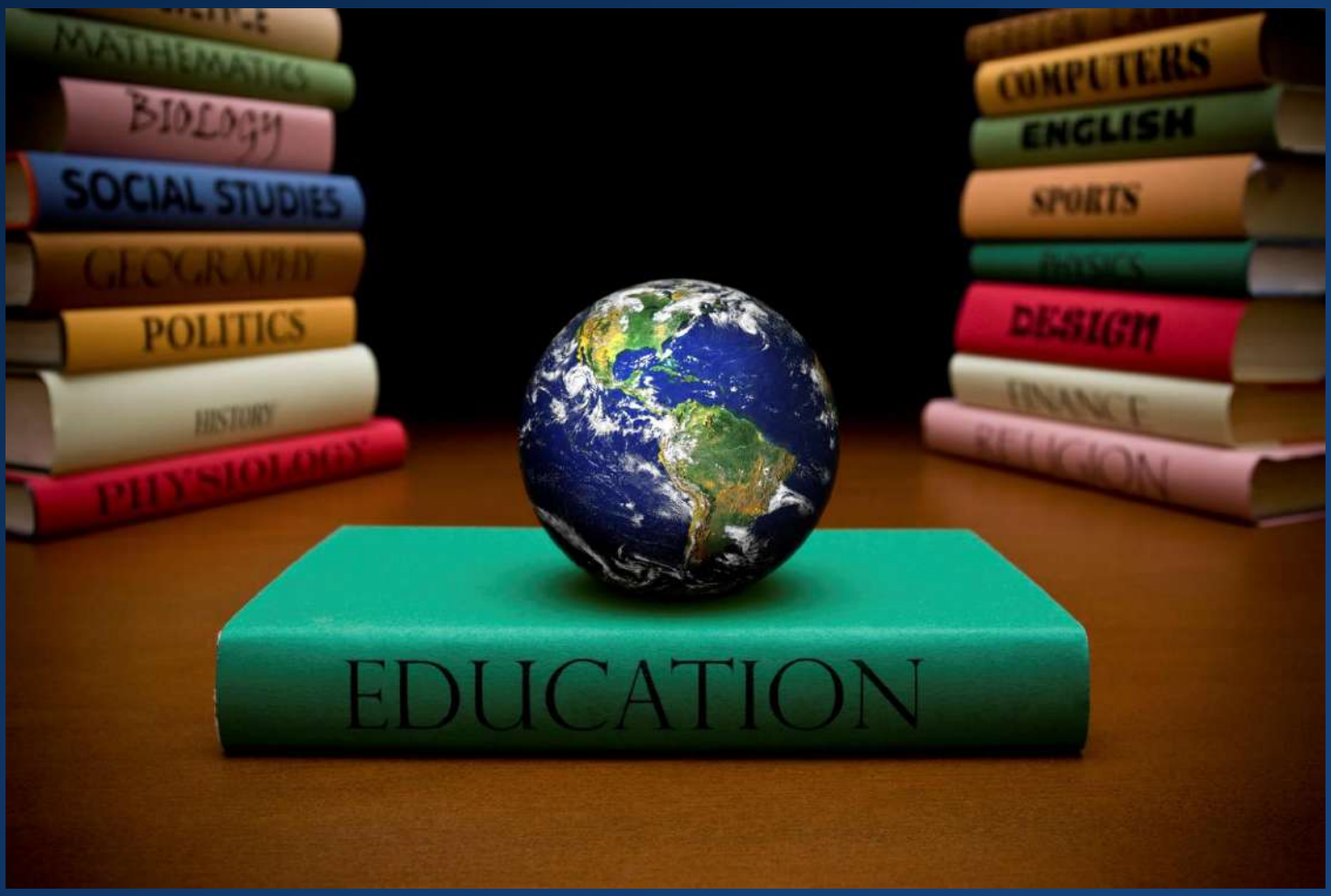
School District 28J

WHA INSURANCE

# Benefits Resource Guide - Retiree








PLAN YEAR | **2021-2022**

# YOUR SERVICE TEAM

## BENEFITS

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

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## CONTACT

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

# Contact Information

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



# Eligibility Information

**Who is Eligible and When:**

Full time employees or any employee regularly scheduled to work 20 or more hours per week will be eligible for all benefits at time of hire.

Effective dates for insurance programs will be the 1st of the month following the month of employment

# Open Enrollment

We are currently in an open enrollment period for the 2021/2022 plan year. Our plans will remain with PacificSource and we will not be making any changes to plans or coverages.

You will not need to complete any forms unless you would like to change plans, add or delete dependents or enroll in the FSA Plan for the 2021/2022 plan year.

If you would like to make changes to your current enrollment, please see the Business Office for the necessary forms or you can obtain the forms from the Districts website at http://www.fernridge.k12.or.us/employee-benefits/

All change requests must be returned to the Business Office by September 9th .


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# Fern Ridge School District

## Plan Comparison

| | PacificSource | | | | | |
|---|---|---|---|---|---|---|
| | $2000 Deductible | | $6000 Deductible | | $2500 HSA | |
| | In-Network | | In-Network | | In-Network | |
| Individual Deductible per Calendar Yea | $2,000 | | $6,000 | | $2,500 | |
| Maximum Family Ded. Per Cal. Yr | $4,000 | | $12,000 | | $5,000 | |
| Out of Pocket Maximum - Individual | $5,500 | | $7,900 | | $5,000 | |
| Out of Pocket Maximum - Family | $11,000 | | $15,800 | | $8,150 | |
| **Preventative Services** | | | | | | |
| Well-Baby care | Covered in Full | | Covered in Full | | Covered in Full | |
| Immunizations all ages | Covered in Full | | Covered in Full | | Covered in Full | |
| Routine physical Exams | Covered in Full | | Covered in Full | | Covered in Full | |
| Routine, preventive colonoscopy | Covered in Full | | Covered in Full | | Covered in Full | |
| **Professional Services** | | | | | | |
| Office Visits | $25 Copay * | | $35 Copay * | | 20% | |
| Specialist Visits | $25 Copay * | | $35 Copay * | | 20% | |
| Urgent Care Office Visits | $25 Copay * | | $35 Copay * | | 20% | |
| Telemedicine Visits | $10 Copay * | | $10 Copay * | | 20% | |
| Diagnostic Lab and X-ray | 20% * | | 20% | | 20% | |
| Advanced Imaging | 20% | | 20% | | 20% | |
| Surgery | 20% | | 20% | | 20% | |
| **Hospital Services** | | | | | | |
| Hospital Stay | 20% | | 20% | | 20% | |
| Maternity Hospital | 20% | | 20% | | 20% | |
| Outpatient day surgery | 20% | | 20% | | 20% | |
| Emergency room visits | 20% after $150 Copay * | | 20% | | 20% | |
| **Other Services** | | | | | | |
| Ambulance (ground) | 20% | | 20% | | 20% | |
| Ambulance (air) | 50% | | 50% | | 20% | |
| Outpatient durable medical equipment | 20% | | 20% | | 20% | |
| Rehabilitation | $25 Copay * | | $35 Copay * | | 20% | |
| Allergy Injections | $5 Copay * | | $5 Copay * | | 20% | |
| **Alternative Care** | | | | | | |
| Chiropractic, Acup. and Naturo. OV | $25 Copay * | | $35 Copay * | | 20% | |
| Massage Therapy Office Visits | $25 Copay * | | $35 Copay * | | 20% | |
| Annual Maximum | $1000 annual max | | $1000 annual max | | $1000 annual max | |
| **Prescription Drug Benefit** | **30 Day** | **90 Day** | **30 Day** | **90 Day** | **30 Day** | **90 Day** |
| Tier 1 | $10 Copay * | $20 Copay * | $10 Copay * | $20 Copay * | 20% | 20% |
| Tier 2 | $50 Copay * | $100 Copay * | $50 Copay * | $100 Copay * | 20% | 20% |
| Tier 3 | $75 Copay * | $150 Copay * | $75 Copay * | $150 Copay * | 20% | 20% |
| Tier 4 | N/A | N/A | N/A | N/A | N/A | N/A |
| Individual Out of Pocket Maximum | Medical OOP Max | | Medical OOP Max | | Medical OOP Max | |
| Family Out of Pocket Maximum | Medical OOP Max | | Medical OOP Max | | Medical OOP Max | |
| **Vision** | | | | | | |
| Benefit Availability | Per calendar year | | Per calendar year | | Per calendar year | |
| Exam | $10 Copay * | | $10 Copay * | | $10 Copay * | |
| Lens Benefits | Up to $400 Allowance | | Up to $400 Allowance | | Up to $400 Allowance | |
| Frame Benefit | | | | | | |
| Contact Lens Benefit *(in place of glasses)* | | | | | | |

**** - Deductible Waived***

*For illustration purposes only. If a conflict arises, carrier information takes precedence.*

**FERN RIDGE SCHOOL DISTRICT 28J**
**Group Health Premium Rates for PacificSource**
**2021-2022 Plan Year**

## LICENSED RETIREES

| $2000 SC OOA | Empl Only | Empl & Sp | Family | Emp & Ch |
|---|---|---|---|---|
| Medical & Rx | $ 902.35 | $ 1,892.30 | $ 2,518.09 | $ 1,715.53 |
| Dental | 74.93 | 132.92 | 217.85 | 159.86 |
| **Total** | **977.28** | **2,025.22** | **2,735.94** | **1,875.39** |
| District Contribution | 1,423.75 | 1,423.75 | 1,423.75 | 1,423.75 |
| *Pre-Tax Out of Pocket* | - | *601.47* | *1,312.19* | *451.64* |
| Vision | 13.53 | 31.12 | 39.51 | 24.89 |
| ***Total Out of Pocket*** | **$ 13.53** | **$ 632.59** | **$ 1,351.70** | **$ 476.53** |

| $2000 SC | Empl Only | Empl & Sp | Family | Emp & Ch |
|---|---|---|---|---|
| Medical & Rx | $ 835.46 | $ 1,752.16 | $ 2,331.51 | $ 1,588.33 |
| Dental | 74.93 | 132.92 | 217.85 | 159.86 |
| **Total** | **910.39** | **1,885.08** | **2,549.36** | **1,748.19** |
| District Contribution | 1,423.75 | 1,423.75 | 1,423.75 | 1,423.75 |
| *Pre-Tax Out of Pocket* | - | *461.33* | *1,125.61* | *324.44* |
| Vision | 13.53 | 31.12 | 39.51 | 24.89 |
| ***Total Out of Pocket*** | **$ 13.53** | **$ 492.45** | **$ 1,165.12** | **$ 349.33** |

| $2500 HSA | Empl Only | Empl & Sp | Family | Emp & Ch |
|---|---|---|---|---|
| Medical & Rx | $ 637.26 | $ 1,335.88 | $ 1,776.47 | $ 1,211.70 |
| Dental | 74.93 | 132.92 | 217.85 | 159.86 |
| **Total** | **712.19** | **1,468.80** | **1,994.32** | **1,371.56** |
| District Contribution | 1,423.75 | 1,423.75 | 1,423.75 | 1,423.75 |
| *Pre-Tax Out of Pocket* | - | *45.05* | *570.57* | - |
| Vision | 13.53 | 31.12 | 39.51 | 24.89 |
| ***Total Out of Pocket*** | **$ 13.53** | **$ 76.17** | **$ 610.08** | **$ 24.89** |

| $6000 SC | Empl Only | Empl & Sp | Family | Emp & Ch |
|---|---|---|---|---|
| Medical & Rx | $ 616.38 | $ 1,291.55 | $ 1,717.07 | $ 1,172.19 |
| Dental | 74.93 | 132.92 | 217.85 | 159.86 |
| **Total** | **691.31** | **1,424.47** | **1,934.92** | **1,332.05** |
| District Contribution | 1,423.75 | 1,423.75 | 1,423.75 | 1,423.75 |
| *Pre-Tax Out of Pocket* | - | *0.72* | *511.17* | - |
| Vision | 13.53 | 31.12 | 39.51 | 24.89 |
| ***Total Out of Pocket*** | **$ 13.53** | **$ 31.84** | **$ 550.68** | **$ 24.89** |

## CLASSIFIED RETIREES

FULL-TIME ***(7.00 - 8.00 HOURS PER DAY OR 35.00 - 40.00 HOURS PER WEEK)***

| $2000 SC OOA | Empl Only | Empl & Sp | Family | Emp & Ch |
|---|---|---|---|---|
| Medical & Rx | $ 902.35 | $ 1,892.30 | $ 2,518.09 | $ 1,715.53 |
| Vision | 13.53 | 31.12 | 39.51 | 24.89 |
| Dental | 74.93 | 132.92 | 217.85 | 159.86 |
| **Total** | **990.81** | **2,056.34** | **2,775.45** | **1,900.28** |
| District Contribution | 1,595.00 | 1,595.00 | 1,595.00 | 1,595.00 |
| ***Total Out of Pocket*** | **$ -** | **$ 461.34** | **$ 1,180.45** | **$ 305.28** |

| $2000 SC | Empl Only | Empl & Sp | Family | Emp & Ch |
|---|---|---|---|---|
| Medical & Rx | $ 835.46 | $ 1,752.16 | $ 2,331.51 | $ 1,588.33 |
| Vision | 13.53 | 31.12 | 39.51 | 24.89 |
| Dental | 74.93 | 132.92 | 217.85 | 159.86 |
| **Total** | **923.92** | **1,916.20** | **2,588.87** | **1,773.08** |
| District Contribution | 1,595.00 | 1,595.00 | 1,595.00 | 1,595.00 |
| ***Total Out of Pocket*** | **$ -** | **$ 321.20** | **$ 993.87** | **$ 178.08** |

| $2500 HSA | Empl Only | Empl & Sp | Family | Emp & Ch |
|---|---|---|---|---|
| Medical & Rx | $ 637.26 | $ 1,335.88 | $ 1,776.47 | $ 1,211.70 |
| Vision | 13.53 | 31.12 | 39.51 | 24.89 |
| Dental | 74.93 | 132.92 | 217.85 | 159.86 |
| **Total** | **725.72** | **1,499.92** | **2,033.83** | **1,396.45** |
| District Contribution | 1,595.00 | 1,595.00 | 1,595.00 | 1,595.00 |
| ***Total Out of Pocket*** | **$ -** | **$ -** | **$ 438.83** | **$ -** |

| $6000 SC | Empl Only | Empl & Sp | Family | Emp & Ch |
|---|---|---|---|---|
| Medical & Rx | $ 616.38 | $ 1,291.55 | $ 1,717.07 | $ 1,172.19 |
| Vision | 13.53 | 31.12 | 39.51 | 24.89 |
| Dental | 74.93 | 132.92 | 217.85 | 159.86 |
| **Total** | **704.84** | **1,455.59** | **1,974.43** | **1,356.94** |
| District Contribution | 1,595.00 | 1,595.00 | 1,595.00 | 1,595.00 |
| ***Total Out of Pocket*** | **$ -** | **$ -** | **$ 379.43** | **$ -** |

**PART-TIME** ***(6.00 - 6.99 HOURS PER DAY OR 30.00 - 34.99 HOURS PER WEEK)***

| $2000 SC OOA | Empl Only | Empl & Sp | Family | Emp & Ch |
|---|---|---|---|---|
| Medical & Rx | $ 902.35 | $ 1,892.30 | $ 2,518.09 | $ 1,715.53 |
| Vision | 13.53 | 31.12 | 39.51 | 24.89 |
| Dental | 74.93 | 132.92 | 217.85 | 159.86 |
| **Total** | **990.81** | **2,056.34** | **2,775.45** | **1,900.28** |
| District Contribution | 1,435.50 | 1,435.50 | 1,435.50 | 1,435.50 |
| ***Total Out of Pocket*** | **$ -** | **$ 620.84** | **$ 1,339.95** | **$ 464.78** |

| $2000 SC | Empl Only | Empl & Sp | Family | Emp & Ch |
|---|---|---|---|---|
| Medical & Rx | $ 835.46 | $ 1,752.16 | $ 2,331.51 | $ 1,588.33 |
| Vision | 13.53 | 31.12 | 39.51 | 24.89 |
| Dental | 74.93 | 132.92 | 217.85 | 159.86 |
| **Total** | **923.92** | **1,916.20** | **2,588.87** | **1,773.08** |
| District Contribution | 1,435.50 | 1,435.50 | 1,435.50 | 1,435.50 |
| ***Total Out of Pocket*** | **$ -** | **$ 480.70** | **$ 1,153.37** | **$ 337.58** |

| $2500 HSA | Empl Only | Empl & Sp | Family | Emp & Ch |
|---|---|---|---|---|
| Medical & Rx | $ 637.26 | $ 1,335.88 | $ 1,776.47 | $ 1,211.70 |
| Vision | 13.53 | 31.12 | 39.51 | 24.89 |
| Dental | 74.93 | 132.92 | 217.85 | 159.86 |
| **Total** | **725.72** | **1,499.92** | **2,033.83** | **1,396.45** |
| District Contribution | 1,435.50 | 1,435.50 | 1,435.50 | 1,435.50 |
| ***Total Out of Pocket*** | **$ -** | **$ 64.42** | **$ 598.33** | **$ -** |

| $6000 SC | Empl Only | Empl & Sp | Family | Emp & Ch |
|---|---|---|---|---|
| Medical & Rx | $ 616.38 | $ 1,291.55 | $ 1,717.07 | $ 1,172.19 |
| Vision | 13.53 | 31.12 | 39.51 | 24.89 |
| Dental | 74.93 | 132.92 | 217.85 | 159.86 |
| **Total** | **704.84** | **1,455.59** | **1,974.43** | **1,356.94** |
| District Contribution | 1,435.50 | 1,435.50 | 1,435.50 | 1,435.50 |
| ***Total Out of Pocket*** | **$ -** | **$ 20.09** | **$ 538.93** | **$ -** |

**PART-TIME** ***(4.00 - 5.99 HOURS PER DAY OR 20.00 - 29.99 HOURS PER WEEK)***

| $2000 SC OOA | Empl Only | Empl & Sp | Family | Emp & Ch |
|---|---|---|---|---|
| Medical & Rx | $ 902.35 | $ 1,892.30 | $ 2,518.09 | $ 1,715.53 |
| Vision | 13.53 | 31.12 | 39.51 | 24.89 |
| Dental | 74.93 | 132.92 | 217.85 | 159.86 |
| **Total** | **990.81** | **2,056.34** | **2,775.45** | **1,900.28** |
| District Contribution | 1,276.00 | 1,276.00 | 1,276.00 | 1,276.00 |
| ***Total Out of Pocket*** | **$ -** | **$ 780.34** | **$ 1,499.45** | **$ 624.28** |

| $2000 SC | Empl Only | Empl & Sp | Family | Emp & Ch |
|---|---|---|---|---|
| Medical & Rx | $ 835.46 | $ 1,752.16 | $ 2,331.51 | $ 1,588.33 |
| Vision | 13.53 | 31.12 | 39.51 | 24.89 |
| Dental | 74.93 | 132.92 | 217.85 | 159.86 |
| **Total** | **923.92** | **1,916.20** | **2,588.87** | **1,773.08** |
| District Contribution | 1,276.00 | 1,276.00 | 1,276.00 | 1,276.00 |
| ***Total Out of Pocket*** | **$ -** | **$ 640.20** | **$ 1,312.87** | **$ 497.08** |

| $2500 HSA | Empl Only | Empl & Sp | Family | Emp & Ch |
|---|---|---|---|---|
| Medical & Rx | $ 637.26 | $ 1,335.88 | $ 1,776.47 | $ 1,211.70 |
| Vision | 13.53 | 31.12 | 39.51 | 24.89 |
| Dental | 74.93 | 132.92 | 217.85 | 159.86 |
| **Total** | **725.72** | **1,499.92** | **2,033.83** | **1,396.45** |
| District Contribution | 1,276.00 | 1,276.00 | 1,276.00 | 1,276.00 |
| ***Total Out of Pocket*** | **$ -** | **$ 223.92** | **$ 757.83** | **$ 120.45** |

| $6000 SC | Empl Only | Empl & Sp | Family | Emp & Ch |
|---|---|---|---|---|
| Medical & Rx | $ 616.38 | $ 1,291.55 | $ 1,717.07 | $ 1,172.19 |
| Vision | 13.53 | 31.12 | 39.51 | 24.89 |
| Dental | 74.93 | 132.92 | 217.85 | 159.86 |
| **Total** | **704.84** | **1,455.59** | **1,974.43** | **1,356.94** |
| District Contribution | 1,276.00 | 1,276.00 | 1,276.00 | 1,276.00 |
| ***Total Out of Pocket*** | **$ -** | **$ 179.59** | **$ 698.43** | **$ 80.94** |

# Medical Insurance
# PacificSource

PacificSource HEALTH PLANS

Fern Ridge School District No 28J

## Medical Benefit Summary
## SmartChoice 2000+25_20 S3

Provider Network: **SmartChoice**

| Deductible Per Calendar Year | In-network | Out-of-network |
|---|---|---|
| **Individual/Family** | $2,000/$4,000 | $5,000/$10,000 |
| **Out-of-Pocket Limit Per Calendar Year** | **In-network** | **Out-of-network** |
| **Individual/Family** | $5,500/$11,000 | $10,000/$20,000 |

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

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

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

| Service/Supply | In-network Member Pays | Out-of-network Member Pays |
|---|---|---|
| **Office procedures and supplies** | No deductible, 0% | After deductible, 40% |
| **Surgery** | After deductible, 20% | After deductible, 40% |
| **Outpatient rehabilitation and habilitation services** | No deductible, $25 | After deductible, 40% |
| **Chiropractic manipulations, acupuncture, and massage therapy ($1,000 per benefit year.)** | No deductible, $25 | After deductible, 40% |
| **Hospital Services** | | |
| **Inpatient room and board** | After deductible, 20% | After deductible, 40% |
| **Inpatient rehabilitation and habilitation services** | After deductible, 20% | After deductible, 40% |
| **Skilled nursing facility care** | After deductible, 20% | After deductible, 40% |
| **Outpatient Services** | | |
| **Outpatient surgery/services** | After deductible, 20% | After deductible, 40% |
| **Advanced diagnostic imaging** | After deductible, 20% | After deductible, 40% |
| **Diagnostic and therapeutic radiology/lab and dialysis** | No deductible, 20% | No deductible, 40% |
| **Urgent and Emergency Services** | | |
| **Urgent care center visits** | No deductible, $25 | After deductible, 40% |
| **Emergency room visits – medical emergency** | No deductible, $150 plus 20%^ | No deductible, $150 plus 20%^ |
| **Emergency room visits – non-emergency** | No deductible, $150 plus 20%^ | After deductible, 40% |
| **Ambulance, ground** | After deductible, 20% | After deductible, 20% |
| **Ambulance, air** | After deductible, 50% | After deductible, 50%+ |
| **Maternity Services**** | | |
| **Physician/Provider services (global charge)** | After deductible, 20% | After deductible, 40% |
| **Hospital/Facility services** | After deductible, 20% | After deductible, 40% |
| **Mental Health and Substance Use Disorder Services** | | |
| **Office visits** | No deductible, $25 | After deductible, 40% |
| **Inpatient care** | After deductible, 20% | After deductible, 40% |
| **Residential programs** | After deductible, 20% | After deductible, 40% |

| Service/Supply | In-network Member Pays | Out-of-network Member Pays |
|---|---|---|
| **Other Covered Services** | | |
| **Allergy injections** | No deductible, $5 | 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% |

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

^ Co-pay waived if admitted into hospital.

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

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

# Additional information

## What is the deductible?

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

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

## What is the out-of-pocket limit?

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

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

## Primary care physician or primary care provider (PCP)

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

## Payments to providers

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

## Preauthorization

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

PacificSource HEALTH PLANS

Fern Ridge School District No 28J

## Prescription Drug Benefit Summary
## OR 10-50-75 S2 ODL

**Formulary** Oregon Drug List (ODL)

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

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

### PacificSource Expanded (Preventive) No-cost Drug List and Affordable Care Act Standard Preventive No-cost Drug List

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

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

| Service/ Supply | Tier 1 Member Pays | Tier 2 Member Pays | Tier 3 Member Pays | Tier 4 Member Pays |
|---|---|---|---|---|
| **In-network Retail Pharmacy** | | | | |
| **Up to a 30 day supply:** | No deductible, $10 | No deductible, $50 | No deductible, $75 | No deductible, the lesser of $150 or 10% |
| **31 - 60 day supply:** | No deductible, $20 | No deductible, $100 | No deductible, $150 | No deductible, the lesser of $300 or 10% |
| **61 - 90 day supply:** | No deductible, $30 | No deductible, $150 | No deductible, $225 | No deductible, the lesser of $450 or 10% |
| **In-network Mail Order Pharmacy** | | | | |
| **Up to a 30 day supply:** | No deductible, $10 | No deductible, $50 | No deductible, $75 | No deductible, the lesser of $150 or 10% |
| **31 - 90 day supply:** | No deductible, $20 | No deductible, $100 | No deductible, $150 | No deductible, the lesser of $300 or 10% |
| **Compound Drugs**** | | | | |
| **Up to a 30 day supply:** | No deductible, $75 | | | |

| Service/ Supply | Tier 1 Member Pays | Tier 2 Member Pays | Tier 3 Member Pays | Tier 4 Member Pays |
|---|---|---|---|---|
| **31 - 60 day supply:** | | No deductible, $150 | | |
| **61 - 90 day supply:** | | No deductible, $225 | | |
| **Out-of-network Pharmacy** | | | | |
| **30 day max fill, no more than three fills allowed per year:** | | No deductible, 90% | | |

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

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

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

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

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

# *HSA Plan – SmartChoice Network*

PacificSource HEALTH PLANS

**Medical Benefit Summary**

## SmartChoice HSA 2500_20+Rx Non-embedded

Fern Ridge School District No 28J

Provider Network: **SmartChoice**

| Deductible Per Calendar Year | In-network | Out-of-network |
|---|---|---|
| **Individual/Family** | $2,500/$5,000 | $7,500/$15,000 |
| **Out-of-Pocket Limit Per Calendar Year** | **In-network** | **Out-of-network** |
| **Individual/Family** | $5,000/$8,150 | $15,000/$30,000 |

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

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

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

| Service/Supply | In-network Member Pays | Out-of-network Member Pays |
|---|---|---|
| **Office procedures and supplies** | After deductible, 20% | After deductible, 40% |
| **Surgery** | After deductible, 20% | After deductible, 40% |
| **Outpatient rehabilitation and habilitation services** | After deductible, 20% | After deductible, 40% |
| **Chiropractic manipulations, acupuncture, and massage therapy ($1,000 per benefit year.)** | After deductible, 20% | After deductible, 40% |
| **Hospital Services** | | |
| **Inpatient room and board** | After deductible, 20% | After deductible, 40% |
| **Inpatient rehabilitation and habilitation services** | After deductible, 20% | After deductible, 40% |
| **Skilled nursing facility care** | After deductible, 20% | After deductible, 40% |
| **Outpatient Services** | | |
| **Outpatient surgery/services** | After deductible, 20% | After deductible, 40% |
| **Advanced diagnostic imaging** | After deductible, 20% | After deductible, 40% |
| **Diagnostic and therapeutic radiology/lab and dialysis** | After deductible, 20% | After deductible, 40% |
| **Urgent and Emergency Services** | | |
| **Urgent care center visits** | After deductible, 20% | After deductible, 40% |
| **Emergency room visits – medical emergency** | After deductible, 20% | After deductible, 20% |
| **Emergency room visits – non-emergency** | After deductible, 20% | After deductible, 40% |
| **Ambulance, ground** | After deductible, 20% | After deductible, 20% |
| **Ambulance, air** | After deductible, 20% | After deductible, 20%+ |
| **Maternity Services**** | | |
| **Physician/Provider services (global charge)** | After deductible, 20% | After deductible, 40% |
| **Hospital/Facility services** | After deductible, 20% | After deductible, 40% |
| **Mental Health and Substance Use Disorder Services** | | |
| **Office visits** | After deductible, 20% | After deductible, 40% |
| **Inpatient care** | After deductible, 20% | After deductible, 40% |
| **Residential programs** | After deductible, 20% | After deductible, 40% |

| Service/Supply | In-network Member Pays | Out-of-network Member Pays |
|---|---|---|
| **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% |

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

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

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

# Additional information

## What is the deductible?

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

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

## What is the out-of-pocket limit?

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

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

## Primary care physician or primary care provider (PCP)

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

## Payments to providers

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

## Preauthorization

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

PacificSource HEALTH PLANS

Fern Ridge School District No 28J

## Prescription Drug Benefit Summary
## OR 20P 2500D S2 ODL

**Formulary** Oregon Drug List (ODL)

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

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

### 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 and Affordable Care Act Standard Preventive No-cost Drug List

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

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

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

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

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

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

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

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

# *$6000 Deductible Plan – SmartChoice Network*

PacificSource HEALTH PLANS

Fern Ridge School District No 28J

**Medical Benefit Summary**
**SmartChoice 6000+35_20 S3**

Provider Network: **SmartChoice**

| Deductible Per Calendar Year | In-network | Out-of-network |
|---|---|---|
| **Individual/Family** | $6,000/$12,000 | $10,000/$20,000 |
| **Out-of-Pocket Limit Per Calendar Year** | **In-network** | **Out-of-network** |
| **Individual/Family** | $7,900/$15,800 | $20,000/$40,000 |

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

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

| Service/Supply | In-network Member Pays | Out-of-network Member Pays |
|---|---|---|
| **Preventive Care** | | |
| **Well baby/Well child care** | No deductible, 0% | After deductible, 40% |
| **Preventive physicals** | No deductible, 0% | After deductible, 40% |
| **Well woman visits** | No deductible, 0% | After deductible, 40% |
| **Preventive mammograms** | No deductible, 0% | After deductible, 40% |
| **Immunizations** | No deductible, 0% | After deductible, 40% |
| **Preventive colonoscopy** | No deductible, 0% | After deductible, 40% |
| **Prostate cancer screening** | No deductible, 0% | After deductible, 40% |
| **Professional Services** | | |
| **Primary care practitioner (PCP) Office and home visits** | No deductible, $35 | After deductible, 40% |
| **Naturopath office visits** | No deductible, $35 | After deductible, 40% |
| **Specialist office and home visits** | No deductible, $35 | After deductible, 40% |
| **Telemedicine visits** | No deductible, $10 | After deductible, 40% |

| Service/Supply | In-network Member Pays | Out-of-network Member Pays |
|---|---|---|
| **Office procedures and supplies** | No deductible, 0% | After deductible, 40% |
| **Surgery** | After deductible, 20% | After deductible, 40% |
| **Outpatient rehabilitation and habilitation services** | No deductible, $35 | After deductible, 40% |
| **Chiropractic manipulations, acupuncture, and massage therapy ($1,000 per benefit year.)** | No deductible, $35 | After deductible, 40% |
| **Hospital Services** | | |
| **Inpatient room and board** | After deductible, 20% | After deductible, 40% |
| **Inpatient rehabilitation and habilitation services** | After deductible, 20% | After deductible, 40% |
| **Skilled nursing facility care** | After deductible, 20% | After deductible, 40% |
| **Outpatient Services** | | |
| **Outpatient surgery/services** | After deductible, 20% | After deductible, 40% |
| **Advanced diagnostic imaging** | After deductible, 20% | After deductible, 40% |
| **Diagnostic and therapeutic radiology/lab and dialysis** | After deductible, 20% | After deductible, 40% |
| **Urgent and Emergency Services** | | |
| **Urgent care center visits** | No deductible, $35 | After deductible, 40% |
| **Emergency room visits – medical emergency** | After deductible, 20% | After deductible, 20% |
| **Emergency room visits – non-emergency** | After deductible, 20% | After deductible, 20% |
| **Ambulance, ground** | After deductible, 20% | After deductible, 20% |
| **Ambulance, air** | After deductible, 50% | After deductible, 50%+ |
| **Maternity Services**** | | |
| **Physician/Provider services (global charge)** | After deductible, 20% | After deductible, 40% |
| **Hospital/Facility services** | After deductible, 20% | After deductible, 40% |
| **Mental Health and Substance Use Disorder Services** | | |
| **Office visits** | No deductible, $35 | After deductible, 40% |
| **Inpatient care** | After deductible, 20% | After deductible, 40% |
| **Residential programs** | After deductible, 20% | After deductible, 40% |

| Service/Supply | In-network Member Pays | Out-of-network Member Pays |
|---|---|---|
| **Other Covered Services** | | |
| **Allergy injections** | No deductible, $5 | 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% |

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

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

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

# Additional information

## What is the deductible?

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

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

## What is the out-of-pocket limit?

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

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

## Primary care physician or primary care provider (PCP)

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

## Payments to providers

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

## Preauthorization

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

PacificSource HEALTH PLANS

Fern Ridge School District No 28J

## Prescription Drug Benefit Summary
## OR 10-50-75 S2 ODL

**Formulary** Oregon Drug List (ODL)

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

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

### PacificSource Expanded (Preventive) No-cost Drug List and Affordable Care Act Standard Preventive No-cost Drug List

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

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

| Service/ Supply | Tier 1 Member Pays | Tier 2 Member Pays | Tier 3 Member Pays | Tier 4 Member Pays |
|---|---|---|---|---|
| **In-network Retail Pharmacy** | | | | |
| **Up to a 30 day supply:** | No deductible, $10 | No deductible, $50 | No deductible, $75 | No deductible, the lesser of $150 or 10% |
| **31 - 60 day supply:** | No deductible, $20 | No deductible, $100 | No deductible, $150 | No deductible, the lesser of $300 or 10% |
| **61 - 90 day supply:** | No deductible, $30 | No deductible, $150 | No deductible, $225 | No deductible, the lesser of $450 or 10% |
| **In-network Mail Order Pharmacy** | | | | |
| **Up to a 30 day supply:** | No deductible, $10 | No deductible, $50 | No deductible, $75 | No deductible, the lesser of $150 or 10% |
| **31 - 90 day supply:** | No deductible, $20 | No deductible, $100 | No deductible, $150 | No deductible, the lesser of $300 or 10% |
| **Compound Drugs**** | | | | |
| **Up to a 30 day supply:** | No deductible, $75 | | | |

| Service/ Supply | Tier 1 Member Pays | Tier 2 Member Pays | Tier 3 Member Pays | Tier 4 Member Pays |
|---|---|---|---|---|
| **31 - 60 day supply:** | | No deductible, $150 | | |
| **61 - 90 day supply:** | | No deductible, $225 | | |
| **Out-of-network Pharmacy** | | | | |
| **30 day max fill, no more than three fills allowed per year:** | | No deductible, 90% | | |

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

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

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

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

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

# Dental Insurance
# PacificSource

PacificSource HEALTH PLANS

Fern Ridge School District No 28J

## Dental Benefit Summary
## Preventive Dental 2000 S3

This dental care plan covers the following services when performed by a licensed dentist, dental hygienist, or denturist to the extent that they are operating within the scope of their license as required under law in the state of issuance, and when determined to be necessary, usual, and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury, including masticatory function (chewing of food).

In-network dentists contract with PacificSource to furnish dental services and supplies for a set fee. That fee is called the contracted allowable fee. In-network providers agree not to collect more than the contracted allowable fee.

| Benefit Maximum Per Calendar Year |
|---|
| $2,000 per person. Applies to Class II and Class III services. |

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

| Service/Supply | All Providers Member Pays |
|---|---|
| **Class I Services** | |
| **Examinations** | 0% |
| **Bitewing films, full mouth x-rays, cone beam x-rays, and/or panorex** | 0% |
| **Dental cleaning (prophylaxis and periodontal maintenance)** | 0% |
| **Fluoride (topical or varnish applications)** | 0% |
| **Sealants** | 0% |
| **Space maintainers** | 0% |
| **Athletic mouth guards** | 0% |
| **Brush biopsies** | 0% |
| **Class II Services** | |
| **Fillings** | 0% |
| **Simple extractions** | 0% |
| **Periodontal scaling and root planing** | 0% |
| **Full mouth debridement** | 0% |
| **Complicated oral surgery** | 0% |
| **Pulp capping** | 0% |
| **Pulpotomy** | 0% |

| Service/Supply | All Providers Member Pays |
|---|---|
| **Root canal therapy** | 0% |
| **Periodontal surgery** | 0% |
| **Tooth desensitization** | 0% |
| **Class III Services** | |
| **Crowns** | 0% |
| **Dentures** | 0% |
| **Bridges** | 0% |
| **Replacement of existing prosthetic device** | 0% |
| **Implants** | 0% |

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

# Additional information

## What is the benefit maximum?

The benefit maximum is the maximum amount payable by this plan for covered services received each calendar year. Expenses for Class I Services do not apply toward the maximum.

## Predetermination

Coverage of certain dental services and surgical procedures are by review. When a planned dental service exceeds $300, PacificSource recommends a predetermination to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. Predeterminations are not a guarantee of payment and do not change your out-of-pocket expense.

This plan covers orthodontia for all eligible members. Enrollment in orthodontia coverage must be the same as enrollment in the dental plan.

**The dollar amount listed below is the maximum benefit allowed for all orthodontic services covered under this benefit, when prescribed by a licensed dentist or licensed orthodontist.**

| Lifetime Benefit Maximum | All Providers Member Pays |
|---|---|
| $1,000 per person | 50% |

## Benefit Limitations

Benefits for orthodontic covered services will be paid monthly on a pro-rated basis over the length of the treatment. If the orthodontic treatment began before the patient was eligible for this plan, this plan will continue to make payments toward the remaining balance due, as of the patient's initial eligibility date. The benefit maximum listed above will apply fully to this amount. PacificSource's obligation to make payment for orthodontic treatment ends when the patient's eligibility ends, or when treatment is terminated before the case is completed.

## Exclusions

This plan does not cover repair or replacement of orthodontic appliances furnished under this program.

Mail order or Internet/web based providers are not eligible providers.

# Vision
# PacificSource

PacificSource HEALTH PLANS

Fern Ridge School District No 28J

**Vision Benefit Summary**
**Vision 10-400 S2**

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

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

| Service/Supply | In-network Member Pays | Out-of-network Member Pays |
|---|---|---|
| **Enrolled Members Age 18 and Younger** | | |
| **Eye exam** | No deductible, $10 | No deductible up to $40 then 100% |
| **Vision hardware** | No deductible, 0% for one pair per year for frames and/or lenses | No deductible, 0% for one pair per year up to $75 then 100% for frames and/or lenses |
| **Enrolled Members Age 19 and Older** | | |
| **Eye exam** | No deductible, $10 | No deductible up to $40 then 100% |
| **Vision hardware** | No deductible, 0% up to $400 | |

### Benefit Limitations: enrolled members age 18 and younger

One vision exam every calendar year.

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

### Benefit Limitations: enrolled members age 19 and older

One vision exam every calendar year.

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

Anti-reflective coatings and scratch resistant coatings are covered.

### Exclusions

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

Expenses covered under any workers' compensation law.

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

Medical or surgical treatment of the eye.

Nonprescription lenses.

Plano contact lenses.

Services or supplies not listed as covered expenses.

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

Special procedures, such as orthoptics or vision training.

Visual analysis that does not include refraction.

## Important information about your vision benefits

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

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

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

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

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

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

Using your preventive care benefits is a good way to maintain and even improve your health. When these services are given by a participating provider and billed as routine preventive services, your plan covers them in full. This is true even if you have not met your annual deductible.

| Preventive Care Services and Limits | |
|---|---|
| Well baby/Well child care | For members age 21 and younger according to the following schedule:<br>- At birth: One standard in-hospital exam<br>- Ages 0-2: 12 additional exams during the first 36 months of life<br>- Ages 3-21: One exam per calendar year |
| Routine physicals | Including appropriate screening radiology and laboratory tests and other screening procedures for members age 22 and older are covered once per calendar year. Screening exams and laboratory tests may include, but are not limited to, blood pressure checks, weight checks, occult blood tests, urinalysis, complete blood count, prostate exams, cholesterol exams, stool guaiac screening, EKG screens, blood sugar tests, and tuberculosis skin tests.<br>Only laboratory tests and other diagnostic testing procedures related to the routine physical exam are covered by this benefit. Any laboratory tests and other diagnostic testing procedures ordered during, but not related to, a routine physical examination are not covered by this preventive care benefit. |
| Well woman visits | Include the following:<br>- One routine gynecological exam each calendar year for women 18 and over. Exams may include Pap smear, pelvic exam, breast exam, blood pressure check, and weight check. Covered lab services are limited to occult blood, urinalysis, and complete blood count.<br>- Pelvic exams and Pap smear exams for women 18 to 64 years of age annually, or at any time when recommended by a women's healthcare provider.<br>- Breast Exams annually for women 18 years of age or older or at any time when recommended by a women's healthcare provider for the purpose of checking for lumps and other changes for early detection and prevention of breast cancer.<br>Members have the right to seek care from obstetricians and gynecologists for covered services without preapproval or preauthorization. |
| Routine mammograms | Routine preventive mammograms for women as recommended |
| Contraceptives | Any deductible, co-payment, and/or co-insurance amounts are waived for Food and Drug Administration (FDA) approved contraceptive methods for all women with reproductive capacity, as supported by the Health Resources and Services Administration (HRSA), when provided by a participating pharmacy. If a generic exists, preferred brand contraceptives will remain subject to regular pharmacy plan benefits unless deemed medically necessary by the member's attending provider. Providers must request formulary exceptions by contacting our Pharmacy Services team. When no generic exists, preferred brands are covered at no cost. If a generic becomes available, the preferred brand will no longer be covered under the preventive care benefit unless deemed medically necessary by the member's attending provider.<br>If an initial three month supply is tried, then a twelve month refill of the same contraceptive is covered, regardless if the initial prescription was covered under this plan. |
| Sterilization | This plan covers tubal ligation and vasectomy procedures. |
| Breastfeeding | Manual and electric breast pumps are covered at no cost once per pregnancy when purchased or rented from a participating licensed provider, or purchased from a retail outlet. Hospital-grade breast pumps are not covered. |
| Immunizations | Age-appropriate childhood and adult immunizations for primary prevention of infectious diseases as recommended and adopted by the Centers for Disease Control and Prevention, American Academy of Pediatrics, American Academy of Family Physicians, or similar standard-setting body. Benefits do not include immunizations for more elective, investigative, unproven, or discretionary reasons (e.g. travel). Covered immunizations include but may not be limited to the following:<br>- Diphtheria, pertussis, and tetanus (DPT) vaccines, given separately or together<br>- Hemophilus influenza B vaccine<br>- Hepatitis A vaccine<br>- Hepatitis B vaccine<br>- Human papillomavirus (HPV) vaccine<br>- Influenza virus vaccine<br>- Measles, mumps, and rubella (MMR) vaccines, given separately or together<br>- Meningococcal (meningitis) vaccine<br>- Pneumococcal vaccine<br>- Polio vaccine<br>- Shingles vaccine for ages 60 and over |

| Preventive Care Services and Limits | |
|---|---|
| | - Varicella (chicken pox) vaccine |
| Routine Colonoscopy | Colorectal cancer screening exams and lab work tests assigned a grade 'A' or 'B' by the U.S. Preventive Task Force which includes the following:<br>- A colonoscopy, including removal of polyps during the screening procedure if a positive result on any fecal test assigned either a grade 'A' or 'B';<br>- A fecal occult blood test;<br>- A flexible sigmoidoscopy; or<br>- A double contrast barium enema.<br>A colonoscopy performed for screen purposes on individuals at 'high risk' under age 50 is also considered a preventive service. An individual is at high risk for colorectal cancer if the individual has:<br>- Family medical history of colorectal cancer<br>- Prior occurrence of cancer or precursor neoplastic polyps<br>- Prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease<br>- Crohn's disease or ulcerative colitis<br>- Other predisposing factors |
| Prostate cancer screening | Including a digital rectal examination and a prostate-specific antigen test. |
| Tobacco cessation program services | Tobacco cessation program services and drugs are covered at no charge. Prescribed tobacco cessation related medication will be covered to the same extent this policy covers other prescription medications. |
| Pharmacy | Unless otherwise stated, a written prescription is required, even if the covered drug is over-the-counter. A 90-day supply is allowed at both participating retail and mail-order pharmacies, unless otherwise noted.<br>- Aspirin to prevent cardiovascular disease and colorectal cancer for ages 50 to 59 and as a preventive medication after 12 weeks of gestation in women who are at high risk of preeclampsia; generic 81mg only.<br>- Low to moderate dose generic statin to prevent cardiovascular disease for age 40 to 75<br>- Fluoride through age 5 years only<br>- Folic Acid supplements for women under 55 who are planning or capable of pregnancy<br>- Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls<br>- Raloxifene and Tamoxifen to reduce primary breast cancer risk in females age 35 and over<br>- Bowel preparation medications for ages 50 through 74 years; Gavilyte-H kit, etc.<br>- Tobacco cessation medications as prescribed by a doctor:<br>o OTC (gum, patches, lozenges) or prescription tobacco cessation medications (bupropion, Zyban, or Chantix) when purchased at a participating pharmacy<br>o 168 day annual limit on tobacco cessation drugs<br><br>Please note this information is reviewed and updated periodically. For the most current information, please visit the website below. |
| Other Medical | - Services that have a rating of 'A' or 'B' from the U.S. Preventive Services Task Force (USPSTF)<br>- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC)<br>- Preventive care and screening for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA)<br>- Preventive care and screening for women supported by the HRSA that are not included in the USPSTF recommendations<br><br>A and B lists for preventive services can be found at:<br>http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/<br><br>The list of Women's preventive services can be found at:<br>http://www.hrsa.gov/womensguidelines/ |

**This is a brief summary. Refer to the benefit policy for more details on benefits, limits, and exclusions.**

# PacificSource Extras

# Value-added Extras For Members

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

## Online Tools and Resources at PacificSource.com

### InTouch for Members

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

### CaféWell

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

### myPacificSource Mobile App

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

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

### Provider Directory

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

## Wellness and Care Management Programs

### 24-Hour NurseLine

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

### Prenatal Program

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

**Email**
cs@pacificsource.com

**Phone**

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

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

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

**TTY**
**Toll-free** (800) 735-2900

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

**PacificSource.com**

PacificSource HEALTH PLANS

*Not all value-added benefits are available on all plans. If you have questions about which programs and services are available on a specific plan, please contact us.

## Prenatal Vitamins

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

## Tobacco Cessation

Our Quit For Life® program, a collaboration between Optum and the American Cancer Society, can help tobacco users kick the habit. Members receive phone and online support, as well as a Quit Kit with information to help keep them on track. The member toll-free number is **(866) 784-8454.**

## Teladoc™

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

## Health and Wellness Education

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

## Weight Management Programs

Members with medical coverage can:

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

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

## Fitness Center Program

The Active&Fit Direct program gives members access to 9,000+ fitness centers and YMCAs nationwide. Sign up for multi-facility access for a $25 initiation fee and a $25 monthly fee (plus applicable taxes). Learn more at **PacificSource.com/ActiveAndFit.**

## Wellness for Kids

Nine- and six-year-olds currently covered by a PacificSource medical plan may be invited by mail to join HealthKicks!, a children's program that promotes healthy behaviors. Contact our wellness team at **wellness@pacificsource.com** for more information.

## Condition Support Program

Personal support is available to members with certain chronic conditions. The program is optional and includes one-on-one coaching with our nurses and dietitian to help participants reach their health and wellness goals. We invite members diagnosed with diabetes, coronary artery disease, heart failure, chronic obstructive pulmonary disease (COPD), or asthma to participate. (Potential participants are identified using pharmacy and medical claims or through referrals from a case manager or physician.)

PacificSource HEALTH PLANS

## AccordantCare® Rare Disease Management Program

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

## Caremark® Specialty Pharmacy

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

## Nurse Case Management

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

## LifeTrac℠ Transplant Network

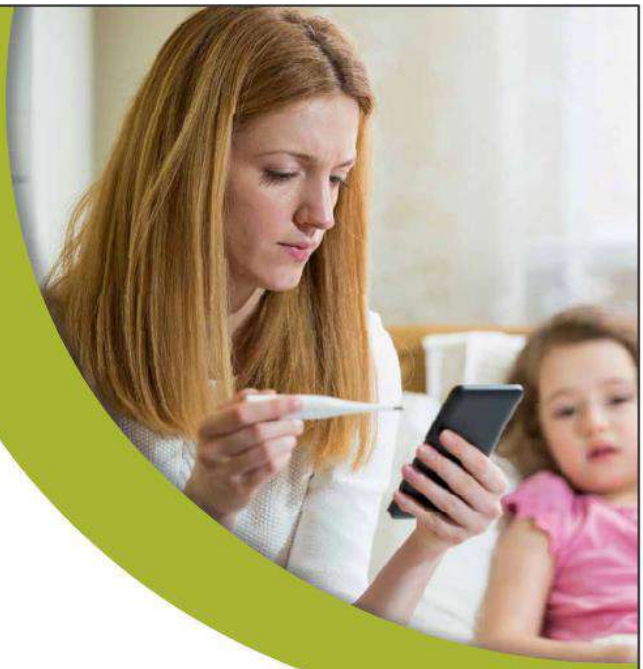
We partner with LifeTrac Transplant Network to ensure that our members requiring transplant services have access to nationally recognized centers of excellence. Our Case Managers assist members by coordinating all phases of transplant services.

# Travel Program

## Assist America® Global Emergency Services

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

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



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

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

## 1. Set up your Teladoc® account

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

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

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

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

## 2. Provide medical history

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

## 3. Request a consult

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

### Talk to a doctor anytime!

**Web**
Teladoc.com

**Phone**
(855) 201-7488

**Mobile App**
Teladoc.com/mobile

*See reverse for FAQ >*

PacificSource HEALTH PLANS

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

# Frequently Asked Questions

## What is Teladoc?

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

## Who are the Teladoc doctors?

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

## Does Teladoc replace my doctor?

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

## What kind of medical care does Teladoc provide?

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

## What consult methods are available?

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

## How do I set up my Teladoc account?

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

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

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

## How do I request a behavioral health visit?

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

## How quickly can I talk to the doctor?

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

## Is there a time limit when talking with a doctor?

There is no time limit for consults.

## Can Teladoc doctors write a prescription?

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

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

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

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

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

## How do I pay for the consult?

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

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

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

## Can I provide consult information to my doctor?

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

PacificSource HEALTH PLANS

# Personalized Guidance for a **Healthier Life**

Taking the first step to making healthy life changes can be tough. That's why we're excited to offer you access to CaféWell: a health engagement portal that offers personalized guidance and support to live a healthier life.

## Achieve Better Health with CaféWell

When you register for CaféWell, you'll have instant access to a variety of resources, such as activities, wellness challenges, and health coaching to help you take the next steps to better health—no matter where you're starting.

## Engage in Your Health

CaféWell offers a variety of resources to help you take charge of your health.

- **Complete an activity.** Participate in a health activity that fits your personal goals and energy level.
- **Talk to a coach.** Get your health questions answered online or during live webinars.
- **Join a community.** Connect with others who are focused on similar health goals.
- **Explore expert content.** Access tips and articles about nutrition, fitness, and more.
- **Complete the health assessment.** Identify your potential health risks and create or revamp a plan to achieve your health goals.

## Customize Your Healthy Life Journey

When you register for CaféWell, you can create a personalized plan that's right for you, based on your health goals.

- **Create your own activity program.** Meet your healthy life goals with your own custom individual or group activity.
- **Follow health and wellness blogs.** You can keep up with, and contribute to, health topics that matter to you.

## Get Started Today

### Step One: Log Into InTouch

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

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

### Step Two: Go to CaféWell

From your InTouch home page:

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

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

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

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

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

**TTY**
Toll-free: (800) 735-2900

**En Español**
Direct: (541) 684-5456
Toll-free: (866) 281-1464

**Email**
cs@pacificsource.com

**PacificSource.com**

PacificSource HEALTH PLANS

CLB129_1217

# Coverage No Matter **Where You Travel**

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

## Help When It's Needed Most

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

Assist America's services can be accessed for:

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

### No Unexpected Cost to Member or Employer

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

## Key Services

### Medical Consultation, Evaluation and Referral

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

### Hospital Admission Guarantee

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

### Emergency Medical Evacuation

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

### Critical Care Monitoring

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

*Continued on next page >*

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

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

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

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

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

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

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

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

**PacificSource.com**

PacificSource HEALTH PLANS

### Medical Repatriation

If medical assistance is required after being discharged from a hospital, Assist America will repatriate the member home or to a rehabilitation facility with a medical or non-medical escort, as necessary.

### Prescription Assistance

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

### Emergency Messages

Assist America will receive and send emergency messages as needed.

### Compassionate Visit

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

### Care of Minor Children

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

### Return of Mortal Remains

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

### Emergency Trauma Counseling

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

### Lost Luggage or Document Assistance

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

### Interpreter and Legal Referrals

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

### Pre-trip Information

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

### Services that Compliment Health Coverage

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

## About Assist America

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

## Questions?

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

# The Active&Fit Direct™ Fitness Center Program

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

## Freedom and flexibility

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

## Get started

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

## Try out a fitness center

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

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

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

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

**TTY**
Toll-free: (800) 735-2900

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

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PacificSource HEALTH PLANS

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