomas_group_inc@us.Aflac.com

*Benefits are paid directly to you for eligible claims, unless you tell us otherwise.

Accident policy form numbers: In Idaho, A36100ID–A36400ID, & A3630FID. In Oklahoma, A361000K– A364000K, & A3630FOK. In Virginia, A35100VA-A35400VA, A35B24VA & A35B0FVA. Short-Term Disability policy form numbers: In Idaho, A57600IDR. In Oklahoma, A576000K and A57600LBOK. In Virginia, A57600VA and A57600LBVA. Hospital Confinement Indemnity policy form numbers: In Idaho, B40100ID & B4010HID. In Oklahoma, B401000K & B4010HOK. In Virginia, A49100VAR–A49400VAR and A4910HVAR. Cancer policy form numbers: In Idaho, A78100ID through A78400ID. In Oklahoma, A781000K through A784000K. In Virginia, A-75100-VA, A-75200-VA, A-75300-VA. Life policy form numbers: In Idaho, Oklahoma, and Virginia, policies ICC64100, ICC64200, ICC64300, and ICC64500; ICC1368100, ICC1368200, ICC1368300, ICC1368400; ICC0965JTO and ICC0965JWO. Critical Illness policy form numbers: In Idaho, A74100ID, A74200ID, A74300ID. In Oklahoma, A741000K, A742000K, A743000K. In Virginia, A74100VA, A74200VA, A74300VA. Policies may not be available in all states. Limitations and exclusions may apply. Benefits are determined by state and plan level selected. **Coverage is underwritten by American Family Life Assurance Company of Columbus. In New York, coverage is underwritten by American Family Life Assurance Company of New York. Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999**

Emergecy Medical Transport
MASA

EMERGENCY TRANSPORTATION COSTS

MASA MTS is here to protect its members and their families from the shortcomings of health insurance coverage by providing them with comprehensive financial protection for lifesaving emergency transportation services, both at home and away fromhome.

Many American employers and employees believe that their health insurance policies cover most, if notall ambulance expenses. The truth is, they DONOT!

Even after insurance payments for emergency transportation, you could receive a bill up to $5,000 for ground ambulance and as high as $70,000 for air ambulance. The financial burdens for medical transportation costs are very real.

HOW MASA IS DIFFERENT

Across the US there are thousands of ground ambulance providers and hundreds of air ambulance carriers. ONLY MASA offers comprehensive coverage since MASA is a PAYER and not a PROVIDER!

ONLY MASA provides over 1.6 million members with coverage for **BOTH ground ambulance and air ambulance transport, REGARDLESS of which provider transports them.**

Members are covered ANYWHERE in all 50 states and Canada!

Worldwide coverage is also available with our Platinum Membership.

Additionally, MASA provides a repatriation benefit: if a member is hospitalized more than 100 miles from home, MASA can arrange and pay to have them transported to a hospital closer to their place of residence.

MASA Medical Transport Solutions™

Any Ground. Any Air. Anywhere.™

OUR BENEFITS

Benefit *	Platinum $39/Month	Emergent Plus $14/Month	Emergent $9/Month
Emergent Ground Transportation	U.S./Canada	U.S./Canada	U.S./Canada
Emergent Air Transportation	U.S./Canada	U.S./Canada	U.S./Canada
Non-Emergent Air Transportation	Worldwide	U.S./Canada	
Repatriation	Worldwide	U.S./Canada	
Escort Transportation	Worldwide		
Mortal Remains Transportation	Worldwide		
Visitor Transportation	BCA**		
Minor Children/ Grandchildren Return	BCA**		
Vehicle Return	BCA**		
Pet Return	BCA**		
Organ Retrieval	U.S./Canada		
Organ Recipient Transportation	U.S./Canada		

** Please refer to the MSA for a detailed explanation of benefits and eligibility.*
*** Basic Coverage Area (BCA) includes U.S., Canada, Mexico, and Caribbean (excluding Cuba).*

A MASA Membership prepares you for the unexpected and gives you the peace of mind to access vital emergency medical transportation no matter where you live, for a minimal monthly fee.

- One low fee for the entire family
- NO deductibles
- NO health questions
- Easy claim process

For more information, please contact
Tony Urioste, *Regional Director*
Western States
541.848.8124 | turioste@masamts.com

EVERY FAMILY DESERVES A MASA MEMBERSHIP

MASA Medical Transport Solutions™

Any Ground. Any Air. Anywhere.

PLATINUM MEMBERSHIP BENEFITS

Emergency Air Medical Transportation	Should a member suffer serious life or limb threatening emergency that requires immediate transport by fixed wing or helicopter air ambulance of that member to the nearest most appropriate medical facility capable of providing required emergency medical treatments, also referred to as "golden hour transports", MASA MTS will cover the out-of-pocket expenses resulting from that transport. (U.S. and Canada only)
Emergency Ground Transportation	Should a member suffer a life or limb emergency requiring emergent ground transport from the site of serious illness or injury, or from a transferring medical facility that is unable to provide services required, to the nearest most appropriate medical facility capable of attending to the member's medical needs MASA MTS will cover the out-of-pocket expenses resulting from that transport. (U.S. and Canada only)
Non-Emergent Air Transportation	Should a member suffer a serious illness or injury resulting in hospitalization and if the member is in need of specialized treatment not available locally but such transportation is not immediately needed for life or limb saving treatment and such transportion can be arranged by MASA, then MASA MTS will coordinate transport to the nearest appropriate medical facility capable of providing such specialized treatment. (Worldwide coverage)
Organ Retrieval**	MASA MTS will provide air transportation of an organ to be used in an organ transplant. (U.S. only)
Organ Recipient Transportation**	MASA MTS will fly a member to the commercial airport nearest the medical facility where an organ transplant is scheduled to happen. (U.S. only)
Recuperation / Repatriation	If a member is hospitalized while away from home, MASA MTS will fly them home to recuperate in familiar surroundings. (Worldwide coverage)
Escort Transportation	If a member requires emergency air transport, MASA MTS will fly the member's spouse, family member or friend to accompany them in the air. (Worldwide coverage)
Visitor Transport	If a member is hospitalized while away from his/her home for more than 7 days, the member may select a family member to visit them during confinement. MASA MTS will provide round trip, common carrier air transportation for the person selected. (Basic coverage area only*)
Minor Children / Grandchildren Return	When minor children or grandchildren are left unattended as a result of a member using MASA MTS air ambulance service, MASA MTS will provide one-way common carrier air transport for return of the children to the commercial airport nearest the place of residence of the children. (Basic coverage only*)
Vehicle Return	MASA MTS will return vehicles such as cars, vans, RVs or trucks owned or rented by the member when illness, injury or death requires use of the air ambulance services provided by MASA MTS. The vehicle will be carried to the member's place of residence or rental vehicles will be returned to the nearest rental company office or agent. (Basic coverage area only*)
Mortal Remains Transport	In the event a member dies while away from his/her place of residence, MASA Assist will return his/her remains to the commercial airport nearest his/her residence. (Worldwide coverage)
Pet Return	MASA MTS will return the Member's dog, cat or smaller animal, should the Member be flown to a hospital near their residence on an air ambulance arranged by the MASA MTS. (Basic coverage area only*)

*Basic Coverage Area includes U.S., Canada, Mexico, and Caribbean (excluding Cuba).
**One (1) year waiting period if pre-existing condition requiring transplant.

There is a 90 day waiting period on pre-existing conditions. This clause is WAIVED for emergent ground and air transports
Dependents are covered up until age 26.

Required Notices

NEWBORNS' AND MOTHER'S HEALTH 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).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Enrollment Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurance apply; see benefit summaries starting on page 4 for specific plan information. If you would like more information on WHCRA benefits, call your plan administrator at (541) 607-9208

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at (541) 607-9208 for more information.

MICHELLE'S LAW

Annual Notice

If a full-time student engaged in a postsecondary education loses full-time student statue due to a severe illness or injury, he/she will maintain dependent status until the earlier of (1) one year after the first day of a medically necessary leave of absence; or (2) the date on which such coverage would otherwise terminate under the terms of the plan. A medically necessary leave of absence or change in enrollment at that institution must be certified by the dependent's attending physician.

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, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – 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://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562

KANSAS – Medicaid	NEVADA – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462

RHODE ISLAND – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH CAROLINA – Medicaid	**WASHINGTON – Medicaid**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH DAKOTA - Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
TEXAS – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
UTAH – Medicaid and CHIP	**WYOMING – Medicaid**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VERMONT– Medicaid	
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

**** Continuation Coverage Rights Under COBRA****

Introduction

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;

- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

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

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the

60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

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

Plan contact information

Keity Crismon
Benefits Coordinator
(541) 416-3800
203 NE Court Street
Prineville OR 97754

HIPAA SPECIAL ENROLLMENT NOTICE

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

If you are declining coverage 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).

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under our health plan.

Marriage, Birth or Adoption

If you have a new dependent as a result of a 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 or placement for adoption.

Example: When you were hired by us, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired by us, your children received health coverage under CHIP and you did not enroll them in our health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact **Keity Crismon,**

(541) 416-3800.

The information in this Benefits Resource Guide is presented for illustrative purposes and is based on information provided by the employer. 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 Benefits Resource 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 this summary, contact Human Resources.