WHA INSURANCE

Crook County
Benefits Resource Guide

PLAN YEAR | **2025**

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.

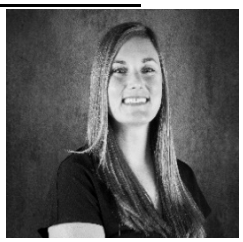
PRIMARY CONTACTS

RICHARD ALLM
CONSULTANT
rallm@whainsurance.com
DIRECT: (541) 284-5853
Cell: (503) 580-3185

KIM NICHOLSEN
ACCOUNT EXECUTIVE
knicholsen@whainsurance.com
DIRECT: (541) 284-5842

FULL TEAM

CHRISTINE WALLACE
ACCOUNT MANAGER
cwallace@whainsurance.com
DIRECT: (541) 284-5837



SAMANTHA BIANCO
ACCOUNT MANAGER
sbianco@whainsurance.com
DIRECT: (541) 284-5849

HOLLY BELL
ACCOUNT MANAGER
hbell@whainsurance.com
DIRECT: (541) 632-8032

CAMERON REESE
ACCOUNT MANAGER
creese@whainsurance.com
DIRECT: (541) 284-5834

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, 2025 through December 31, 2025
Contribution based on 24% increase and 10% Employee Cost Share of $1500 deductible plan

	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)	Covered in Full	Covered in Full	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 VEBA Contribution	Annual VEBA Contribution	Monthly VEBA Contribution	Annual VEBA Contribution
Employee Only	107.61	$1,291.37	-39.19	-$470.23	-81.01	-$972.07
Employee + Spouse	234.00	$2,808.00	-86.74	-$1,040.88	-178.11	-$2,137.32
Employee + Family	268.34	$3,220.04	-90.60	-$1,087.24	-192.85	-$2,314.24
Employee + Child(ren)	183.28	$2,199.31	-61.91	-$742.97	-131.75	-$1,581.05

	Total Premium	Employer Contribution	Total Premium	Employer Contribution	Total Premium	Employer Contribution
Employee Only	$1,076.14	$968.53	$929.34	$968.53	$887.52	$968.53
Employee + Spouse	$2,340.00	$2,106.00	$2,019.26	$2,106.00	$1,927.89	$2,106.00
Employee + Family	$2,683.37	$2,415.03	$2,324.43	$2,415.03	$2,222.18	$2,415.03
Employee + Child(ren)	$1,832.76	$1,649.48	$1,587.57	$1,649.48	$1,517.73	$1,649.48

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		
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.

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		
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.

Crook County

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	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
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 for in-network and out-of-network providers. 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.

Crook County

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, 0% up to $300	

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.

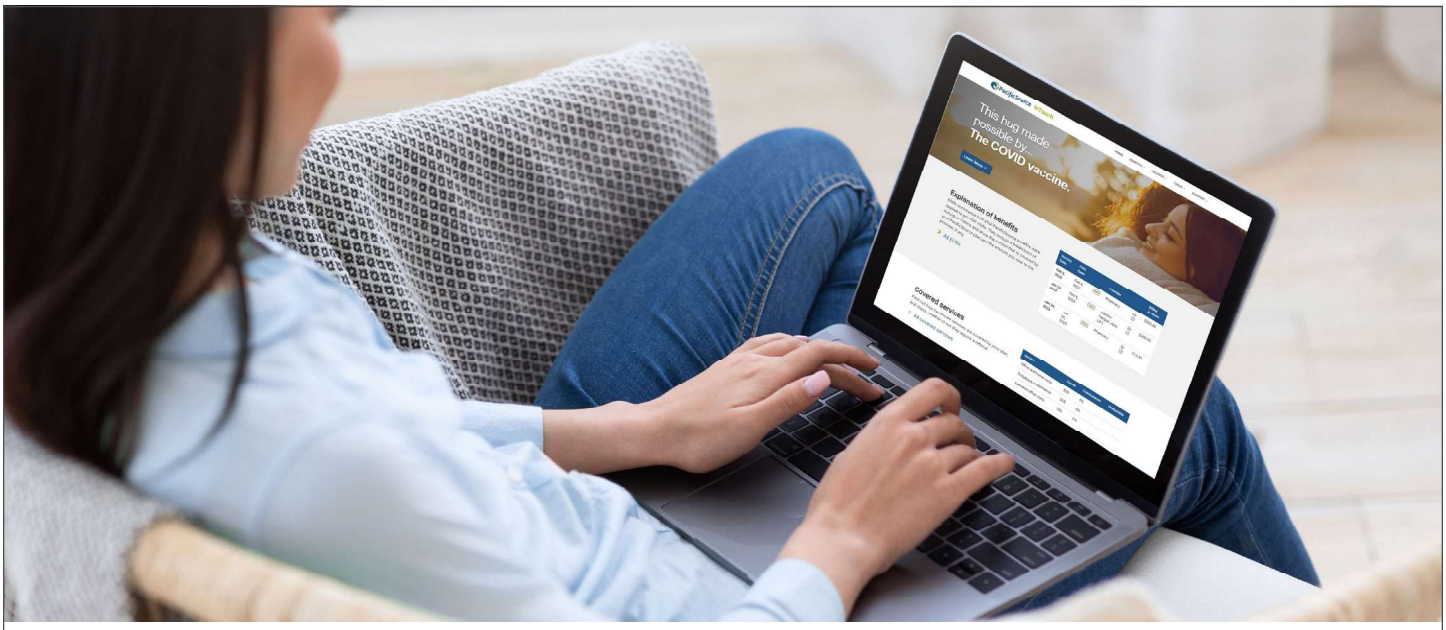
Paying for Services: Our provider contracts require in-network providers to bill us directly whenever you receive covered services and supplies. Providers will verify your vision benefits.

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



InTouch lets you manage your benefits whenever, wherever

MyPacificSource puts InTouch in your pocket

Our smartphone app makes it easy to find in-network doctors and hospitals wherever you are. Search for primary care doctors, specialists, alternative care providers, and more.

You can also:

- View your digital member ID card
- Call our 24-hour NurseLine
- See if you've met your deductible and out-of-pocket max
- Find out which services are covered
- View your Explanation of Benefits statements

First create your InTouch account, then download the app and log in.

Scan this code with your phone's camera and create your account. Scroll down the page for links to download the MyPacificSource app.

PacificSource HEALTH PLANS

Provider Telemedicine and Telehealth FAQ

This FAQ is specific to our Commercial, Medicaid and Medicare lines of business. Any distinctions between lines of business are called out.

Definitions

Telemedicine
Refers to actual medical consultations provided in real-time over an electronic mechanism as allowed below. This includes, but is not limited to, the Teladoc-style web doctor services. Telemedicine visits typically result in normal claims specifically coded as telemedicine visits.

Telehealth
Telehealth refers to health and wellness programs, nurse lines, and other services supporting patient health that are delivered by live video or live chat evaluation. Telehealth may be used to diagnose or consult on minor conditions (e.g., colds, sinus infections, sprains, or rashes), on-going conditions (e.g., mental health, substance abuse or chronic conditions), and/or follow-up appointments. It can also be used to prescribe medications. In-network providers may offer this service, and plan-specific copays apply.

Televideo and Telephonic
Services that are eligible for reimbursement must be delivered by real-time, interactive, two-way video and phone communication when determined medically necessary, evidence-based, and a covered benefit.

Originating Site
The originating site means the physical location of the patient and/or provider (receiving or rendering telemedical health services), be that a healthcare facility, home, school, or workplace, etc.

Question & Answers

What are the PacificSource guidelines for eligible reimbursement for telemedicine and telehealth services?
Billing expectations and billing practices are the same as any other service rendered by our provider partners. Prior to rendering any service, providers are expected to check eligibility and benefits.

How do I know if a service or medication requires a prior authorization?
If the service requires preauthorization when done in person, then preauthorization is required when done as telemedicine and telehealth. To determine if a service and/or medication requires preauthorization, consult our Prior Authorization Grid (authgrid.pacificsource.com).

Federal and State Guidelines for COVID-19 will be applied as updates develop.

How are telemedicine and telehealth services identified on a claim?
Billing place of service (POS) 02 is required. We also allow GT modifier to be included when billing to identify type of service, however it's not required.

As a provider, what limitations to telemedicine and telehealth should I be aware of?
Services must meet all of the following criteria to be eligible for coverage.

- Limited to two-way real-time video and phone communication.
- Services must be medically necessary and eligible for coverage if the same service were provided in person.
- Services are subject to all terms and conditions of the plan.
- Place of Service 02 is required when billing.
- Facility fee charges from the originating site are ineligible for reimbursement (Commercial only).
- Some office visits and/or procedures will be subject to retrospective review.

Are there state-specific criteria?
Yes.

- Oregon/Montana: Allows services to be both video and/or phone visits.
- Idaho/Washington: Requires services to be video specifically; voice-only is not allowed.

Does PacificSource have a policy and procedure specific to telemedicine and telehealth?
Yes, upon request we can share this with providers.

Medicaid Specific:

How do I know if a service is covered under the Oregon Health Plan (OHP)?
This can be identified by using LineFinder. LineFinder is an online tool to assist providers in determining what is covered by OHP. OHP generally updates the information quarterly. (intouch.pacificsource.com/LineFinder) *State Guidelines for COVID-19 will be applied as updates develop.*

Applies to members covered by PacificSource Health Plans, PacificSource Community Health Plans or PacificSource Community Solutions.

PRV523_0320

Get Rx delivered by mail

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:

- **Online via your InTouch account.** Follow our step-by-step guide
- **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

Toll-free
888-977-9299
TTY 711

En Español
866-281-1464

PacificSource.com

PacificSource HEALTH PLANS

CLB286_0121

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 PacificSource.com/extras.

Wellness programs

24-Hour NurseLine

You'll never be without a registered nurse to talk to when you have health-related questions. To talk to a nurse, call toll-free: **855-834-6150.**

Tobacco cessation

Our Quit For Life® program, brought to you by Optum, offers one-on-one treatment sessions with a professional Quit Coach to help tobacco users kick the habit. Prescription medications are also available, when prescribed by your doctor.

Health and wellness education

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

Prenatal program

Our Prenatal Program helps expectant parents learn more about pregnancy and the development of their child. Participants receive educational materials and phone support from a nurse consultant. High-risk members receive additional support through a specialized program.

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 PacificSource.com/prenatal.

Weight management programs

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's website offers a gym locator, educational materials, online fitness tracking, and wellness product discounts.

Continue >

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

How to access care nationally

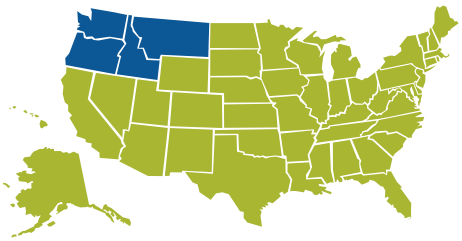
Whether you're on vacation, traveling for work, or you reside outside the PacificSource four-state network footprint, it's reassuring to know you can easily access healthcare*.

Nationwide in-network coverage for doctors and hospitals across the Northwest — and across the nation.

Outside Idaho, Montana, Oregon, and Washington, you can get in-network care through our collaboration with Aetna Signature Administrators®.

Aetna's PPO network includes more than 1.5 million participating physicians and ancillary providers, including more than 6,000 hospitals.

You will receive your plan's in-network level of benefits when you visit providers and facilities in the Aetna PPO.



PacificSource Service Area
(Idaho, Montana, Oregon, and Washington)

Aetna PPO

Provider directories

To find providers within Idaho, Montana, Oregon, or Washington, search our directory at PacificSource.com/find-a-doctor.

To find a provider outside our four-state service area, search the Aetna PPO directory at Aetna.com/ASA.

*Some exceptions apply for Individual members residing outside our service areas.

Sign in or register for our secure member portal, InTouch

InTouch.PacificSource.com

Email
CS@PacificSource.com

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

PacificSource.com

PacificSource HEALTH PLANS

Frequently asked questions

What if the provider I want to use is not a member of the network?

If the provider is not in your plan's network or our national network, you will receive your plan's out-of-network provider benefits, unless it is a true medical emergency. If you have a true medical emergency, go directly to the nearest emergency room or appropriate facility, and there will be no reduction in benefits.

If you would like to request that a provider join either network, you may contact our Customer Service team for a nomination form. Give the form to the provider to complete and return to PacificSource. Keep in mind that sending in a nomination form doesn't mean the provider will automatically be added to the network. The nomination process may take up to nine months, and not all providers are approved.

What if I need nonemergency hospitalization?

Check the Aetna directory for an in-network hospital nearby. Then, check with your doctor to see if they have hospital privileges with that hospital. Finally, have your doctor get prior authorization for your admission by calling our Health Services team at **888-691-8209.**

How are my claims paid when I receive treatment?

When you use an Aetna PPO provider, simply show your PacificSource member ID card. The provider will send your claim to us automatically, and you won't have to file any paperwork.

If you go to an out-of-network provider, the provider may or may not bill us directly. If they don't bill us directly, you'll need to pay for the services up front, then send PacificSource a claim for reimbursement. Your claim must include a copy of the provider's itemized bill, along with your name, member ID number, group name and number, and the patient's name. If you were treated for an accidental injury, please also include the date, time, place, and circumstances of the accident.

How do providers obtain information on benefits, prior authorization, and eligibility?

Show your PacificSource member ID card to the provider office when obtaining services. It contains important provider information. For prior authorization, providers should contact our Health Services team at **888-691-8209.** To verify benefits and member eligibility, they can call our Customer Service team at **888-977-9299.**

What if I'm traveling in another country?

Depending on your specific medical plan benefits, if you experience a medical emergency while traveling 100 or more miles from home or abroad, you can access services at no cost. Medical services arranged by Assist America® Global Emergency Services (or partner Scholastic Emergency Services) are provided at no cost to you. Services include medical consultation and evaluation, medical referrals, foreign hospital admission guarantee, critical care monitoring, and when medically necessary, evacuation to a facility that can provide treatment. For more information, visit PacSrc.co/assist-america.

What if there are no network providers where I live?

The networks are growing and adding new providers all the time. If a network provider is not available where you live, your plan pays your covered expenses based on usual, customary, and reasonable charges for that area, at the out-of-network cost-share rate.

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 abroad, 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/drug-info.

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.

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 CareTeam provides individual follow-up care and support.

Care management services

If you have an ongoing medical need, our Care Managers can help. 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 PacificSource.com/mobile.

Personalized wellness support

Accessible via desktop and mobile app, Virgin Pulse is an engaging well-being experience that gives you tools and resources to help you reach your unique health and wellness goals. It can help, whether you want to increase physical activity, eat better, or manage a health condition. Virgin Pulse includes social connections, daily actions, customized goal roadmaps, a healthcare tracker, nutrition and sleep guides, interactive videos, and more.

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 PacificSource.com/find-a-doctor.

Find more information at PacificSource.com/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.

DENTAL

2025 Delta Dental PPO Plan Benefit Summary

Delta Dental of Oregon & Alaska

Crook County

Custom Passive PPO: 100/100/50/2000_PF

	PPO provider	Premier provider	Out-of-network non-participating provider
Calendar year costs			
Calendar year maximum, per member		$2,000	
Calendar year deductible, per member		$0	
Calendar year deductible, 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.

** Preventative care 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-

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 once in any 6-month period. 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 once in any six-month period. 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 once in any 6-month period for members until age 19. For members age 19 and older, topical application of fluoride is covered once in any 6-month period 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 except for evidence of clinical failure.

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
- **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 seven (7) year period on any tooth.
- **Prosthodontic** A bridge or denture (full or partial, including alternate benefits) will be covered once in a seven (7) year period only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the past seven (7) years. Specialized or personalized prosthetics are limited to the cost of standard devices.
- **Occlusal Guard** (night guard) covered at 100% once in a five year period, up to $150 maximum. Over-the-counter night guards are excluded.
- **Athletic mouth guard** covered at 50%, once in any 12-month period for members age 15 and under and once in any 24-month period age 16 and over. Over-the-counter athletic mouth guards are excluded.

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 or broken appointments.
- Precision attachments.
- Orthodontic services (except when an orthodontia rider is included).
- Services for cosmetic reasons.
- Claims submitted more than 12 months after the date of service are not covered.
- All other services or supplies, not specifically covered.

participating allowable.

2025 Delta Dental Premier Plan Benefit Summary

Delta Dental of Oregon & Alaska

Adult & Child Ortho 1500

Lifetime maximum	$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.

AC1500

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.

2025 HSA Contribution limit *(employer and employee)*	Self Only: $4,300 Family: $8,550
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)

Crook County

Flexible Spending Account Summary

January 1, 2025 – December 31, 2025

A Flexible Spending Account (FSA) is a type of plan that allows you to receive certain benefits on a pretax basis. This means you will not have to pay Social Security/Medicare taxes or federal/state income taxes on the money. Think of it as a tax-free, interest-free loan to yourself.

The Plans The following FSA components are available through your employer. These expenses are for your tax dependents. Examples include you, your spouse, or child(ren), even if they are not covered on your employer's group insurance plan.

Insurance Premium Component

- If your employer charges you to have yourself and/or any dependents enrolled on the employer-sponsored benefits, your cost will automatically be deducted from your paycheck on a pre-tax basis.

Health FSA Component – includes the following account(s)

Maximum Election $133.34 per pay period, $3,200.00 annual

- You can use this account for healthcare expenses for you and your taxable dependents, including medical, dental, and vision expenses that are either not covered or only partially covered by your insurance plan.
- Your full election amount is available at the start of the plan year.
- When you have a qualified change in status—such as if you add or remove dependents from your insurance plan—you can increase or decrease your election.

Health Related Expense Account (HRE) - the General Purpose FSA

- Eligible expenses include medical, dental, and vision expenses not paid for by insurance: copays, coinsurance, deductibles, etc.
- Over the count medicines and supplies are eligible, examples include pain relief and allergy medications, bandages, thermometers, etc. Some vitamins and supplements may be eligible with a Letter of Medical Necessity or doctor's prescription.

Limited-Purpose Flexible Spending Account (LFSA)

- This plan is available for employees, who they themselves or their family contribute to a health savings account (HSA).
- You can use this plan for eligible expenses including dental, vision and preventive medical care expenses.

Dependent Care Assistance Plan (DCAP) Component

Maximum Election $208.34 per pay period, $5,000 annual ($2,500 annual max if married filing separately)

- You can use this account for childcare expenses for your tax dependents under 13 or disabled taxable dependent who is unable to care for themselves, including elder care expenses.
- This account is accrual-based, and reimbursements will be issued as funds are posted and claims received.
- When you have a qualified change in status—such as if your spouse's employment changes—you can increase or decrease how much you put into your account.

Claims Reimbursement

Reimbursement Time Frame

Dates of service must be between **January 1, 2025,** and **December 31, 2025**

- Reimbursements may be requested during the plan year or after it ends.
- The last date to submit claims is **March 31, 2026**

Submitting Claims

Claims can be submitted through manual submission, using your Prepaid Benefit Card, or enrolling in the EasyPay program. If you're reimbursed for a claim and it is later determined that the expense was not eligible for reimbursement, you will be liable for repaying the money to your FSA. Additional information is listed below.

Manual Claims

We offer several ways you can submit your claims for reimbursement:

1. Submit your claim online using our PSAConsumer portal: https://psa.consumer.pacificsource.com
2. Submit your claim via our Mobile App: myPacificSource Admin (PSA)
3. Mail or fax a Request for Reimbursement Form. You'll find the form at https://pacificsource.com/media/32811

Prepaid Benefit Card

When you opt to receive the card, you will receive two benefits cards.

A Prepaid Benefits Debit Card gives you an easy, automatic way to pay for qualified healthcare expenses. Simply swipe your benefits card as you would a credit/debit card (and select "credit" rather than "debit"). When you use the card to make a purchase or payment, it deducts funds directly from your FSA.

Date of service is important! It's assumed the date of service is the day the card is swiped. If you are paying for a prior service, only use your card if the service date is within your current plan year. Prior year services need to be submitted as manual claims for reimbursement. Replacements or additional cards can be purchased for $10 per set of two cards.

When you use your debit card, you should request an itemized receipt for reimbursement in case we need you to substantiate a charge. (*You must save all expense documentation, such as itemized receipts, per IRS regulations.)* You may occasionally receive a notice if your transaction is ineligible or needs additional documentation. You will be required to submit the documentation, refund the account, or "offset" the expense as indicated in the notice. If the transaction issue hasn't been resolved within the allotted time, the card will be suspended. Amounts for transactions that aren't properly documented or that have been deemed ineligible may be included as wages on your W-2.

EasyPay

EasyPay is a great option that will automatically reimburse you for eligible PacificSource Health Plans claims on your behalf. You must be enrolled in your employer's PacificSource insurance plan to be eligible for and enroll in EasyPay. If you or any dependents have coverage through another health plan other than your group-sponsored insurance plan through PacificSource, you are not eligible for EasyPay.

- You will be automatically enrolled in the EasyPay program if your insurance coverage is through PacificSource Health Plans. You must notify PSA if you or any dependents have coverage through another health plan other than your group-sponsored insurance plan through PacificSource so we can make sure you are not enrolled in EasyPay.

Note: You may elect either EasyPay or the Benefits Debit card, but not both.

Funds Remaining After the Plan Ends

If the plan year ends before you've used all your Health FSA funds, you're allowed to have up to $640 carry over to the next FSA plan year. If you have more than the $640 remaining, you'll lose those additional funds, along with all other account balances. Carryover funds will be automatically rolled after the prior plan year ends.

What Happens if I Terminate Employment during the Plan Year?

If you terminate employment or lose eligibility, your participation in the plan will end on the date your employment status changes or with your final payroll contribution – whichever offers the greater period of eligibility. You may be eligible to continue the Health FSA under COBRA or by making an additional pre-tax contribution out of your last paycheck.

Forms, Fliers and instructions

Available online. Examples include:

- Request for Reimbursement Form
- Health FSA Eligible Expenses
- FSA Prepaid Benefits Card Flier
- Online Account Access for Participants
- FSA Participant Guide
- Direct Deposit Form
- PSA Mobile App
- Authorization to Disclose PHI

Questions?

Our Customer Service Team is happy to help.

Phone

Direct: (541) 485-7488
Toll-free: (800) 422-7038

Email

psacustomerservice@pacificsource.com

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

› 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 ELIGIBLE MEMBER & COUNTY COMMISSIONERS	
Eligibility Requirement	You must be actively working a minimum of 20 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

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 **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

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®

Z2400594 EXP 6/25

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

MASA Medical Transport Solutions®

$39/MONTH

DID YOU KNOW?

25 MILLION PEOPLE
are sent to the emergency room through ground or air ambulance every year*.

Insurance companies may not cover all air and ground ambulance expenses which can result in max in-network out-of-pocket costs of:**

$8,700 Individual
$17,400 Family

Ground ambulance out-of-network transportation costs may be even higher than in-network since the No Surprises Act does not apply to ground ambulance at this time.

PLATINUM MEMBERSHIP BENEFITS

A MASA MTS Membership provides the ultimate peace of mind at an aff ordable rate for emergency ground and air transportation assistance expenses within the continental United States, Alaska, Hawaii, and while traveling in Canada, regardless of whether the provider is in or out of your group healthcare benefits network. After the group health plan pays its portion, MASA works with providers to make certain our Members have no out-of-pocket expenses~ for emergency ambulance transportation assistance and other related services.

Emergency Air Ambulance Coverage[3]
MASA MTS covers out-of-pocket expenses associated with emergency air transportation to a medical facility for serious medical emergencies deemed medically necessary for you or your dependent family member.

Emergency Ground Ambulance Coverage[3]
MASA MTS covers out-of-pocket expenses associated with emergency ground transportation to a medical facility for serious medical emergencies deemed medically necessary for you or your dependent family member.

Hospital to Hospital Ambulance Coverage[3]
MASA MTS covers out-of-pocket expenses that you or a dependent family member may incur for hospital transfers, due to a serious emergency, to the nearest and most appropriate medical facility when the current medical facility cannot provide the required level of specialized care by air ambulance to include medically equipped helicopter or fixed-wing aircraft.

Repatriation to Hospital Near Home Coverage[1]
MASA MTS provides services and covers out-of-pocket expenses for the coordination of a Member's non-emergency transportation by a medically equipped, air or ground ambulance in the event of hospitalization more than one hundred (100) miles from the Member's home if the treating physician and MASA MTS' Medical Director says it's medically appropriate and possible to transfer the Member to a hospital nearer to home for continued care and recuperation.

Patient Return Transportation Coverage[1]
MASA MTS provides services and covers the out-of-pocket expenses associated with coordinating a Member's transportation when hospitalized more than one hundred (100) miles from home, after discharge from the medical facility, by a regularly scheduled commercial airline to the commercial airport nearest the Member's home.

MASA Medical Transport Solutions®

$39/MONTH

PLATINUM MEMBERSHIP BENEFITS

Companion Transportation Coverage[2]

MASA MTS provides services associated with the coordination of transportation for the Member's spouse, other family member, or companion to accompany the Member's emergency transport by a medically equipped, rotary (i.e., helicopter) or fixed-wing aircraft, giving due priority to the medical personnel and/or equipment and the welfare and safety of the patient.

Hospital Visitor Transportation Coverage[2]

MASA MTS provides services and covers air transportation expenses associated with coordinating a round-trip, regularly scheduled, commercial airfare for Member's spouse, other family Member or companion to join the Member in the event of in-patient hospitalization more than one hundred (100) statute miles from Member's home.

Minor Return Transportation Coverage[2]

MASA MTS provides services and covers out-of-pocket expenses associated with minor return transportation to a parent, legal guardian, or another person that can be responsible for the minor in the event that the minor is unattended as a result of Member's Emergency Air or Ground Ambulance, Hospital to Hospital Ambulance, Repatriation to Hospital Near Home, or Mortal Remains Transportation coverages. MASA MTS also provides for a qualified attendant to accompany the minor during travel when the minor's age and/or medical condition may require such care.

Vehicle & RV Return Coverage[2]

MASA MTS provides services and covers the out-of-pocket expenses associated with vehicle return transportation for one (1) a safe operational car, truck, van, motorcycle, travel trailer, or motor home to the Member's home. This service is available when a Member uses Emergency Air or Ground Ambulance, Hospital to Hospital Ambulance, Repatriation to Hospital Near Home, Patient Return Transportation or Mortal Remains Transportation Coverages. MASA MTS pays the cost of fuel, oil and driver.

Pet Return Transportation Coverage[2]

MASA MTS provides services and covers out-of-pocket expenses for the return transportation to a Member's home for up to two (2) pet(s) belonging to the Member that includes either a dog, cat or other small animal(s). This service is available when a Member uses Emergency Air or Ground Ambulance, Hospital to Hospital Ambulance, Repatriation to Hospital Near Home, Patient Return Transportation or Mortal Remains Transportation Coverages.

Organ Retrieval & Organ Recipient Transportation Coverage[4]

MASA MTS provides services and covers air transportation expenses associated with coordinating transportation for an organ when the Member requires an organ transplant. MASA MTS will also provide service and cover transportation costs of Member and Member's spouse, other family Member or a companion should the Member need to travel to the location where the procedure will occur. If medically necessary, the organ will be transported by a medically equipped fixed-wing aircraft; otherwise, the organ is delivered by a commercial airline to the suitable airport nearest the location of the operation.

Mortal Remains Transportation Coverage[1]

MASA MTS covers the air transportation expense for a Member's mortal remains in the event of their death when it occurs more than one hundred (100) statute miles from home. Remains are transported by a regularly scheduled commercial airline to the commercial airport nearest a Member's home.

Contact Your MASA MTS Representative to learn more about membership plan options.

TONY URIOSTE - WESTERN STATES SR. DIRECTOR

@ turioste@masamts.com ☎ (541) 848-8124

MASA Medical Transport Solutions®

$14/MONTH

DID YOU KNOW?

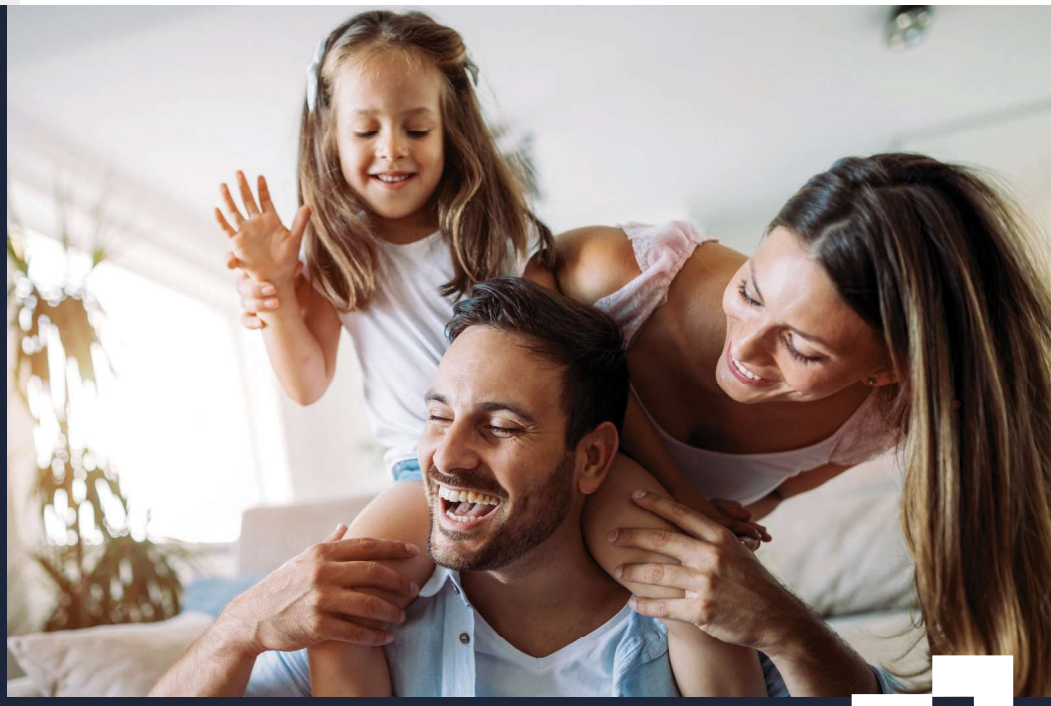
25 MILLION PEOPLE

are sent to the emergency room through ground or air ambulance every year*.

Insurance companies may not cover all air and ground ambulance expenses which can result in max in-network out-of-pocket costs of:**

$8,700 Individual
$17,400 Family

Ground ambulance out-of-network transportation costs may be even higher than in-network since the No Surprises Act does not apply to ground ambulance at this time.



EMERGENT PLUS MEMBERSHIP BENEFITS

A MASA MTS Membership provides the ultimate peace of mind at an affordable rate for emergency ground and air transportation assistance expenses within the continental United States, Alaska, Hawaii, and while traveling in Canada, regardless of whether the provider is in or out of your group healthcare benefits network. After the group health plan pays its portion, MASA works with providers to make certain our Members have no out-of-pocket expenses~ for emergency ambulance transportation assistance and other related services.

Emergency Air Ambulance Coverage[1]

MASA MTS covers out-of-pocket expenses associated with emergency air transportation to a medical facility for serious medical emergencies deemed medically necessary for you or your dependent family member.

Emergency Ground Ambulance Coverage[1]

MASA MTS covers out-of-pocket expenses associated with emergency ground transportation to a medical facility for serious medical emergencies deemed medically necessary for you or your dependent family member.

Hospital to Hospital Ambulance Coverage[1]

MASA MTS covers out-of-pocket expenses that you or a dependent family member may incur for hospital transfers, due to a serious emergency, to the nearest and most appropriate medical facility when the current medical facility cannot provide the required level of specialized care by air ambulance to include medically equipped helicopter or fixed-wing aircraft.

Repatriation to Hospital Near Home Coverage[1]

MASA MTS provides services and covers out-of-pocket expenses for the coordination of a Member's non-emergency transportation by a medically equipped, air or ground ambulance in the event of hospitalization more than one hundred (100) miles from the Member's home if the treating physician and MASA MTS' Medical Director says it's medically appropriate and possible to transfer the Member to a hospital nearer to home for continued care and recuperation.

Contact Your MASA MTS Representative to learn more about membership plan options.

TONY URIOSTE - WESTERN STATES SR. DIRECTOR

@ turioste@masamts.com ☎ (541) 848-8124

MASA Medical Transport Solutions®

$9/MONTH

DID YOU KNOW?

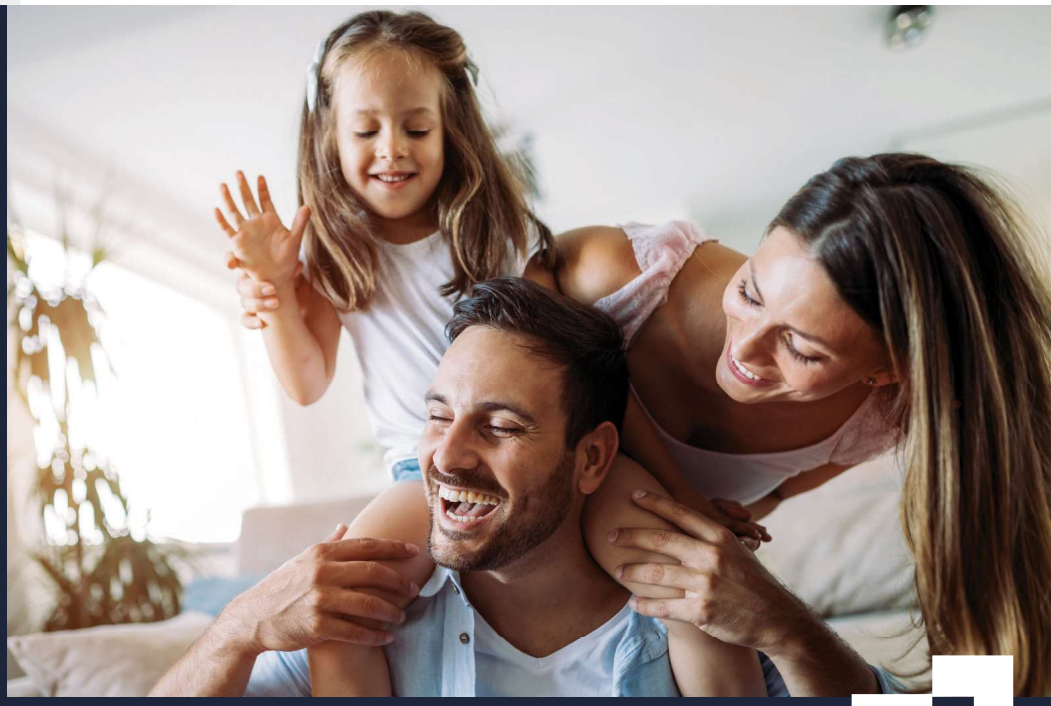
25 MILLION PEOPLE

are sent to the emergency room through ground or air ambulance every year*.

Insurance companies may not cover all air and ground ambulance expenses which can result in max in-network out-of-pocket costs of:**

$8,700 Individual
$17,400 Family

Ground ambulance out-of-network transportation costs may be even higher than in-network since the No Surprises Act does not apply to ground ambulance at this time.



EMERGENT MEMBERSHIP BENEFITS

A MASA MTS Membership provides the ultimate peace of mind at an affordable rate for emergency ground and air transportation assistance expenses within the continental United States, Alaska, Hawaii, and while traveling in Canada based on benefit coverage area, regardless of whether the provider is in or out of your group healthcare benefits network. After the group health plan pays its portion, MASA works with providers to make certain our Members have no out-of-pocket expenses~ for emergency ambulance transportation assistance and other related services.

Emergency Air Ambulance Coverage[1]

MASA MTS covers out-of-pocket expenses associated with emergency air transportation to a medical facility for serious medical emergencies deemed medically necessary for you or your dependent family member.

Emergency Ground Ambulance Coverage[1]

MASA MTS covers out-of-pocket expenses associated with emergency ground transportation to a medical facility for serious medical emergencies deemed medically necessary for you or your dependent family member.

Contact Your MASA MTS Representative to learn more about membership plan options.

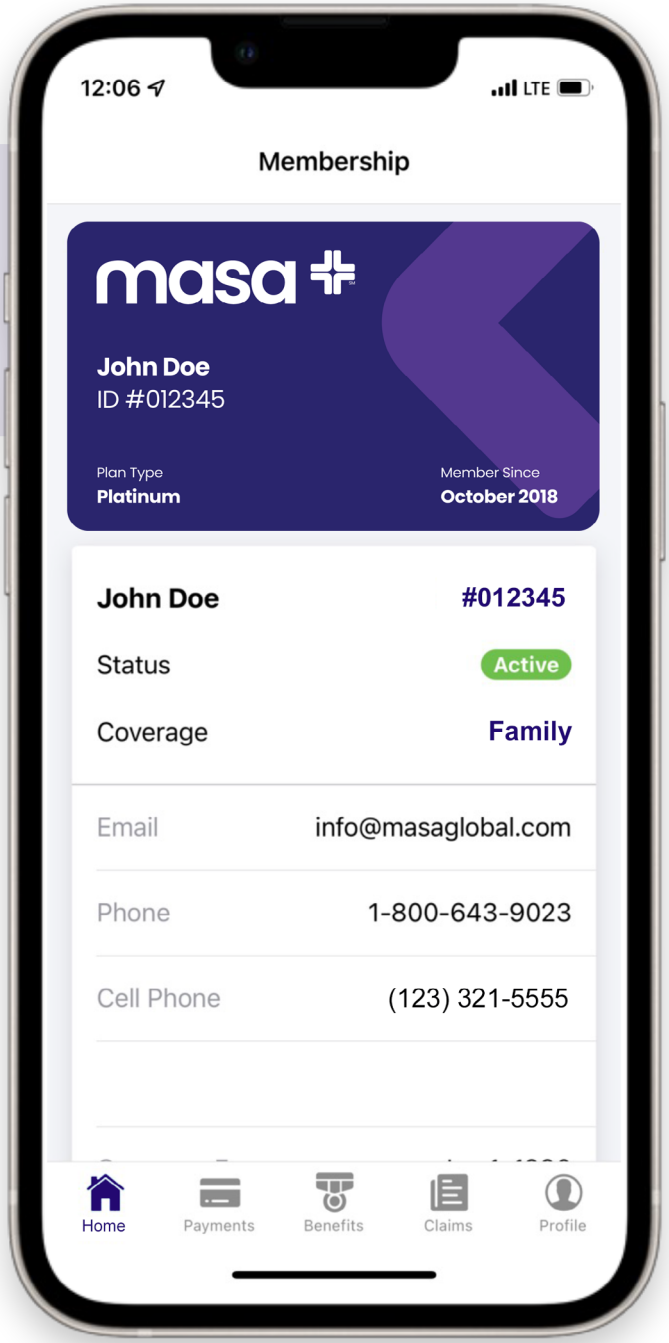
TONY URIOSTE / SR. STATE DIRECTOR

@ turioste@masamts.com ☎ (541) 848-8124

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

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

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

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

Model General Notice of COBRA Continuation Coverage Rights

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

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

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

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

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

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.