WHA INSURANCE

Crook County
Benefits Resource Guide

PLAN YEAR | **2026**

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.

PRIMARY CONTACTS

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FULL TEAM

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CONTACT

LOCAL OFFICE	TOLL FREE	FAX
(541) 342-4441	(800) 852-6140	(541) 484-5434

Eugene Office – 2930 Chad Drive, Eugene, OR 97408
Wilsonville Office – 29100 SW Town Center Loop, Suite 160, Wilsonville, OR 97070

Contact Information

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

Eligibility Information

Who is Eligible and When:

All full-time employees are eligible for benefits the first of the month following their date of hire.

Employer Pays:

Crook County pays 90% of the medical, dental, and 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.

Eligible family members include: Spouses, domestic partners and dependent children of a subscriber, subscriber's spouse, or subscriber's domestic partner who meet eligibility requirements outlined in the PacificSource Eligibility and Enrolling New Family Members sections of the PacificSource Member Handbook.

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
January 1, 2026
Contribution based on 15% increase and 10% Employee Cost Share of $1500 deductible plan

WHA INSURANCE

	PacificSource Renewal Plans					
	$1500 Custom		$3000 Custom		$2000 HSA	
	Navigator $1500 Deductible		Navigator $3000 Deductible		Navigator $2000 Deductible	
Medical & Prescription Benefits	In-Network - Voyager		In-Network - Voyager		In-Network	
Individual Deductible per person	$1,500		$3,000		$2,000	
Family Deductible	$3,000		$6,000		$4,000	
Coinsurance	20%		20%		20%	
Individual OOP Max	$3,500		$5,000		$4,000	
Family OOP Max	$7,000		$10,000		$8,000	
OOP Max includes Deductible	*YES*		*YES*		*YES*	
OOP Max includes Copays	*YES; Including Prescription Copays*		*YES; Including Prescription Copays*		*YES; Including Prescription Copays*	
Preventative Office Visit	Covered in Full		Covered in Full		Covered in Full	
Virtual Office Visit (vendor)	1st 3 visits $5 then	$0	1st 3 visits $5 then	$0	1st 3 visits $5 then	20%
Primary Care Office / Virtual Visit		$25		$25		20%
Specialist Office / Virtual Visit	$25		$25		20%	
Urgent Care Visit	$25		$25		20%	
Naturopath Visit	$25		$25		20%	
Maternity - Delivery and Postnatal	$250 per pregnancy		$250 per pregnancy		20%	
Maternity Hospital Stay	20%		20%		20%	
Hospital Services	20%		20%		20%	
Outpatient Services	20%		20%		20%	
Diagnostic Lab/X-Ray	20%		20%		20%	
CT, PET, MRI & MRA Lab	20%		20%		20%	
Emergency Room Services	$250 Copay		$250 Copay		20%	
Ambulance Services (Ground)	20%		20%		20%	
Physical Therapy	$25		$25		20%	
Durable Medical Equipment	20%		20%		20%	
Allergy Injections	20%		20%		20%	
Prescription						
Prescription Supply	30 Day	90 Day	30 Day	90 Day	90 Day	90 Day Mail
Pharmacy Deductible	N/A		N/A		Medical Deductible	
Tier 1	$15	$30	$15	$30	20%	20%
Tier 2	$45	$135	$45	$135	20%	20%
Tier 3	$45	$135	$45	$135	20%	20%
Tier 4	$45	$135	$45	$135	20%	20%
Compound	50%		50%		20%	
Alternative Care						
Copay	$25		$25		20%	
Benefit Maximum	Chiropractic 20 visits Acupuncture 12 visits per benefit year		Chiropractic 20 visits Acupuncture 12 visits per benefit year		Chiropractic 20 visits Acupuncture 12 visits per benefit year	
Vision						
Exam	$10 Copay		$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		Under age 19: No Charge Over age 19: No Charge up to $300	
Frequency	Per Benefit Year		Per Benefit Year		Per Benefit Year	
Dental - Moda						
Deductible	None		None		None	
Preventative	Covered in Full		Covered in Full		Covered in Full	
Basic - Restorative	Covered in Full		Covered in Full		Covered in Full	
Basic - Complicated	Covered in Full		Covered in Full		Covered in Full	
Major	50%		50%		50%	
Annual Maximum	$2000		$2000		$2000	
Orthodontia	50% to $1500 lifetime maximum		50% to $1500 lifetime maximum		50% to $1500 lifetime maximum	

	Monthly Employee Contribution	Annual Employee Contribution	Monthly HRA Veba Contribution	Annual HRA Veba Contribution	Monthly HSA Contribution	Annual HSA Contribution
Employee Only	122.94	$1,475.22	-45.90	-$550.74	-93.99	-$1,127.82
Employee + Spouse	267.47	$3,209.68	-101.39	-$1,216.64	-206.46	-$2,477.48
Employee + Family	305.80	$3,669.55	-106.98	-$1,283.81	-224.57	-$2,694.89
Employee + Child(ren)	208.86	$2,506.36	-73.11	-$877.28	-153.43	-$1,841.12

	Total Premium	Employer Contribution	Total Premium	Employer Contribution	Total Premium	Employer Contribution
Employee Only	$1,229.35	$1,106.42	$1,060.52	$1,106.42	$1,012.43	$1,106.42
Employee + Spouse	$2,674.73	$2,407.26	$2,305.87	$2,407.26	$2,200.80	$2,407.26
Employee + Family	$3,057.96	$2,752.16	$2,645.18	$2,752.16	$2,527.59	$2,752.16
Employee + Child(ren)	$2,088.63	$1,879.77	$1,806.66	$1,879.77	$1,726.34	$1,879.77

This comparison is for illustrative purposes only. If a conflict arises, carrier information takes precedence.

Deductible Applies
Deductible Waived

MEDICAL

Benefit Year: Calendar Year

Provider Network: Navigator

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

Note: Your actual costs for services provided out-of-network may exceed this plan's out-of-pocket limit for out-of-network services. In addition, out-of-network providers may in certain situations bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company (called balance billing). Balance billing amounts are not counted toward the out-of-network out-of-pocket limit. For additional information about balance billing or allowable fees, see your 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		
PCP office and home visits	First three visits no deductible, $5. Subsequent visits, no deductible, $25*	No deductible, 40%
Naturopath office visits	No deductible, $25	No deductible, 40%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Specialist office and home visits	No deductible, $25	No deductible, 40%
Telehealth visits	First three visits no deductible, $5. Subsequent visits, no deductible, $25*	No deductible, 40%
Office procedures and supplies	After deductible, 20%	After deductible, 40%
Surgery	After deductible, 20%	After deductible, 40%
Outpatient rehabilitation and habilitation services	No deductible, $25	After deductible, 40%
Acupuncture (12 visits per benefit year)	No deductible, $25	No deductible, 40%
Chiropractic manipulation/Spinal manipulation (20 visits 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%
Diagnostic imaging – advanced	No deductible, 20%	After deductible, 40%
Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced	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%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
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	First three visits no deductible, $5. Subsequent 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%
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 handbook for additional information or a further explanation of benefits, limitations, and exclusions.

^ Copay applies to ER physician and facility charges only. Copay waived if admitted into hospital.

*First three visits per benefit year combined for Professional Services – Office and home visits, Telehealth visits, and Mental Health and Substance Use Disorder Services – Office visits.

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

+Cochlear implants will not be subject to a deductible.

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.

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 services during the benefit 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 benefit 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 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 limit.

Payments to providers

Payment to providers is based on the prevailing or allowable fee for covered services. In-network providers accept the allowable fee as payment in full. Services of out-of-network providers could result in out-of-pocket expense in addition to the percentage indicated.

Prior authorization

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called prior authorization. Prior authorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. Prior authorization does not change your out-of-pocket expense. You can search for procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business).

Discrimination is against the law

PacificSource Health Plans complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PacificSource does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Benefit Year: Calendar Year

Formulary: Oregon Drug List (ODL)

This 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/find-a-drug.

The amount you pay for covered prescriptions at in-network pharmacies applies toward your plan's in-network medical out-of-pocket limit, the amount you pay for covered prescriptions at out-of-network pharmacies applies toward your plan's out-of-network out-of-pocket limit which is shown on the Medical Benefit Summary. The copayment and/or coinsurance for prescription drugs obtained from an in-network or out-of-network pharmacy are waived during the remainder of the benefit 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 preventive care drugs at no cost to you and are not subject to a deductible or MAC penalties when filled at an in-network pharmacy. This benefit includes some drugs required by the Affordable Care Act, including tobacco cessation drugs. These drugs are identified on the drug list as Tier 0.

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

Service/ Supply	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays	Tier 4 Member Pays
Compound Drugs**				
Up to a 90 day supply:		No deductible, 50%		
Out-of-network Pharmacy				
30 day maximum fill, no more than three fills allowed per year:		No deductible, 90%		

*Prescription insulin is not subject to a deductible and is limited to $35 copay per 30 day supply when filled at an in-network pharmacy.

**Compounded medications are subject to a prior authorization 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 copayment and/or coinsurance 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 copayment and/or coinsurance. The cost difference between the brand name and generic drug does not apply toward the medical out-of-pocket limit. Does not apply to preventive bowel prep kits covered under USPSTF guidelines.

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

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

Benefit Year: Calendar Year

Provider Network: Navigator

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

Note: Your actual costs for services provided out-of-network may exceed this plan's out-of-pocket limit for out-of-network services. In addition, out-of-network providers may in certain situations bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company (called balance billing). Balance billing amounts are not counted toward the out-of-network out-of-pocket limit. For additional information about balance billing or allowable fees, see your 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		
PCP office and home visits	First three visits no deductible, $5. Subsequent visits, no deductible, $25*	No deductible, 40%
Naturopath office visits	No deductible, $25	No deductible, 40%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Specialist office and home visits	No deductible, $25	No deductible, 40%
Telehealth visits	First three visits no deductible, $5. Subsequent visits, no deductible, $25*	No deductible, 40%
Office procedures and supplies	After deductible, 20%	After deductible, 40%
Surgery	After deductible, 20%	After deductible, 40%
Outpatient rehabilitation and habilitation services	No deductible, $25	After deductible, 40%
Acupuncture (12 visits per benefit year)	No deductible, $25	No deductible, 40%
Chiropractic manipulation/Spinal manipulation (20 visits 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%
Diagnostic imaging – advanced	No deductible, 20%	After deductible, 40%
Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced	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%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
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	First three visits no deductible, $5. Subsequent 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%
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 handbook for additional information or a further explanation of benefits, limitations, and exclusions.

^ Copay applies to ER physician and facility charges only. Copay waived if admitted into hospital.

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What is the out-of-pocket limit?

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

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Prior authorization

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Benefit Year: Calendar Year

Formulary: Oregon Drug List (ODL)

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The amount you pay for covered prescriptions at in-network pharmacies applies toward your plan's in-network medical out-of-pocket limit, the amount you pay for covered prescriptions at out-of-network pharmacies applies toward your plan's out-of-network out-of-pocket limit which is shown on the Medical Benefit Summary. The copayment and/or coinsurance for prescription drugs obtained from an in-network or out-of-network pharmacy are waived during the remainder of the benefit 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 preventive care drugs at no cost to you and are not subject to a deductible or MAC penalties when filled at an in-network pharmacy. This benefit includes some drugs required by the Affordable Care Act, including tobacco cessation drugs. These drugs are identified on the drug list as Tier 0.

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

Service/ Supply	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays	Tier 4 Member Pays
Compound Drugs**				
Up to a 90 day supply:		No deductible, 50%		
Out-of-network Pharmacy				
30 day maximum fill, no more than three fills allowed per year:		No deductible, 90%		

*Prescription insulin is not subject to a deductible and is limited to $35 copay per 30 day supply when filled at an in-network pharmacy.

**Compounded medications are subject to a prior authorization 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 copayment and/or coinsurance 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 copayment and/or coinsurance. The cost difference between the brand name and generic drug does not apply toward the medical out-of-pocket limit. Does not apply to preventive bowel prep kits covered under USPSTF guidelines.

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

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

Benefit Year: Calendar Year

Provider Network: Navigator

Deductible Per Benefit Year	In-network	Out-of-network
Individual/Family	$2,000/$4,000	$7,500/$15,000
Out-of-Pocket Limit Per Benefit 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 out-of-network may exceed this plan's out-of-pocket limit for out-of-network services. In addition, out-of-network providers may in certain situations bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company (called balance billing). Balance billing amounts are not counted toward the out-of-network out-of-pocket limit. For additional information about balance billing or allowable fees, see your 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		

Service/Supply	In-network Member Pays	Out-of-network Member Pays
PCP office and home visits	First three visits after deductible, 0%. Subsequent 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%
Telehealth visits	First three visits after deductible, 0%. Subsequent visits, after deductible, 20%*	After deductible, 50%
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%
Acupuncture (12 visits per benefit year)	After deductible, 20%	After deductible, 50%
Chiropractic manipulation/Spinal manipulation (20 visits 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%
Diagnostic imaging – advanced	After deductible, 20%	After deductible, 50%
Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced	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%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
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	First three visits after deductible, 0%. Subsequent visits, after deductible, 20%*	After deductible, 50%
Inpatient care	After deductible, 20%	After deductible, 50%
Residential programs	After deductible, 20%	After deductible, 50%
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 handbook for additional information or a further explanation of benefits, limitations, and exclusions.

*First three visits per benefit year combined for Professional Services – Office and home visits, Telehealth visits, and Mental Health and Substance Use Disorder Services – Office visits.

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

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, you and your dependents must satisfy the family deductible before benefits are paid.

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

What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for covered services during the benefit 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 benefit year. The individual out-of-pocket limit applies only if you enroll without dependents. If you and one or more dependents enroll, you and your dependents must satisfy the family out-of-pocket limit. Be sure to check your 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.

Payments to providers

Payment to providers is based on the prevailing or allowable fee for covered services. In-network providers accept the allowable fee as payment in full. Services of out-of-network providers could result in out-of-pocket expense in addition to the percentage indicated.

Prior authorization

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called prior authorization. Prior authorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. Prior authorization does not change your out-of-pocket expense. You can search for procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business).

Discrimination is against the law

PacificSource Health Plans complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PacificSource does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Benefit Year: Calendar Year

Formulary: Oregon Drug List (ODL)

This 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/find-a-drug.

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

Medical Deductible

You must meet the medical deductible, which is shown on the Medical Benefit Summary, before your prescription drug benefits begin.

PacificSource Expanded (Preventive) No-cost Drug List

Your prescription benefit includes certain outpatient drugs as a preventive benefit at no deductible, $0 copay. 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 and select Find a Drug.

Affordable Care Act Standard Preventive No-cost Drug List

Your prescription benefit includes preventive care drugs at no cost to you and are not subject to a deductible or MAC penalties when filled at an in-network pharmacy. This benefit includes some drugs required by the Affordable Care Act, including tobacco cessation drugs. These drugs are identified on the drug list as Tier 0.

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 90 day supply:	After deductible, 20%*	After deductible, 20%*	After deductible, 20%*	After deductible, 20%
In-network Mail Order Pharmacy				
Up to a 90 day supply:	After deductible, 20%*	After deductible, 20%*	After deductible, 20%*	After deductible, 20%

Service/ Supply	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays	Tier 4 Member Pays
Compound Drugs**				
Up to a 90 day supply:		After deductible, 20%		
Out-of-network Pharmacy				
30 day maximum fill, no more than three fills allowed per year:		After deductible, 90%		

*Prescription insulin is not subject to a deductible and is limited to $35 copay per 30 day supply when filled at an in-network pharmacy.

**Compounded medications are subject to a prior authorization 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 copayment and/or coinsurance plus the difference in cost between the brand name drug and its generic equivalent after the medical deductible is met. 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 copayment and/or coinsurance after the medical deductible is met. The cost difference between the brand name and generic drug does not apply toward the medical deductible or out-of-pocket limit. Does not apply to preventive bowel prep kits covered under USPSTF guidelines.

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

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

VISION

Benefit Year: Calendar Year

The following shows the vision benefits available under this plan 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 member turns 19. Copayment and/or coinsurance for covered charges apply to the medical plan's out-of-pocket limit.

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

Benefit Limitations: members age 18 and younger

- One vision exam every benefit year.
- Vision hardware includes glasses (lenses and frames) or contacts (lenses and fitting) once per benefit year.

Benefit Limitations: members age 19 and older

- One vision exam every benefit year.
- Vision hardware includes glasses (lenses and frames) and/or contacts (lenses and fitting). Benefit maximum is per benefit 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.
- Non-prescription lenses.
- Plano contact lenses.

- Services or supplies not listed as covered services.
- 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 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 copayments 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.

PACIFICSOURCE EXTRAS

Manage your benefits with InTouch whenever, wherever

Easily find in-network doctors, hospitals, specialists, alternative care providers, and more with **InTouch**—our secure web portal for members.

You can also:

- View your digital member ID card
- See if you've met your deductible and out-of-pocket max
- Find out which services are covered
- View your Explanation of Benefits statements

PacSrc.co/account

Create your InTouch account

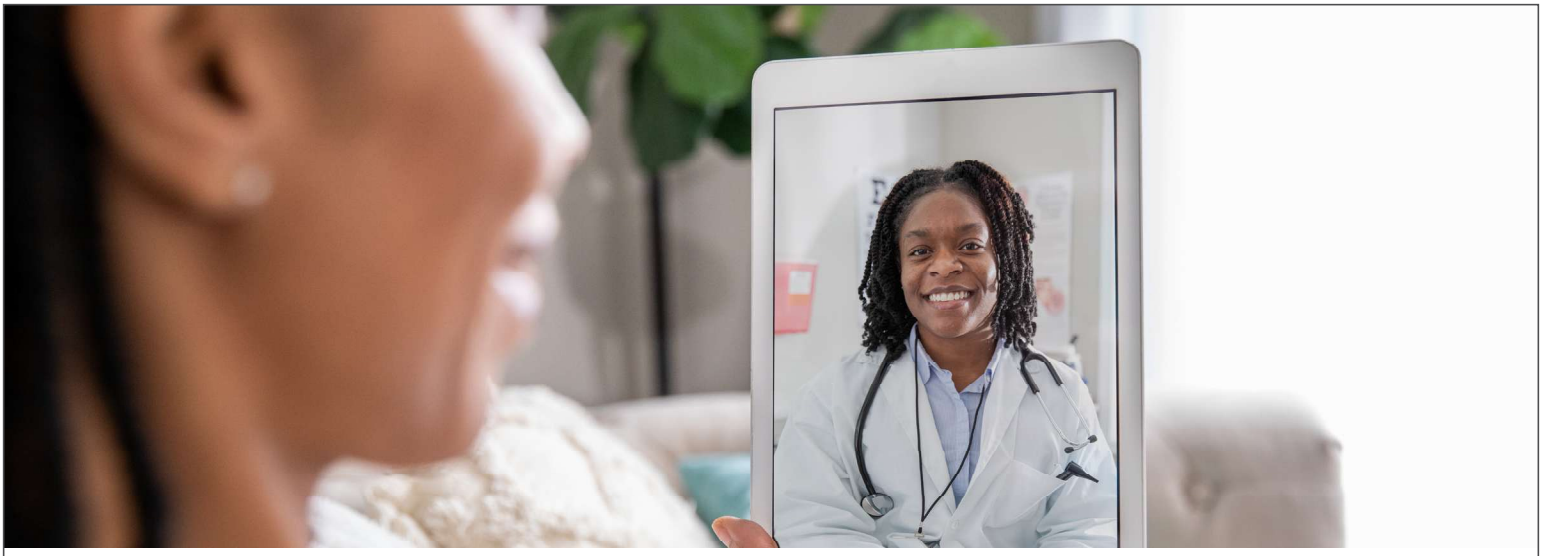
1. Scan QR code
2. Click "Create account"
3. Follow the steps provided

Our app puts InTouch in your pocket

The myPacificSource app is a convenient way to access InTouch from your smartphone or tablet. You'll find links to download the iOS or Android app at the page linked above.

After you create your InTouch account, use your username and password to log in to the app.

PacificSource HEALTH PLANS



Doctor's appointments via phone, video, or mobile app with Teladoc®

As a PacificSource member*, you have on-demand 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 options to get started. Note: When asked to enter the name of your employer or insurance carrier, please use "**PacificSource**" in the field.

Online: Log in or register with InTouch for Members through PacificSource.com. Find the "Teladoc - Remote Care" link under "Tools" to set up your account.

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

Phone: Teladoc can help you register your account over the phone at **855-201-7488.**

2. Provide your medical history

This provides Teladoc doctors with the information they need to make an accurate diagnosis.

3. Request an appointment

Once your account is set up, request an appointment any time you need care. And talk to a doctor by phone, web, or mobile app.

*Employer group members: To see if Teladoc is available on your plan, contact PacificSource Customer Service at **888-977-9299**, TTY: 711 (we accept all relay calls), or CS@PacificSource.com. You can also check with your employer.

See reverse for FAQ >

Talk to a doctor anytime!

Web
Teladoc.com

Phone
855-201-7488

Mobile App
Teladoc.com/mobile

PacificSource HEALTH PLANS

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 doctor visits.

Who are the Teladoc doctors?

Teladoc doctors are U.S. board certified in internal medicine, family practice, or pediatrics. They average 20 years of 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 non-emergency 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. Note: If setting up your account online, enter "**PacificSource**" for the name of your employer or insurance carrier.

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 20 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 canceled 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 drugs, and/or certain other drugs, which may be harmful because of their potential for 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 be responsible for is based on your specific plan 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. Your payment method will be set up when you register for Teladoc, and can be changed anytime.

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's 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

Get your prescriptions delivered

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

Why use home delivery for your prescriptions?

- **Convenience.**
  Ordering is easy, and your medication will come by mail.
- **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.

How to get started

Our service partner is CVS Caremark® Mail Service Pharmacy.

Visit PacificSource.com and choose one of three sign-up options:

- **Via your InTouch account.** Find the Caremark link under Tools.
- **By mail.** Download the form and mail it to:
  CVS Caremark, PO Box 659541, San Antonio, TX 78265-9541
- **Call CVS Caremark toll-free:** 866-329-3051, TTY: 711

*You can order a 30-day, 60-day, or 90-day supply, depending on your specific plan benefits. See your policy or pharmacy benefit summary for details.

Email
CS@PacificSource.com

Phone
888-977-9299
TTY: 711
We accept all relay calls.
En español: 866-281-1464

PacificSource.com

PacificSource HEALTH PLANS

CLB286_0523

The Active&Fit Direct™ Fitness Center Program

Members get discounted access to a broad network of participating fitness centers.

Choose standard or premium

- Select the standard or premium fitness center option that best fits you.
- Stop or switch options any time.
- **Discounts range from 20% to 70%** on average.

Freedom and flexibility

- 12,500+ participating centers/YMCAs nationwide. (See PacSrc.co/ActiveAndFitSearch.)
- Switch fitness centers to ensure you find the right fit.
- Find fitness centers with the web-based locator.
- Track your progress with the online fitness tracker.
- 12,000+ online workout videos—for home, work, or on-the-go.
- Receive unlimited 1:1 well-being coaching in areas such as fitness, nutrition, stress management, and sleep.

Get started

1. Visit PacificSource.com/ActiveAndFit for details. Or sign in at InTouch.PacificSource.com/members to register.
2. View and print your Active&Fit membership card.
3. Once the fitness center verifies your enrollment in the 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.

Note: Your participation is month-to-month after an initial two-month commitment.

Free fitness center trial

- Many fitness centers/YMCAs offer guest passes.
- Request a guest-pass letter for a gym at PacSrc.co/ActiveAndFitSearch. You will need to register and sign in to request the 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.

Questions? We're happy to help

Email

CS@PacificSource.com

Phone

888-977-9299
TTY: 711
We accept all relay calls.

En Español 866-281-1464

PacificSource.com

PacificSource HEALTH PLANS

Value-added extras for you

These extras help you make the most of your plan and live a healthier life. You can find more information about these programs and services at PacSrc.co/extras.

Wellness programs

Health and wellness education

Receive up to $150 reimbursement per plan year for health and wellness education classes in your area.

Prenatal program

Our prenatal program helps expectant parents learn more about pregnancy and their child's development throughout pregnancy. Participants receive educational materials, and high-risk members receive an enhanced specialized program designed to support their needs throughout pregnancy.

Prenatal vitamins

Women between the ages of 15 and 50 with prescription drug coverage can receive physician-prescribed prenatal vitamins at no cost—all copays and deductibles are waived—when filled through an in-network pharmacy. For more information, visit PacSrc.co/prenatal.

Weight management program

As a part of your PacificSource medical coverage, participate in a WW® (Weight Watchers) program and receive an annual reimbursement of $100 ($40 if an online WW participant) for your WW membership. Complete a minimum of ten weeks during a consecutive four-month period to maintain eligibility.

Discounted gym membership

Active&Fit Direct™ gives you access to more than 12,500 fitness facilities nationwide. The program offers a gym locator, 12,000+ online workout videos, online fitness tracking, and wellness product discounts.

Continued >

Email
CS@PacificSource.com

Phone
888-977-9299
TTY: 711
We accept all relay calls.
En Español 866-281-1464

PacificSource.com

PacificSource HEALTH PLANS

Travel emergency assistance program

Assist America® global emergency services

If you experience a medical emergency while traveling 100 or more miles from home or outside the US, you can access services provided by Assist America at no cost. Services include filling a prescription that was left at home, finding medical care in another country, locating lost luggage, and pre-trip safety and security checks for your destination country.

Pharmacy

Rx delivery by mail

We partner with CVS Caremark® for home delivery by mail. If your plan includes prescription drug coverage, the mail delivery service is a convenient and cost-saving option. Visit PacSrc.co/rxmail.

CVS Caremark
Web: Caremark.com
Phone: 866-329-3051

Care management

Condition support

Personal support is available to members with the following chronic conditions: diabetes, coronary artery disease, heart failure, chronic obstructive pulmonary disease (COPD), or asthma. It's optional and includes one-on-one coaching with our nurses and dietitian to help you reach your health and wellness goals. PacSrc.co/condsupport.

Rare disease support

Our AccordantCare™ Rare Disease Program provides ongoing one-on-one support and care coordination to people with certain chronic, rare conditions. The program helps ensure optimal care, decrease complications, and improve health outcomes. For more information, visit Accordant.com.

Specialty medication support

Members with conditions that require injectable medications and biotech drugs can access our specialty pharmacy program through Caremark Specialty Pharmacy Services. A pharmacist-led care team provides individual follow-up care and support.

Care management services

If you have an ongoing medical need, our Care Managers can help. The PacificSource clinical and member support staff has extensive experience for working with you and your healthcare providers to ensure continuity of care and to coordinate your health needs.

Phone and video doctor visits

Teladoc® is a national network of U.S. board-certified physicians and pediatricians that you can see on-demand 24/7, via phone or online video consultations, from wherever you happen to be. With most plans, you won't pay anything for a virtual visit with Teladoc. If you have an HSA plan, a virtual visit with Teladoc is subject to deductible. Check your plan summary's telemedicine benefit to confirm your cost share.

Online resources

PacificSource.com offers you a wealth of tools, information, and resources to help you make the most of your benefits.

InTouch: access coverage and benefit information

By logging into InTouch, you can easily and conveniently manage your insurance coverage and health 24/7. Look up coverage information, check the status of a claim, view explanation of benefits (EOB) statements for paid claims, and more.

myPacificSource mobile app

The easiest way to view and manage your benefits while on the go. Available for both iPhone® and Android™. Visit PacSrc.co/mobile-app.

Provider directory

Our online provider directory makes it easy to find in-network healthcare providers for your plan. You can search by specialty, name, location, or other details to access a listing of providers that fit your criteria. Or, you can create your own personalized provider directory to download and print.

To access the directory, go to PacSrc.co/findadoc.

Find more information at PacSrc.co/extras.

Please note: These value-added programs are not available with all plans. Check with your plan administrator or our Customer Service team for details.

Get care when traveling

Tips for when you need medical attention or emergency services.

Always carry your PacificSource member ID

Your member ID card lets providers know you're covered and includes helpful network and contact information. The myPacificSource app features a convenient way to carry your member ID on your phone. Learn more and download at PacSrc.co/mobile-app.

When traveling in the US

Whenever possible, see an in-network provider: Either from our four-state network while in Idaho, Montana, Oregon, and Washington; or across the US through our collaboration with Aetna Signature Administrators®. Find in-network doctors at PacSrc.co/dr-search.

When traveling outside of the US, or seeing an out-of-network provider

Contact us if hospitalized

If you're admitted to a hospital, notify us at **888-691-8209** (country code 001) as soon as possible.

Pay for the services you receive

PacificSource will reimburse you for the itemized services that are covered under your plan, up to the amount specified by your plan.

Get an itemized bill

The bill must include an itemized list of all services performed, the date of services, a diagnosis, and the fees charged for services.

Have information translated into English, if possible

This will speed up the reimbursement process. If you're unable to have the information translated, our translation service will do so.

Submit your bill to PacificSource for reimbursement

Email, mail, or fax us your itemized bill. Make sure to include the member's name, member ID number, and group number.

We'll process the claim and determine if you owe any additional money. We'll mail you a reimbursement check if one is due. Please confirm that we have your correct mailing address.

Services may require prior authorization

Medical services received while outside the United States, except unexpected illness or injury while traveling or residing out of the country, require prior authorization from PacificSource and might not be covered. Please see your plan materials for more information, or call us at **888-691-8209.**

Questions?

We're happy to help.

Email

CS@PacificSource.com

Phone

888-977-9299
TTY: 711
We accept all relay calls.
En Español 866-281-1464

PacificSource.com

PacificSource HEALTH PLANS

Assist America® global emergency services

If you experience an emergency while traveling 100 or more miles from home or outside the US, you can access services provided by Assist America at no cost. Services include filling a prescription that was left at home, finding medical care in another country, locating lost luggage, and pre-trip safety and security checks for your destination country.

Assist America is for:

- Business and pleasure travel
- All members, including spouses and dependents enrolled in a PacificSource medical plan
- Travel periods of 90 days or less

Medical emergency services include:

- Medical consultation, evaluation, and referral
- Foreign hospital admission assistance
- Emergency medical evacuation
- Critical care monitoring and communication
- Escorted medical repatriation to home or rehab facility
- Prescription assistance

Travel assistance services include:

- Care for minor children and transportation costs
- Transportation for a visit from a family member or friend
- Return of mortal remains
- Return of vehicle
- Emergency message transmission

Download the Assist America mobile app

Access a wide range of global emergency assistance services with the Assist America mobile app for iPhone® and Android®.

Features include:

- Phone or Wi-Fi calls to Assist America's 24/7 Operations Center
- Country-specific information to prepare for your trip
- Alerts on urgent global situations that may impact travel
- Locate the nearest embassy/consulate of 23 countries
- Find local pharmacies near you (when traveling in the US)
- Your Assist America mobile ID card

Scan the QR code or visit your mobile device's app store to download the Assist America app. When prompted for your reference number, enter **01-AA-PSH-10073.**

Scan to download the app.

ANDROID APP ON Google play

Available on the App Store

How to access Assist America services

You'll need your Assist America reference number to access services or set up the mobile app. Your Assist America reference number is: **01-AA-PSH-10073.** When contacting them for services, Assist America will ask for your PacificSource Member ID information to verify that you are a PacificSource Health Plans member. Your Member ID can be found on your Member ID card, the myPacificSource app, or by signing into your member portal, InTouch, at PacSrc.co/intouch.

For more details, visit PacSrc.co/assist-america.

DENTAL

2026 Delta Dental PPO Benefit Summary

Delta Dental of Oregon & Alaska

Crook County

Delta Dental Custom Passive PPO 100/100/50/2000_PF

	PPO provider	Premier provider	Out-of-network non-participating provider
Annual Maximum Benefit**			
Per member		$2,000	
Deductible			
Per member		$0	
Per family		$0	
Class 1*			
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 services.

** Preventive care other than cone beam x-rays does not accumulate to the annual max.

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.DeltaDentalOR.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 or comprehensive examinations or consultations covered twice in a calendar year. Supplementary bitewing x-rays are covered once in any 12-month period. 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 twice in a calendar year for members until age 19. For members age 19 and older, topical application of fluoride is covered twice in a calendar year if there is a recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment. 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 a 5-year period on any tooth.
- **Prosthodontic** A bridge or denture (full or partial, including alternate benefits) will be covered once in a 5-year period only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the last 5 years. Specialized or personalized prosthetics are limited to the cost of standard devices.
- **Occlusal guard** (nightguard) covered at 100% once in a 5-year period, up to $200 maximum. Over-the-counter nightguards are excluded.
- **Athletic mouthguard** covered at 50% once in any 12-month period for members age 15 and under and once in any 2-year period age 16 and over. Over-the-counter athletic mouthguards are excluded.

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 (e.g. nitrous oxide) 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 the dentist’s office.
- Plaque control and oral hygiene or dietary instructions.
- Experimental procedures.
- Missed appointment charges.
- Precision attachments.
- 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.

2026 Delta Dental Ortho Benefit Summary

Delta Dental of Oregon & Alaska

Adult & Child Ortho AC1500

Lifetime maximum benefit	$1,500
	What members pay
Members age 19+	50%
Members under age 19	50%

Eligible Employees and their covered dependents

How to use this dental plan
When you visit your dental provider, tell them you are a Delta Dental member.

Pre-determination
Your dental office can submit a pre-treatment plan to Delta Dental of Oregon on your behalf. We will return it to them indicating the dollar allowance which will be covered by your plan before you go forward with treatment.

Delta Dental of Oregon & Alaska

DELTA DENTAL®

MEMBER DASHBOARD

Get your benefits on the go

As a member, you have a personalized Member Dashboard that puts the information you need at your fingertips.

What's in the Member Dashboard?

The Member Dashboard is a one-stop resource for all you need to get the most out of your plan, including:

- ID cards
- Claim status
- Benefits overview
- Provider search
- Calculate costs
- Explanation of Benefits (EOBs)
- Customer service contact information

OVER→

If you don't have a Member Dashboard account, creating one is easy. Go to deltadentalOR.com and enter your information. Be sure to have your member ID card handy.

Access the Member Dashboard on your smartphone

The easiest way to open the Member Dashboard is to add a shortcut on your phone. Anytime you want to access your benefits or resources, just tap the Member Dashboard icon.

On an iPhone

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

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

On an Android device:

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

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

Questions?

We're here to help. Call us toll-free at 888-217-2365. TTY users, please call 711.

1619 OR (6/21)

HEALTH REIMBURSEMENT ARRANGEMENT VEBA

For those enrolled on the $3000 Navigate Network plan only. Please see page 9 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 SAVINGS ACCOUNT BPAS

Grandfathered for employees enrolled prior to January 1, 2025

For those enrolled on the HSA $2000 Navigate Network plan only. Please see page 9 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. Contributions 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.

2026 HSA Contribution limit *(employer and employee)*	Self Only: $4,400 Family: $8,750
HSA Catch-Up Contribution *(Age 55 or older)*	$1,000

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

FLEXIBLE SPENDING ACCOUNT (FSA)

For those enrolled in the FSA & DCA Accounts:

The Flexible Spending Account (FSA):

You can use your FSA funds to pay for a variety of expenses for you, your spouse, and your dependents.

You can use your FSA funds for:
Out of pocket Medical expenses such as: Deductibles, Copays, etc
Vision Care: Eye exams, Prescription sunglasses, contact lenses, etc
Dental Care: Copays, orthodontia, dentures, etc
Products at the Store or the FSA Store: www.fsastore.com

2026 FSA Contribution Limit:	$3,400	
2026 Rollover from 2025:	$660	($680 in 2026)

FSA store

The Dependent Care Account (DCA) can be used for:

Daycare costs
After school programs
Summer Camps

2026 DCA Limit:	$7,500

FREQUENTLY ASKED QUESTIONS

ABOUT FLEXIBLE SPENDING ACCOUNTS

A Flexible Spending Account (FSA) is a tax-advantaged account offered by employers that allows employees to pay for eligible out-of-pocket healthcare and dependent care expenses with pre-tax dollars. FSAs are exempt from federal taxes, Social Security (FICA) taxes and state income taxes.[1]

Common Types of Flexible Spending Accounts

Health Flexible Spending Account (Health FSA)
allows employees to pay for eligible healthcare expenses not covered by insurance with pre-tax dollars.[2]

Limited Purpose Flexible Spending Account (LPFSA)
allows employees to pay for eligible dental, vision and preventive care expenses not covered by insurance with pre-tax dollars.[2]

Dependent Care Flexible Spending Account (DCFSA)
allows employees to pay for qualified dependent care services (e.g., daycare) with pre-tax dollars.

FSA General Questions

Q What are the general features and tax benefits of a Health FSA?[1,2]

- Your contributions are pre-tax or tax-deductible.
- You get immediate access to the full amount of your annual election amount on the first day of your plan year.
- Tax-free distributions are used to pay for qualified medical expenses.

FSA dollars can be used during the plan year; however, they may not carry over from year to year depending on your employer's plan.

For more details, please refer to the "Additional FSA Questions" section at the end of this document.

Q Why should I enroll in an FSA?

With an FSA, your out-of-pocket health and/or dependent care expenses are paid with tax-free dollars.[1]

Q Can I use my FSA to pay for family members' eligible expenses?

You can use your FSA to pay for eligible expenses incurred by you, your spouse and your eligible dependents. Eligible dependents include qualifying children and may include domestic partners if they qualify as a tax dependent.[1]

Q Can I change my FSA election mid-year?

Certain change-in-status events (e.g., marriage, divorce, birth, death, or a change in the cost of dependent care) may allow you to change your election amount.[1] Please refer to your employer's Plan Document for further guidance on qualifying change-in-status events that may impact you.

There is a wide range of healthcare expenses that are eligible for reimbursement under a Health FSA.

Q What are eligible Health FSA expenses?[3]

There is a wide range of healthcare expenses (e.g., medical, dental, co-pays, vision care products and services, office visits, lab work and immunizations) that are eligible for reimbursement under a Health FSA.[1]

Important Note: Expenses are treated as having been incurred at the time the medical care was provided, not when you are formally billed, charged, or pay for the medical expenses. You cannot receive reimbursement for future or projected expenses. All submitted expenses are reviewed for eligibility according to Internal Revenue Code Section 125 guidelines.

Please consult IRS publication 502 available at **http://www.irs.gov/pub/irs-pdf/p502.pdf** for reference.

For informational purposes only, you may also reference the FSA and HSA Eligible Expenses List (213(d) Eligible Expenses), for a summary of common expenses claimed against Health Flexible Spending Accounts (Health FSAs) and Health Savings Accounts (HSAs), in the "My Resources" tab on the PNC BeneFit Plus Consumer Portal.

Q Am I eligible to participate in a Dependent Care Flexible Spending Account (DCFSA)?

You should refer to your employer's Plan Document for DCFSA eligibility requirements. Most employers, however, offer the DCFSA benefit to eligible employees so they can remain gainfully employed. Employees can use the funds toward eligible expenses incurred for the care of qualifying individuals.

Q What are eligible DCFSA expenses?[1]

In order to remain gainfully employed, you may be required to incur expenses in connection with caring for qualifying individuals. Expenses related to daycare or certain household services may be considered eligible expenses.

For example, you may receive a tax benefit if you paid someone to care for your dependent under age 13, or for your spouse or a dependent who is unable to care for himself or herself.

Please consult IRS publication 503 available at **http://www.irs.gov/pub/irs-pdf/p503.pdf** for reference.

Q What is automatic dependent care reimbursement?

You may be reimbursed automatically for dependent care expenses by filling out one form instead of filing multiple claims throughout your plan year.

To set up automatic dependent care reimbursement, complete the Recurring Dependent Care Request Form (under the "Forms" section of the "My Resources" tab on the PNC BeneFit Plus Consumer Portal).

The Recurring Dependent Care Request Form needs to be completed each plan year. Changes can be made at any time by submitting an updated Recurring Dependent Care Request Form to PNC BeneFit Plus Consumer Services.

Q How do I access my account information?

Please follow these steps to access your account online:

Go to the PNC BeneFit Plus Consumer Portal login page at **participant.pncbenefitplus.com**

- If you are a new user, click the "Create your new username and password" link.
- If you forgot your username, click the "I forgot my username" link.
- If you forgot your password, click the "I forgot my password" link.

FSA Debit Card Questions

Q How does my PNC BeneFit Plus Debit Card work?

First, activate your card by calling the toll-free number on the activation sticker on your card and following the prompts. Your card allows you to directly access the funds set aside in your FSA and any other accounts you may have through your employer's benefits offering.

Simply use your card when making a purchase or paying for eligible expenses, rather than having to submit for reimbursement later. Remember to save all of your receipts.

Q Will I need a PIN?

Generally, you will not need a PIN to make purchases or pay for services. Just select "credit" at checkout and sign for your purchase. If you would like to use a PIN with your card to make purchases where entering a PIN is allowed, you may obtain a PIN during the card activation process. If you prefer, you can always request or reset a PIN by calling the number on the back of your card.

You may not use your debit card to obtain cash at an ATM or bank branch, nor to obtain cash back with a purchase transaction.

Q What dollar amount can be accessed by my card once it is activated?

Transactions are limited to the amount of money available in your account(s).

You can view your account balance by logging in to your account(s) at **participant.pncbenefitplus.com**, by using the PNC BeneFit Plus Mobile App[4] or by calling PNC BeneFit Plus Consumer Services using the phone number located on the back of your card (1-844-356-9993).

Q Where can I use my PNC BeneFit Plus Debit Card?

Health FSA — The PNC BeneFit Plus Debit Card can be used at healthcare-related merchants, such as hospitals, vision, dental, and doctor's offices. It can also be used at drugstores, pharmacies, and grocery stores that have implemented the IIAS (Inventory Information Approval System) or certified 90% of their gross sales are FSA eligible (see "My Resources" tab on the PNC BeneFit Plus Consumer Portal). As always, save itemized receipts, bills, or statements any time you use your card.

Dependent Care FSA — The PNC BeneFit Plus Debit Card may be used at daycare providers that accept Visa and have a valid merchant category code signifying they are a daycare provider. The debit card may not be used if you pre-pay daycare expenses, since the expense must be incurred before reimbursement can be made from your DCFSA.

Q Whom do I call for questions about my card or if I want additional cards for my dependents?

You may request additional debit cards for your eligible dependents (age 18 or older) online through the PNC BeneFit Plus Consumer Portal (see "Profile" tab). You can call PNC BeneFit Plus Consumer Services using the phone number shown on the back of your card (1-844-356-9993) with any questions.

Q Why might I be asked to provide documentation for a PNC BeneFit Plus Debit Card purchase? Wasn't my payment already approved?

PNC is required to obtain itemized receipts for transactions that are not automatically substantiated at the point of sale. Remember to save all of your receipts. If additional documentation is required to substantiate and approve the claim, PNC will send requests for documentation.

Should a charge remain unsubstantiated 60 days after the date of the card transaction, the debit card will be suspended and placed in a temporary hold status. The debit card will be re-activated as soon as the necessary documentation has been received to substantiate the expense.

Download the **PNC BeneFit Plus Mobile App** today

Download on the App Store · GET IT ON Google Play

Download the PNC BeneFit Plus Mobile App today

1. Go to the App Store® or Google Play™
2. Search for "PNC BeneFit Plus"
3. Download the PNC BeneFit Plus Mobile App

Q What if my card is lost or stolen?

Call the PNC BeneFit Plus Customer Service Center number on the back of your card (1-844-356-9993) to report your card lost or stolen as soon as you realize it is missing. PNC will cancel your current card(s) and issue replacement card(s) to you. You can also report your card lost or stolen via your PNC BeneFit Plus Mobile App[4] or on the PNC BeneFit Plus Consumer Portal at **participant.pncbenefitplus.com**.

If you identify transactions that you do not recognize or did not make, you will need to provide us with a completed dispute form within ninety (90) days after the unauthorized transaction was debited or credited to your account. Please refer to the PNC BeneFit Plus Debit Card Agreement for details.

Filing FSA Claims

Q If I don't use my PNC BeneFit Plus Debit Card for a medical expense, how can I reimburse myself?[3]

If you do not use your PNC BeneFit Plus Debit Card, you may conveniently file claims for reimbursement in several ways:

- **File an online claim.** First, log in to your account. Click on the file claim link on your homepage and follow the steps to enter the details of the claim. You can easily upload any required supporting documentation during the claim filing process.
- **File your claim using the PNC BeneFit Plus Mobile App.**[4] Follow the prompts on your mobile device to complete the claim. You can take a picture of any supporting documentation and securely attach it to your mobile claim for processing.
- **File your claim using the Reimbursement Request Form** (available on the "My Resources" tab). Follow the provided instructions to complete this form. Claims and copies of your supporting documentation can be sent to:

  Mail: PNC BeneFit Plus Consumer Services
  P.O. Box 2865, Fargo, ND 58108-2865

  Fax Number: 855-628-5950

Q What type of documentation is acceptable for reimbursement or substantiation?

Documentation for Health FSA expenses includes a third-party receipt or Explanation of Benefits containing the following information:

- Date(s) of service or purchase(s) made
- Type(s) of service or name(s) of item(s) purchased
- Dollar amount(s) (after insurance, if applicable)[1]

For example, an Explanation of Benefits from your insurance company or itemized statements from the provider are excellent documentation.

Documentation for Dependent Care FSA (DCFSA) expenses includes a third-party receipt containing the following information:

- Date(s) of service
- Dollar amount
- Name of daycare provider

When submitting a receipt for a copayment amount, please be sure the copayment description is on the receipt.

Q What is the "run out" period?

The "run out" is a specified period of time after the end of the plan year, or following your termination in the plan, during which you may continue to submit claims incurred during your period of coverage. This is not a period when you are able to continue to incur new expenses, but rather it allows you time to gather and submit expenses before forfeitures are applied.

For example, if your plan has a 90-day "run out" period, you will have 90 days from your date of termination to submit expenses incurred prior to the termination date.

You should refer to your employer's Plan Document for an explanation of how balances will be handled in your FSA.

Additional FSA Questions

Q What happens to my FSA if I terminate employment?

Participation in an FSA ends if you terminate employment. This means only expenses incurred prior to the date your participation in the plan ends are eligible for reimbursement. Claims for expenses incurred prior to the termination of your employment must be submitted for reimbursement within the "run out" period. The run out period is explained in your employer's Plan Documents.

Q What happens if I do not use all the money in my account by the end of the plan year?

You should refer to your employer's Plan Document for an explanation of how balances will be handled in your FSA. Depending on your employer's plan, you may:

- Have a grace period of up to 2½ months after your plan year ends during which you can continue to incur eligible expenses and any funds left in your account.
- Forfeit any money left unspent in your account at the end of your plan year. This is more commonly known as the "use-it-or-lose-it" rule.
- Carry over up to $660 left in your account from one plan year to the next.

Check with your employer's Plan Document to determine what is applicable for you.

Ready to Help

For more information:

- Visit **pnc.com/pncbenefitplus**
- Call PNC BeneFit Plus Consumer Services at **844-356-9993**
- Contact your employer

1 PNC does not provide legal, tax or accounting advice. Consult your tax advisor about tax benefits applicable to Health Savings Accounts or other benefit accounts such as FSAs, HRAs or QTAs.

2 To view current IRS annual contribution limits for FSAs, see IRS Publication 969, available at http://www.irs.gov/pub/irs-pdf/p969.pdf

3 To view a partial list of qualified medical expenses, see IRS Publication 502, available at http://www.irs.gov/pub/irs-pdf/p502.pdf

4 Standard message and data rates may apply.

WKP PDF 1024-0150-2564301

FREQUENTLY ASKED QUESTIONS

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Families often need help with child and elder care. A Dependent Care Flexible Spending Account (DCFSA) lets you save on dependent care expenses using pre-tax dollars.[1] You can spend your dependent care account funds on a wide range of care for eligible members of your family. Some of the expenses covered include adult day care, child day care, babysitting, before- and after-school programs, and sick child care.

General

Q Why should I enroll in a DCFSA?

With a DCFSA, you use pre-tax dollars to pay qualified out-of-pocket dependent care expenses. The money you contribute to a DCFSA is not subject to payroll taxes, so you end up paying less in taxes and taking home more of your paycheck.

- Reduce your overall tax burden[2] – funds are withdrawn from your paycheck for deposit into your account before taxes are deducted. For example, someone in the 30% tax bracket who sets aside $1,000 annually will save $300.
- Take advantage of several convenient payment and reimbursement options.

Q What qualifies as dependent care?

Eligible expenses are daycare expenses for eligible dependents that are incurred so that a single parent or both married parents can work. To qualify, a single parent or both married parents must be employed, or the spouse must be a full-time student.

If you're married and you file a joint return, or you file a single or head-of-household return, the annual IRS limit is $5,000. If you're married and file separate returns, you can each elect $2,500 for the calendar year.

Eligible dependents include:

- Children under age 13 who are claimed as a dependent for tax purposes
- Care of a disabled spouse or disabled dependent of any age

Ineligible expenses:

- Costs already claimed as a dependent care tax credit on your income tax return
- Nursing home, respite care or other residential care centers
- Nighttime babysitting expenses that are not work related
- Expenses while absent from work for more than two weeks at a time
- Costs paid to your own dependents, under age 19, who are caring for your dependents
- Expenses paid for schooling for kindergarten or higher

You can spend your dependent care account funds on a wide range of care for eligible members of your family.

Contributions

Q How much can I contribute to my DCFSA?

Your election may not exceed the maximum amount specified in Section 129 of the Internal Revenue Code. Currently, the maximum annual amount is $5,000 per year ($2,500 each if you are married and file separate returns). Your maximum allocation may not exceed the earned income limitation. If you are single, the earned income limitation is your salary (excluding your contributions to the plan). If you are married, the earned income limitation is the lesser between your salary (excluding your contributions to the plan) or your spouse's salary.

Q What if my spouse participates in a DCFSA?

Contribution limits are based on the IRS limits outlined on the previous page. Please note you may not "double-dip" expenses, meaning expenses reimbursed under your DCFSA may not be reimbursed under your spouse's DCFSA and vice versa.

Q Can I change the amount I contribute to my DCFSA during the year?

The amount you contribute to your DCFSA cannot be changed during the year unless you experience a change in status or a change in the cost or coverage of services.[3] As determined by the IRS, a change in status is an event that causes your dependent to meet or no longer meet eligibility requirements.

Eligible changes in status include:

- Change in legal marital status
- Change in number of dependents due to birth, adoption or death
- Change in employment status
- Change in cost or coverage charges

Qualified Dependents

Q Who qualifies as a dependent?

A qualifying dependent is defined by the IRS as:

- Your qualifying child who is your dependent and who was under age 13 when the care was provided
- Your spouse who was not physically or mentally able to care for himself or herself and lived with you for more than half the year
- A person who was not physically or mentally able to care for himself or herself, lived with you for more than half the year, and either was your dependent; or would have been your dependent except that he or she received a gross income of $3,900 or more, filed a joint tax return, or you (or your spouse if filing jointly) could be claimed as a dependent on someone else's tax return

Q If my child turns 13 this year, can I use the DCFSA for the whole year?

No, you may only submit claims for reimbursement for expenses incurred before your child reaches the age of 13.

Q My child is over age 13, has special needs, and is considered disabled. Can I still use my DCFSA to pay for his or her care?

Yes, the IRS allows that a dependent who is not physically or mentally able to care for himself or herself and lived with you for more than half the year qualifies. Since the dependent is over age 13, when submitting the claim on the PNC BeneFit Plus portal, select "Adult" under the category and "Adult Daycare" under the type of expense.

Q Are there special circumstances for divorced or separated parents?

If you are divorced or separated from your spouse and are a parent, IRS guidelines state that even if you cannot claim your child as a dependent, he or she is treated as a qualifying person if:

- The child was under age 13 or was not physically or mentally able to care for himself or herself
- The child received over half of his or her support during the calendar year from one or both parents who are divorced or legally separated under a divorce or separate maintenance decree, or are separated under a written separation agreement, or lived apart at all times during the last six months of the calendar year
- The child was in the custody of one or both parents for more than half the year
- You were the child's custodial parent

The "custodial parent" is the parent with whom the child lived for the greater number of nights during the past calendar year. If the child was with each parent for an equal number of nights, the custodial parent is the parent with the higher adjusted gross income. The noncustodial parent cannot treat the child as a qualifying person even if that parent is entitled to claim the child as a dependent under the special rules for a child of divorced or separated parents.

Check with your legal or tax advisor to see if special rules apply to you that would enable your child to be claimed by the noncustodial parent or by both parents.

Expenses

Q What if my eligible dependent care expenses during the plan year are less than the annual amount I have elected?

All money contributed to a DCFSA must be used to reimburse qualified expenses incurred during that plan year.

The unused portion of your DCFSA may not be paid to you in cash or other benefits, including transferring money between FSAs. Funds not used to reimburse eligible expenses by the end of the plan year are forfeited.

Q What are my payment or reimbursement options?

PNC makes it as easy as possible to use your DCFSA. You can pay for eligible expenses in two ways:

- Pay for the expense yourself: If your expenses are unpredictable or if you don't have sufficient funds in your account when it's time to pay for dependent care expenses, you can pay for the qualified expense from another source, and then submit a claim and be reimbursed via direct deposit to your personal bank account or by check.
  - You can submit your dependent care claim for reimbursement through the PNC BeneFit Plus portal, the PNC BeneFit Plus mobile application, or by mailing or faxing a Dependent Care Form to the PNC BeneFit Plus Service Center.[4]
- Pay with your PNC BeneFit Plus debit card: Pay for your dependent care expenses with your PNC BeneFit Plus debit card. Please note you can only pay up to the available balance in your account. It is also important to save your dependent care receipts and/or invoice as it may be required to fully substantiate your claim.

Q Do I have access to my entire DCFSA election amount at the beginning of the year?

No, you will only have access to DCFSA funds that have been deducted from your paycheck each pay period.

Q What happens if my claim amount is greater than the balance in my DCFSA?

If your claim amount that you submit is more than what you have in your DCFSA, you will be reimbursed up to the amount that is in your account, and the rest of your claim will be held until your account is funded. At that time, PNC BeneFit Plus will automatically reimburse you for the rest of your claim.

Download the **PNC BeneFit Plus Mobile App** today

Download on the App Store

GET IT ON Google Play

Download the PNC BeneFit Plus Mobile App today

1. Go to the App Store® or Google Play™
2. Search for "PNC BeneFit Plus"
3. Download the PNC BeneFit Plus Mobile App

Q Do I need to submit a claim request each month for my dependent care expenses?

Automatic dependent care enables participants to be automatically reimbursed for dependent care expenses by filling out one form instead of filing multiple claims throughout your plan year.

Automatic dependent care works in one of two ways:

1. If the cost of care per month *meets or exceeds* your monthly payroll deduction, reimbursement will be issued as payroll deductions to your DCFSA.
2. If the cost of care is *less* than your monthly payroll deductions, reimbursement will be made once per month at the end of the month.

To set up automatic dependent care reimbursement, complete the FSA Automatic Dependent Care Request Form. To download the form, log in to your account and visit the Tools and Support tab.

The FSA Automatic Dependent Care Request Form needs to be completed each plan year. Changes can be made at any time by submitting an updated FSA Automatic Dependent Care Request Form.

Automatic dependent care enables participants to be automatically reimbursed for dependent care expenses by filling out one form instead of filing multiple claims throughout your plan year.

Please consult with a tax advisor to determine whether the FSA plan or the dependent care tax credit is more beneficial in your individual case. Generally, the higher your income, the more beneficial it is to participate in the DCFSA.

Q Is tuition an eligible dependent care expense?

No, fees associated with kindergarten as well as tuition for children in first grade and above are not eligible for reimbursement under a DCFSA. Expenses related to before- and after-school care or nursery school expenses are eligible if the care is primarily custodial in nature.

Q If I participate in the DCFSA, will I still be able to claim the household and dependent care credit on my federal income tax return?

You cannot claim a dependent care tax credit for amounts received under an employer's FSA plan. Please consult with a tax advisor to determine whether the FSA plan or the dependent care tax credit is more beneficial in your individual case. Generally, the higher your income, the more beneficial it is to participate in the DCFSA.

Ready to Help

For more information on your Flexible Spending Account options, please visit **pnc.com/pncbenefitplus**, call PNC BeneFit Plus Consumer Services at **844-356-9993** and/or contact your employer.

Eligibility information based on IRS Publication 503 available at http://www.irs.gov/pub/irs-pdf/p503.pdf unless otherwise noted.

1 PNC does not provide legal, tax or accounting advice. Consult your tax advisor about tax benefits applicable to Flexible Spending Accounts.

2 Your tax savings will vary based on your specific tax bracket and state of residence. See the IRS Federal Tax Rates on www.irs.gov to calculate your own savings rate.

3 Please consult IRS Regulations regarding Section 125 plans at https://www.irs.gov/pub/irs-regs/td8878.pdf for reference.

4 Standard message and data rates may apply.

CIB TM PDF 0722 080 2086402

pnc.com/pncbenefitplus

PNC

LIFE INSURANCE
Basic Life
& Voluntary Life

United of Omaha Life Insurance Company
A Mutual of Omaha Company

› Term Life Insurance

Help Protect What Matters – You, Your Family & Your Future

We understand you've worked hard to get where you are today. Ensuring your loved ones can maintain financial stability if an unexpected death should occur is something to consider when planning for the future.

We've Got You Covered

As an active employee of Crook County, you have access to a life insurance policy from United of Omaha Life Insurance Company.

It replaces the income you would have provided, and helps pay funeral costs, manage debt and cover ongoing expenses.

How much insurance is enough?

When determining how much life insurance you need, think about the expenses you may encounter now and through every stage of your life.

Coverage guidelines and benefits are outlined in the chart below.

ELIGIBILITY - ALL OTHER ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by the policyholder. There is no cost to you for this insurance.
BENEFITS	
Life Insurance Benefit Amount	For You: An amount equal to 1 times your annual salary, but in no event less than $10,000 or more than $150,000 In the event of death, the benefit paid will be equal to the benefit amount after any age reductions less any living care/accelerated death benefits previously paid under this plan.
Accidental Death & Dismemberment (AD&D) Benefit Amount	For You: The Principal Sum amount is equal to the amount of your life insurance benefit.
FEATURES	
Living Care/ Accelerated Death Benefit	80% of the amount of the life insurance benefit is available to you if terminally ill, not to exceed $120,000.

Waiver of Premium	If it is determined that you are totally disabled, your life insurance benefit will continue without payment of premium, subject to certain conditions.
Additional AD&D Benefits	In addition to basic AD&D benefits, you are protected by the following benefits: - Seat Belt - Airbag
Conversion	If your employment or class membership ends, you may apply for an individual life insurance policy from Mutual of Omaha without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
SERVICES	
Travel Assistance	The Travel Assistance program is an added benefit that provides assistance for your travels over 100 miles away from home or outside the country.
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.
Will Prep Services	We work with Epoq, Inc. to offer employees online will prep tools. In just a few clicks you can complete a basic will or other documents to protect your family and property. To get started visit www.willprepservices.com.

United of Omaha Life Insurance Company
A Mutual of Omaha Company

› Voluntary Term Life Insurance

Help Protect What Matters – You, Your Family & Your Future

We understand you've worked hard to get where you are today. Ensuring your loved ones can maintain financial stability if an unexpected death should occur is something to consider when planning for the future.

We've Got You Covered

As an active employee of Crook County, you have access to a life insurance policy from United of Omaha Life Insurance Company.

It replaces the income you would have provided, and helps pay funeral costs, manage debt and cover ongoing expenses.

How much insurance is enough?

When determining how much life insurance you need, think about the expenses you may encounter now and through every stage of your life.

Coverage guidelines and benefits are outlined in the chart below.

ELIGIBILITY - ALL OTHER ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.
Dependent Eligibility Requirement	To be eligible for coverage, your dependents must be able to perform normal activities, and not be confined (at home, in a hospital, or in any other care facility), and any child(ren) must be under age 26. In order for your spouse and/or child(ren) to be eligible for coverage, you must elect coverage for yourself.
Premium Payment	The premiums for this insurance are paid in full by you.

COVERAGE GUIDELINES			
	Minimum	**Guarantee Issue**	**Maximum**
For You	$10,000	5 times annual salary, up to $100,000	$500,000, in increments of $10,000, but no more than 5 times annual salary
Spouse	$5,000	100% of employee's benefit, up to $30,000	50% of employee's benefit, in increments of $5,000, up to $250,000
Child(ren)	$2,000	100% of employee's benefit	50% of employee's benefit, in increments of $1,000, up to $10,000

Subject to any reductions shown below. Guarantee Issue is available to new hires. Amounts over the Guarantee Issue will require a health application/evidence of insurability. For late entrants, all amounts will require a health application/evidence of insurability.

BENEFITS	
Life Insurance Benefit Amount	Within the coverage guidelines defined above, you select the amount of life insurance coverage you want. This plan includes the option to select coverage for your spouse and dependent child(ren). Child(ren) include those up to age 26. In the event of death, the benefit paid will be equal to the benefit amount after any age reductions less any living care/accelerated death benefits previously paid under this plan.
Accidental Death & Dismemberment (AD&D) Benefit Amount	For you, your spouse and your dependent child(ren): The Principal Sum amount is equal to the amount of the life insurance benefit. AD&D coverage is available if you or your dependents are injured or die as a result of an accident, and the injury or death is independent of sickness and all other causes. The benefit amount depends on the type of loss incurred, and is either all or a portion of the Principal Sum.
FEATURES	
Living Care/ Accelerated Death Benefit	80% of the amount of the life insurance benefit is available to you and your spouse if terminally ill, not to exceed $400,000.
Waiver of Premium	If it is determined that you are totally disabled, your life insurance benefit will continue without payment of premium, subject to certain conditions.
Annual Benefit Amount Increase	If you enroll for even the minimum amount of coverage during your initial enrollment, you have the ability to increase your coverage at your next enrollment by up to $10,000, provided the total amount of insurance does not exceed your maximum benefit amount. This feature allows you to secure additional life insurance protection in the event your needs change (ex. you get married or have a child). Amounts over the Guarantee Issue will require evidence of insurability (proof of good health).
Additional AD&D Benefits	In addition to basic AD&D benefits, you are protected by the following benefits: - Seat Belt - Airbag
Portability	Allows you to continue this insurance program for yourself and your dependents should you leave your employer for any reason, without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
Conversion	If your employment or class membership ends, you may apply for an individual life insurance policy from Mutual of Omaha without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
SERVICES	
Travel Assistance	The Travel Assistance program is an added benefit that provides assistance for your travels over 100 miles away from home or outside the country.
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.
Will Prep Services	We work with Epoq, Inc. to offer employees online will prep tools. In just a few clicks you can complete a basic will or other documents to protect your family and property. To get started visit www.willprepservices.com.

Voluntary Term Life and AD&D Coverage Selection and Premium Calculation

Please note that the premium amounts presented below may vary slightly from the amounts provided on your enrollment form, due to rounding.

To select your benefit amount and calculate your premium, do the following:

1) Locate the benefit amount you want from the top row of the employee premium table. Your benefit amount must be in an increment of $10,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.
2) Find your age bracket in the far left column.
3) Your premium amount is found in the box where the row (your age) and the column (benefit amount) intersect.
4) Enter the benefit and premium amounts into their respective areas in the Voluntary Life and AD&D section of your enrollment form.

If the benefit amount you want to select is greater than any amount in the table below, select the benefit amount from the top row that when multiplied by another number results in the benefit amount you want. For example, if you want $150,000 in coverage, you obtain your premium amount by multiplying the rate for $50,000 times 3.

EMPLOYEE PREMIUM TABLE (12 PAYROLL DEDUCTIONS PER YEAR)										
Age	**$10,000**	**$20,000**	**$30,000**	**$40,000**	**$50,000**	**$60,000**	**$70,000**	**$80,000**	**$90,000**	**$100,000**
0 - 34	$1.00	$2.00	$3.00	$4.00	$5.00	$6.00	$7.00	$8.00	$9.00	$10.00
35 - 39	$1.30	$2.60	$3.90	$5.20	$6.50	$7.80	$9.10	$10.40	$11.70	$13.00
40 - 44	$1.90	$3.80	$5.70	$7.60	$9.50	$11.40	$13.30	$15.20	$17.10	$19.00
45 - 49	$2.80	$5.60	$8.40	$11.20	$14.00	$16.80	$19.60	$22.40	$25.20	$28.00
50 - 54	$5.30	$10.60	$15.90	$21.20	$26.50	$31.80	$37.10	$42.40	$47.70	$53.00
55 - 59	$8.20	$16.40	$24.60	$32.80	$41.00	$49.20	$57.40	$65.60	$73.80	$82.00
60 - 64	$9.60	$19.20	$28.80	$38.40	$48.00	$57.60	$67.20	$76.80	$86.40	$96.00
65 - 69	$10.90	$21.80	$32.70	$43.60	$54.50	$65.40	$76.30	$87.20	$98.10	$109.00
70 - 74	$16.00	$32.00	$48.00	$64.00	$80.00	$96.00	$112.00	$128.00	$144.00	$160.00
75+	$38.20	$76.40	$114.60	$152.80	$191.00	$229.20	$267.40	$305.60	$343.80	$382.00

Follow the method described above to select a benefit amount and calculate premiums for optional dependent spouse and/or child(ren) coverage. **Your spouse's rate is based on your age,** so find your age bracket in the far left column of the Spouse Premium Table. Your spouse's premium amount is found in the box where the row (the age) and the column (benefit amount) intersect. Your spouse's benefit amount must be in an increment of $5,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.

SPOUSE PREMIUM TABLE (12 PAYROLL DEDUCTIONS PER YEAR)										
Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**
0 - 34	$0.50	$1.00	$1.50	$2.00	$2.50	$3.00	$3.50	$4.00	$4.50	$5.00
35 - 39	$0.65	$1.30	$1.95	$2.60	$3.25	$3.90	$4.55	$5.20	$5.85	$6.50
40 - 44	$0.95	$1.90	$2.85	$3.80	$4.75	$5.70	$6.65	$7.60	$8.55	$9.50
45 - 49	$1.40	$2.80	$4.20	$5.60	$7.00	$8.40	$9.80	$11.20	$12.60	$14.00
50 - 54	$2.65	$5.30	$7.95	$10.60	$13.25	$15.90	$18.55	$21.20	$23.85	$26.50
55 - 59	$4.10	$8.20	$12.30	$16.40	$20.50	$24.60	$28.70	$32.80	$36.90	$41.00
60 - 64	$4.80	$9.60	$14.40	$19.20	$24.00	$28.80	$33.60	$38.40	$43.20	$48.00
65 - 69	$5.45	$10.90	$16.35	$21.80	$27.25	$32.70	$38.15	$43.60	$49.05	$54.50

ALL CHILDREN PREMIUM TABLE (12 PAYROLL DEDUCTIONS PER YEAR)*								
$2,000	**$3,000**	**$4,000**	**$5,000**	**$6,000**	**$7,000**	**$8,000**	**$9,000**	**$10,000**
$0.50	$0.75	$1.00	$1.25	$1.50	$1.75	$2.00	$2.25	$2.50

*Regardless of how many children you have, they are included in the "All Children" premium amounts listed in the table above.

LONG TERM DISABILITY

United of Omaha Life Insurance Company
A Mutual of Omaha Company

› Long-Term Disability Insurance

Your Ability to Earn an Income May Be Your Most Important Asset

Most people don't think twice about insuring their home, automobile or health. However, many people don't recognize just how important it is to insure their income.

We've Got You Covered

As an active employee of Crook County, you have access to a disability income insurance policy from United of Omaha Life Insurance Company.

A lengthy disability can be devastating, and is more common than you might think. It may lead to a loss of income, independence and financial security.

A disability income insurance policy can help provide security when you need it most. It pays you cash benefits when you're sick or hurt and can't work.

Coverage guidelines and benefits are outlined in the chart below.

ELIGIBILITY - ALL OTHER ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by the policyholder. There is no cost to you for this insurance.
BENEFITS	
Elimination Period	Your benefits begin on the later of 90 calendar days after the onset of your disabling injury or illness or the date your short-term disability ends.
Monthly Benefit	Your benefit is equivalent to 60% of your before-tax monthly earnings, not to exceed the plan's maximum monthly benefit amount less other income sources. The premium for your long-term disability coverage is waived while you are receiving benefits.
Maximum Monthly Benefit	$6,000
Minimum Monthly Benefit	$50

Maximum Benefit Period	If you become disabled prior to age 62, benefits are payable to age 65, your Social Security Normal Retirement Age or 3.5 years, whichever is longest. At age 62 (and older), the benefit period will be based on a reduced duration schedule.
Partial Disability Benefits	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits.
DEFINITIONS	
Own Occupation	2 Years
Own Occupation Earnings Test	99%
Definition of Monthly Earnings	Monthly earnings for salaried employees is the gross annual salary in effect immediately prior to the date disability begins, divided by 12. Monthly earnings for hourly employees is the hourly rate of pay multiplied by the average number of hours worked per month during the 6 month period immediately prior to the date disability begins. If employed for part of the prior 6 month period, monthly earnings is the hourly rate of pay multiplied by the average number of hours worked.
FEATURES	
Vocational Rehabilitation Benefit	If you become disabled and participate in the vocational rehabilitation program, you will be eligible for a monthly benefit increase of 10%.
Survivor Benefit	If you pass away while receiving disability benefits, a lump sum equal to 3 times your monthly benefit will be paid to your eligible survivor.
Reasonable Accommodation	Provides a benefit to the employer to assist in covering costs incurred to make workplace modifications for you to return to work.
SERVICES	
Travel Assistance	The Travel Assistance program is an added benefit that provides assistance for your travels over 100 miles away from home or outside the country.
Employee Assistance Program (EAP)	Mutual of Omaha's team of master's level EAP professionals are available 24/7/365 to provide you and your loved ones resources for assistance with personal and workplace issues. Access to EAP services is obtained by calling 1-800-316-2796 or by using an online submission form for employee convenience at www.mutualofomaha.com/eap. Online are valuable resources and links for additional assistance, including current events, family and relationships, emotional well-being, financial wellness, substance abuse and addiction, legal assistance and work and career.
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Public Safety EAP
A division of ESI

Police Department Only

Your EAP Benefit Summary

Each of us encounters personal problems from time to time. We partner with ESI EAP to provide you with the best possible solutions for issues you or your family may face. **Your EAP is here to help.**

The following free benefits are available for Employees and Family Members.

Counseling Benefits

Help from experienced Masters or Ph.D. level counselors for personal issues such as: relationships/ family, depression/anxiety, grief and more. Multiple counseling options include in-the-moment telephonic, live therapy through text messaging, chat, audio, and video, and in-person therapy.

Peak Performance Coaching

Personal and professional coaching is available from senior-level ESI coaches. Get one-to-one telephonic coaching and support, as well as online self-help resources and trainings.

Training And Personal Development Benefits

Access to our extensive library of online personal and professional development trainings in a variety of easy-to-use formats. Some training topics include: debt, budgeting, communication, business skills, working remotely, stress management, and emotional intelligence.

Talkspace Go App

A mobile app with 400+ self-guided, interactive programs, live weekly therapist-led anonymous classes, on demand sessions and more. The App empowers couples, individuals, and parents to improve their mental health in as little as five minutes a day.

Self-Help Resources

Access to thousands of tools, videos, webinars, self-assessments, financial calculators and informative articles covering virtually every issue you might face, such as adoption, relationships, legal and financial matters, cancer and other illnesses, and more.

Work/Life Benefits

Assistance for financial and legal issues, child & elder care, LGBTQIA+ issues, military life, and more.

Personal Research Assistant

Help for everyday issues, including finding a local medical or dental provider, summer camp options, pet care, and more.

Wellness Benefits

Videos and resources to improve you and your family's overall health, including fitness, nutrition, diet, tobacco cessation, sleep health, and information on illnesses.

Lifestyle Savings Benefit

Thousands of discounts, rewards, and perks in a variety of categories: Health & Wellness, Auto, Electronics, Apparel, Restaurants, Beauty & Spa, Flowers & Gifts, Sports & Fitness and more! Benefits are accessible from ESI's Member website.

Contact the EAP toll-free at **1.888.327.1060.** All calls are **CONFIDENTIAL** and answered by a Masters or Ph.D. level counselor; your counselor will work with you on a plan beginning with the first call. Or go to **www.PublicSafetyEAP.com** and create a username and password.

TotalCare EAP
A division of ESI

All Other Employees

Your EAP Benefit Summary

Each of us encounters personal problems from time to time. We partner with ESI EAP to provide you with the best possible solutions for issues you or your family may face. **Your EAP is here to help.**

The following free benefits are available for Employees and Family Members.

Counseling Benefits

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Contact the EAP toll-free at **800.252.4555.** All calls are **CONFIDENTIAL** and answered by a Masters or Ph.D. level counselor; your counselor will work with you on a plan beginning with the first call. Or go to **www.theEAP.com** and create a username and password.

TRAVEL ASSISTANCE

56134596

MUTUAL SOLUTIONS

WORLDWIDE TRAVEL ASSISTANCE THAT TRAVELS WITH YOU

Take comfort in knowing that Travel Assistance* travels with you worldwide, offering access to a network of professionals who can help you with local medical referrals or provide other emergency assistance services in foreign locations.

Enjoy Your Trip

We'll Be There If You Need Us — 24/7

Travel Assistance can help you avoid unexpected bumps in the road anywhere in the world. For you, your spouse and dependent children on any single trip, up to 120 days in length, more than 100 miles from home.

Pre-trip Assistance**

Minimize travel hassles by calling us pre-departure for:

- Information regarding passport, visa or other required documentation for foreign travel
- Travel, health advisories and inoculation requirements
- Domestic and international weather forecasts
- Daily foreign currency exchange rates
- Consulate and embassy locations
- Translation and Interpreter Services for emergency situations while traveling internationally

Emergency Travel Support Services

- **Telephonic translation and interpreter services —** 24/7 access to telephone translation services
- **Locating legal services —** referrals for local attorney or consular offices and help maintain business and family communications until legal counsel is retained (includes coordination of financial assistance for bonds/bail)
- **Baggage —** assistance with lost, stolen or delayed baggage while traveling on a common carrier
- **Emergency payment and cash —** assistance with advance of funds for medical expenses or other travel emergencies by coordinating with your credit card company, bank, employer, or other sources of credit; includes arrangements for emergency cash from a friend, family member, business or credit card
- **Emergency messages —** assistance with recording and retrieving messages between you, your family and/or business associates at any time
- **Document replacement —** coordination of credit card, airline ticket or other documentation replacement
- **Vehicle return —** if evacuation or repatriation is necessary, return your unattended vehicle to the car rental company

Mutual of Omaha

613210 *Brought to you by Mutual of Omaha Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175. Services provided by AXA Assistance USA (AXA)
**Available at any time, not subject to 100 mile travel radius

Worldwide Travel Assistance

Services available for business and personal travel.

For inquiries within the U.S. call toll free:
1-800-856-9947

Outside the U.S. call collect:
(312) 935-3658

Worldwide Travel Assistance

Services available for business and personal travel.

For inquiries within the U.S. call toll free:
1-800-856-9947

Outside the U.S. call collect:
(312) 935-3658

Medical Assistance

- Locating medical providers and referrals
- Communication on your medical status with family, physicians, employer, travel company and consulate
- Emergency evacuation if adequate medical facilities are not available, including payment of covered expenses
- Transportation home for further treatment – in the event of death, assist in the return of mortal remains
- Transportation arrangements for the visit of a family member or friend if your hospitalization is more than seven calendar days
- Return home for dependent children if your hospitalization is more than seven calendar days
- Assistance with lodging arrangements if convalescence is needed prior to, or after, medical treatment
- Coordination with your health insurance carrier during a medical emergency
- Assistance obtaining prescription drugs or other necessary personal medical items

Identity Theft

Your Travel Assistance benefit automatically includes Identity Theft Assistance, coordinated at no additional cost. Whether at home or traveling, this benefit provides education, prevention and recovery information to help you protect your identity.

Education and Prevention

- Comprehensive ID theft assistance guide
- Tips to defend against ID theft

Recovery Information

- Information regarding the steps to recover from credit card and check fraud
- Guidelines if your Social Security number is compromised
- Instructions for lost or stolen passport
- Contact list for financial institutions, credit bureaus and check companies

Assistance

If you need help with an ID theft issue, case managers are available 24 hours a day, seven days a week and can be reached by calling the same toll-free number used to contact AXA: 800-856-9947.

Travel Assistance Plan Limitations

AXA will not pay emergency evacuation, medically necessary repatriation, repatriation of remains or other expenses incurred while traveling within 100 miles of participant's place of residence, or for any one of the following reasons:

- A single trip lasts more than 120 days in length
- Traveling against the advice of a physician
- Traveling for medical treatment
- Pregnancy and childbirth (exception: complications of pregnancy)

There is a maximum benefit amount per person associated with emergency evacuation, medical repatriation and/or return of mortal remains.

All additional costs would be the responsibility of the member. This includes medical costs which are the responsibility of the person receiving medical services. Services must be authorized and arranged by AXA Assistance USA, Inc. designated personnel to be eligible for this program. No reimbursement claims for out-of-pocket expenses will be accepted.

Travel assistance services are independently offered and administered by AXA Assistance USA, Inc. (AXA). Insurance benefits provided as part of Travel Assistance underwritten by a third party. AXA is not affiliated in any way with Mutual of Omaha companies. Each company is responsible for its own financial and contractual obligations. There may be times when circumstances beyond AXA Assistance USA's control hinder its endeavors to provide services. AXA Assistance USA will make all reasonable efforts to help you resolve the emergency situation. Both companies are responsible for their own contractual and financial obligations. Additional limitations may apply. Please contact AXA for specifics.

Carry this card with you when you travel

Brought to you by Mutual of Omaha.
Services provided by AXA Assistance USA.

Carry this card with you when you travel

Brought to you by Mutual of Omaha.
Services provided by AXA Assistance USA.

Get care when traveling

Tips for when you need medical attention or emergency services.

Always carry your PacificSource member ID

Your member ID card lets providers know you're covered and includes helpful network and contact information. The myPacificSource app features a convenient way to carry your member ID on your phone. Learn more and download at PacSrc.co/mobile-app.

When traveling in the US

Whenever possible, see an in-network provider: Either from our four-state network while in Idaho, Montana, Oregon, and Washington; or across the US through our collaboration with Aetna Signature Administrators®. Find in-network doctors at PacSrc.co/dr-search.

When traveling outside of the US, or seeing an out-of-network provider

Contact us if hospitalized

If you're admitted to a hospital, notify us at **888-691-8209** (country code 001) as soon as possible.

Pay for the services you receive

PacificSource will reimburse you for the itemized services that are covered under your plan, up to the amount specified by your plan.

Get an itemized bill

The bill must include an itemized list of all services performed, the date of services, a diagnosis, and the fees charged for services.

Have information translated into English, if possible

This will speed up the reimbursement process. If you're unable to have the information translated, our translation service will do so.

Submit your bill to PacificSource for reimbursement

Email, mail, or fax us your itemized bill. Make sure to include the member's name, member ID number, and group number.

We'll process the claim and determine if you owe any additional money. We'll mail you a reimbursement check if one is due. Please confirm that we have your correct mailing address.

Services may require prior authorization

Medical services received while outside the United States, except unexpected illness or injury while traveling or residing out of the country, require prior authorization from PacificSource and might not be covered. Please see your plan materials for more information, or call us at **888-691-8209.**

Questions?

We're happy to help.

Email

CS@PacificSource.com

Phone

888-977-9299
TTY: 711
We accept all relay calls.
En Español 866-281-1464

PacificSource.com

PacificSource HEALTH PLANS

Assist America® global emergency services

If you experience an emergency while traveling 100 or more miles from home or outside the US, you can access services provided by Assist America at no cost. Services include filling a prescription that was left at home, finding medical care in another country, locating lost luggage, and pre-trip safety and security checks for your destination country.

Assist America is for:

- Business and pleasure travel
- All members, including spouses and dependents enrolled in a PacificSource medical plan
- Travel periods of 90 days or less

Medical emergency services include:

- Medical consultation, evaluation, and referral
- Foreign hospital admission assistance
- Emergency medical evacuation
- Critical care monitoring and communication
- Escorted medical repatriation to home or rehab facility
- Prescription assistance

Travel assistance services include:

- Care for minor children and transportation costs
- Transportation for a visit from a family member or friend
- Return of mortal remains
- Return of vehicle
- Emergency message transmission

Download the Assist America mobile app

Access a wide range of global emergency assistance services with the Assist America mobile app for iPhone® and Android®.

Features include:

- Phone or Wi-Fi calls to Assist America's 24/7 Operations Center
- Country-specific information to prepare for your trip
- Alerts on urgent global situations that may impact travel
- Locate the nearest embassy/consulate of 23 countries
- Find local pharmacies near you (when traveling in the US)
- Your Assist America mobile ID card

Scan the QR code or visit your mobile device's app store to download the Assist America app. When prompted for your reference number, enter **01-AA-PSH-10073.**

Scan to download the app.

ANDROID APP ON Google play

Available on the App Store

How to access Assist America services

You'll need your Assist America reference number to access services or set up the mobile app. Your Assist America reference number is: **01-AA-PSH-10073.** When contacting them for services, Assist America will ask for your PacificSource Member ID information to verify that you are a PacificSource Health Plans member. Your Member ID can be found on your Member ID card, the myPacificSource app, or by signing into your member portal, InTouch, at PacSrc.co/intouch.

For more details, visit PacSrc.co/assist-america.

AFLAC

Your benefits aren't complete without Aflac

Aflac for Crook County

The reality is that health insurance isn't designed to cover everything, which can leave you with unexpected medical bills. That's why there's Aflac. We can help with the expenses that health insurance doesn't cover.

Aflac supplemental insurance policies

Cancer/Specified-Disease Insurance

Aflac cancer/specified-disease policy provides robust benefits so you can seek the treatment you need while easing the financial concerns that often accompany it–before, during and after diagnosis.

Critical Illness (Specified Health Event) Insurance

An Aflac specified health event policy is designed to help with the costs of treatment if you experience a covered health event.

Accident Insurance

Individual accident insurance can help with unexpected expenses associated with an accidental injury, so you can focus on getting better.

Short-Term Disability Insurance

What if you couldn't work due to injury or illness? Aflac Short-Term Disability insurance helps replace some of your income and keeps working when you can't.

Hospital Confinement Indemnity Insurance

Health insurance isn't meant to cover all expenses associated with hospitalization – like deductibles and copays. Aflac hospital insurance can help minimize those out-of-pocket costs so you can focus on recovery.

Your open enrollment starts today.

Contact your Aflac benefits advisor:

Kate Thomas
541.382.4451
kate_thomas_group_inc@us.aflac.com

Aflac®

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Your benefits aren't complete without Aflac

1 **Aflac helps with expenses health insurance doesn't cover:** Health insurance pays doctors and/or hospitals. Aflac pays cash directly to you, unless assigned otherwise. You can use your benefits your way — whether it's for leftover medical bills or any other expense that affects your financial security.

2 **Aflac belongs to you, not your company:** When you have an Aflac insurance policy, it's yours. You own it. Even if you change jobs or retire, you can take your Aflac policy with you.

3 **Aflac is affordable:** Our policies are designed to help meet individual needs and budgets. We'll be there to help in your time of need when you're hurt or sick. And, Aflac rates don't go up even when you file a claim.

4 **Aflac processes claims quickly:** Aflac provides prompt service and fast payment of qualified claims to help you pay your bills. While you're focusing on your health, we focus on getting you cash as quickly as possible.

5 **Aflac is accountable:** Aflac has been named to Ethisphere's list of World's Most Ethical Companies[1] 17 years in a row *and FORTUNE's list of World's Most Admired Companies 22 times.*[2]

6 **Aflac cares:** For more than 28 years, Aflac has made helping children and families facing pediatric cancer and other blood disorders a key component of its mission to give back to the community. Aflac's more than $165 million commitment has positively affected both childhood cancer and rare blood disorders, including sickle cell disease. Much of Aflac's support comes from its independent sales agents who donate from their monthly commission checks, as well as Aflac employees who contribute each month through payroll deduction.

To learn more, contact your Aflac benefits advisor, Kate Thomas, , at 541-382-4451 or kate_thomas_group_inc@us.aflac.com.

Aflac®

[1]Ethisphere Magazine, March 2023.
[2]FORTUNE, 2023. World's Most Admired Companies are registered trademarks of Time Inc. and are used under License. FORTUNE and Time Inc. are not affiliated with, and do not endorse products or services of Aflac.
Aflac | WWHQ | 1932 Wynnton Road | Columbus, GA 31999.
Aflac New York | 22 Corporate Woods Boulevard, Suite 2 | Albany, NY 12211.
Z240028

EXP 1/25

MASA MEDICAL TRANSPORT

Download the MASA mobile app today!

Registration is easy with your member ID.

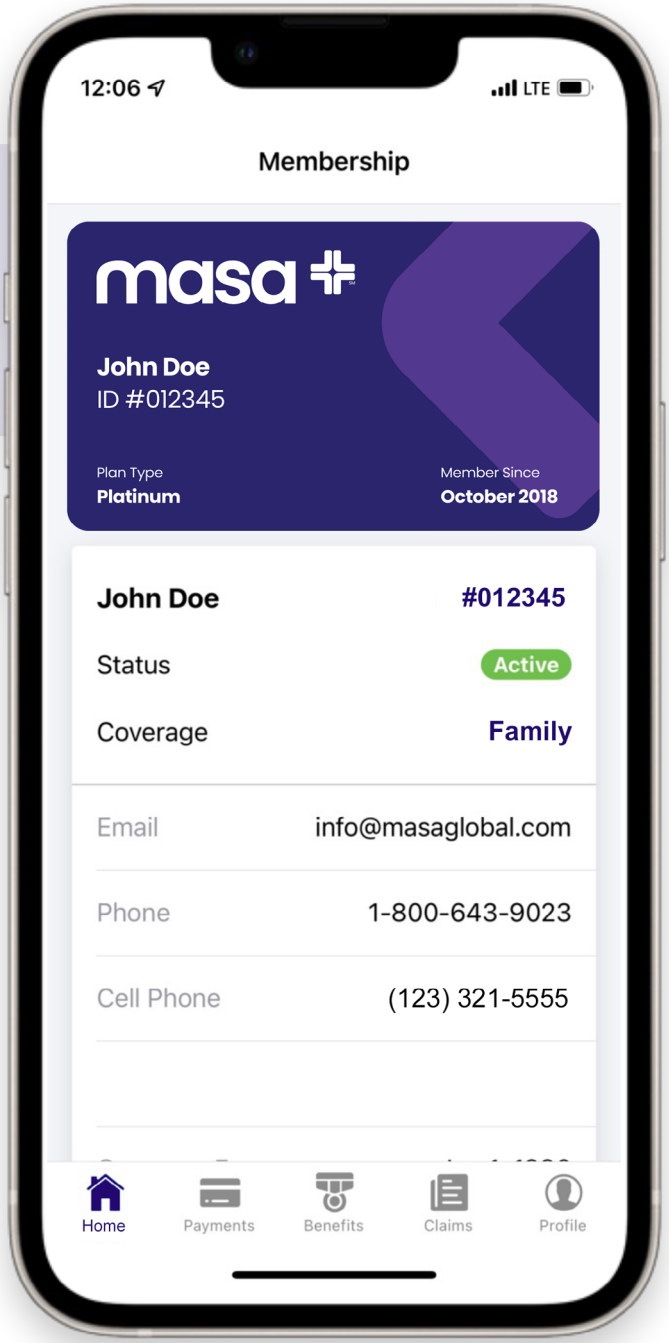
- Access your digital ID cards.
- View plan documents and benefits.
- View your claims history.

You now have access to emergency transportation solutions in the palm of your hand. The MASA App allows you to check and update your membership information, view payment history, immediately access benefits and to view up-to-the minute claims processing information, along with many more exciting features to come.

This one stop shop is a must have app for all MASA Global members, while at home or traveling.

Download on the App Store

GET IT ON Google Play



masa

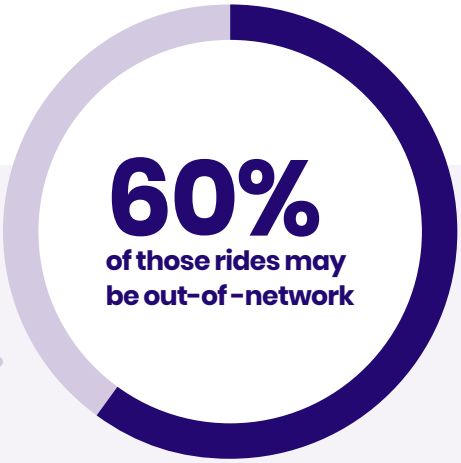
Why choose MASA?

MASA protects your finances and gives you compassionate support for medical transport.

No one should have to worry about transport bills during or after an emergency. Unfortunately — even for the insured — these costly bills have become a normal, expected part of emergency care and continue to rise every year.

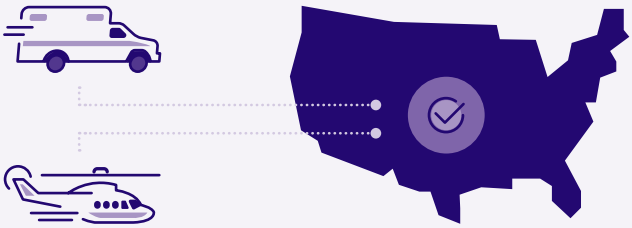
MASA is the simple solution to a complex problem for millions of Americans. As the leading provider of emergency and medical transport benefits, MASA supports members by protecting them from out-of-pocket costs for medical transport while also offering benefits for use during recovery and beyond.

1 in 15 families
need an ambulance each year



MASA has been trusted for over 50 years and supports 2 million members globally.

Emergency medical transports are covered nationwide — no network needed for MASA protection.



Specialized services for emergencies away from home are available — like return transports for the patient, their pets, vehicles, and children.

MASA claims team is focused on paying, not denying, with an easy process — just send us the bill.

Enroll today!

1: MASA, Emergency medical transportation: The true costs — and how they're rising, 2024
2: FAIR Health, 2023

masa Access

Compare plans

Get emergency medical transportation coverage to protect what matters most.

With a MASA plan, you'll have an additional layer of financial protection from the out-of-pocket costs of medical transportation. Explore the options below to compare the benefits offered in each plan.

Gain peace of mind and shield your finances knowing there's a MASA plan best suited for your needs.

		$14.00 mo. Family	$19.00 mo. Family	$29.00 mo. Single $39.00 mo. Family
		Emergent Plus plan	**Emergent Premier plan**	**Platinum plan**
Emergency Ground Ambulance Coverage		● [2]	● [2]	● [2]
Emergency Air Ambulance Coverage		● [2]	● [2]	● [2]
Hospital to Hospital Ambulance Coverage		● [2]	● [2]	● [2]
Repatriation to Hospital Near Home Coverage		● [2]	● [3]	● [4]
Post Admission Continued Care Transportation Coverage			● [1]	
Sick While Away From Home Expense Protection			● [4]	
Minor Return Transportation Coverage			● [3]	● [3]
Pet Return Transportation Coverage			● [3]	● [3]
Patient Return Transportation Coverage				● [4]
Companion Transportation Coverage				● [3]
Hospital Visitor Transportation Coverage				● [3]
Mortal Remains Transportation Coverage				● [4]
Vehicle & RV Return Coverage				● [3]
Organ Retrieval & Organ Recipient Transportation Coverage				● [1]

masa Access

Stay prepared with MASA® Access℠

Comprehensive coverage and care for emergency transport.

Our Platinum membership plan includes:

Emergency Ground Ambulance Coverage[2]

Your out-of-pocket expenses for your emergency ground transportation to a medical facility are covered with MASA.

Emergency Air Ambulance Coverage[2]

Your out-of-pocket expenses for your emergency air transportation to a medical facility are covered with MASA.

Hospital to Hospital Ambulance Coverage[2]

When specialized care is required but not available at the initial emergency facility, your out-of-pocket expenses for the ground or air ambulance transfer to the nearest appropriate medical facility are covered with MASA.

Repatriation to Hospital Near Home Coverage[4]

Should you need continued care and your care provider has approved moving you to a hospital nearer to your home, MASA coordinates and covers the expense for ambulance transportation to the approved medical facility.

Patient Return Transportation Coverage[4]

Once you're discharged from medical care and able to travel without medical transport, MASA coordinates and covers the costs associated with your commercial airline transport home.

Did you know?

51.3 million

emergency responses occur each year

MASA protects families against uncovered costs for emergency transportation and provides connections with care services.

Source: NEMSIS, National EMS Data Report, 2023

About MASA

MASA is coverage and care you can count on to protect you from the unexpected. With us, there is no "out-of-network" ambulance. Just send us the bill when it arrives and we'll work to ensure charges are covered. Plus, we'll be there for you beyond your initial ride, with expert coordination services on call to manage complex transport needs during or after your emergency — such as transferring you and your loved ones home safely.

Protect yourself, your family, and your family's financial future with MASA.

Companion Transportation Coverage[3]

MASA coordinates services and covers the cost for a companion to accompany you during your emergency air ambulance transport.

Hospital Visitor Transportation Coverage[3]

Should you be hospitalized more than 100 miles from home, MASA coordinates and covers the cost of round-trip air transportation for a companion to join you.

Minor Return Transportation Coverage[3]

In the event your minor child traveling with you is left unattended due to your emergency transport, MASA coordinates services and covers expenses to return your child safely home.

Pet Return Transportation Coverage[3]

If you are traveling with your pets and an emergency occurs requiring your medical transport, MASA coordinates services and covers expenses for returning up to two pets to your home.

Mortal Remains Transportation Coverage[4]

In the event that you pass away more than 100 miles from home, MASA coordinates services and covers the cost of air transport for your remains to be returned home.

Vehicle & RV Return Coverage[3]

Should a travel emergency occur requiring you to leave your vehicle or RV by ambulance, MASA provides services and covers expenses associated with returning your vehicle or RV to your home.

Organ Retrieval & Organ Recipient Transportation Coverage[1]

Should you need an organ transplant, MASA coordinates and covers the cost of getting you or the organ to the transplant location.

masa Access

Coverage territories

1: United States only.

2: United States and Canada.

3: United States, Canada, Mexico, the Caribbean (excluding Cuba), the Bahamas and Bermuda.

4: Worldwide coverage to include any region with the exclusion of Antarctica and not prohibited by U.S. law or under certain U.S. travel advisories as long as the member has provided ten (10) day notice.

Disclaimers

This material is for informational purposes only and does not provide any coverage. The benefits listed, and the descriptions thereof, do not guarantee coverage and do not represent the full terms and conditions applicable for usage and may only be offered in some memberships or policies. Premiums, benefits, and coverage vary depending on the plan selected. For a complete list of benefits, premiums, terms, conditions, and restrictions, please refer to the applicable member services agreement or policy for your state. For additional information and disclosures about MASA plans, visit: https://info.masamts.com/masa-mts-disclaimers

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 your plans benefit summaries in this Guide for specific plan information. If you would like more information on WHCRA benefits call your benefits administrator.

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 for more information.

MICHELLE'S LAW

Annual Notice

If a full-time student engaged in a postsecondary education loses full-time student status 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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)
Menu Option 4, Ext. 61565

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

Paperwork Reduction Act Statement

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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 the Benefits Administrator

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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a

"special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator. 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.

HIPAA Special Enrollment Notice

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health 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 under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this 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, 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 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, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this 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 your benefits administrator.
Kathy Puckett
Payroll Accountant/Benefits Administrator (541) 477-6554 ext 161
203 NE Court Street
Prineville OR 97754

NOTES

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.