



**HEALTH  
INSURANCE**



**2022-2023**  
**Employee Benefits Guide**  
Licensed Employees



# Sources of Assistance

	CARRIER	GROUP #	PHONE NUMBER	WEBSITE
Medical, Rx, Dental & Vision	PacificSource	G0020201	888-977-9299	www.pacificsource.com
Life and AD&D	Standard Insurance	137212	800-628-8600	www.standard.com
Voluntary Life and AD&D	Standard Insurance	137212	800-628-8600	www.standard.com
Long Term Disability	Standard Insurance	137212	800-368-1135	www.standard.com
Flexible Spending Account (FSA)	PacificSource Administrators	Bethel SD	800-422-7038	www.psacustomerservice@pacificsource.com
Employee Assistance Program (EAP)	Standard Insurance	137212	888-293-6948	www.standard.com
Benefit Resource Center (BRC)	USI Insurance	N/A	866-468-7272	Email: BRCWest@usi.com

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# Eligibility & Enrollment

## Eligibility Rules

Eligibility rules determine who is eligible for the plan. Eligibility rules are based on your status as an employee or contractor, your relationship to an eligible employee, and your age. Eligibility rules also determine when you can enroll in the plan. Eligibility rules are subject to change without notice. For more information, see the plan document.

## Enrollment Is Simple

Enrollment is simple. You can enroll in the plan during the open enrollment period. You can also enroll in the plan during a special enrollment period. Enrollment is simple and straightforward. For more information, see the plan document.

## When Can You Enroll?

Open enrollment periods are held annually.

- Open enrollment periods are held annually.
- Open enrollment periods are held annually.
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If you do not enroll at the above times, you must wait for the next annual open enrollment period.

## Making Changes

Changes to your enrollment can be made during the open enrollment period. Changes to your enrollment can also be made during a special enrollment period. Changes to your enrollment are subject to the plan document. For more information, see the plan document.

- Change in your work status
- Change in your spouse's work status that affects his or her benefits
- Change in your child's eligibility for benefits
- Change in your child's eligibility for benefits
- Change in your child's eligibility for benefits

For more information, see the plan document. The plan document contains the complete terms and conditions of the plan. For more information, see the plan document.

# Benefits at a Glance

## Medical / Rx Insurance

Employees are eligible for Medical and Prescription Drug Insurance. Employees are responsible for a portion of the cost. Employees may also elect to pay for their own health insurance.

## Dental Insurance

Employees are eligible for Dental Insurance. Employees are responsible for a portion of the cost. Employees may also elect to pay for their own dental insurance. Employees are eligible for Vision Insurance. Employees are responsible for a portion of the cost. Employees may also elect to pay for their own vision insurance.

## Vision Insurance

Employees are eligible for Vision Insurance. Employees are responsible for a portion of the cost. Employees may also elect to pay for their own vision insurance.

## Life and AD&D Insurance (Company-Paid Life and AD&D)

Employees are eligible for Life and AD&D Insurance. Employees are responsible for a portion of the cost. Employees may also elect to pay for their own Life and AD&D insurance.

## Voluntary Additional Insurance

Employees are eligible for Voluntary Additional Insurance. Employees are responsible for a portion of the cost. Employees may also elect to pay for their own Voluntary Additional Insurance.

## Long Term Disability (LTD)

Employees are eligible for Long Term Disability (LTD) Insurance. Employees are responsible for a portion of the cost. Employees may also elect to pay for their own Long Term Disability (LTD) insurance.

## Flexible Spending Account (FSA)

Employees are eligible for a Flexible Spending Account (FSA). Employees are responsible for a portion of the cost. Employees may also elect to pay for their own Flexible Spending Account (FSA).

## Employee Assistance Program (EAP)

Employees are eligible for the Employee Assistance Program (EAP). Employees are responsible for a portion of the cost. Employees may also elect to pay for their own Employee Assistance Program (EAP).



<b>Service/Supply</b>	<b>In-network Member Pays</b>	<b>Out-of-network Member Pays</b>
<b>Office procedures and supplies</b>	No deductible, 0%	After deductible, 40%
<b>Surgery</b>	After deductible, 10%	After deductible, 40%
<b>Outpatient rehabilitation and habilitation services</b>	No deductible, \$25	After deductible, 20%
<b>Chiropractic manipulation/Spinal manipulation (20 visits per benefit year)</b>	No deductible, \$25	No deductible, \$25
<b>Acupuncture (12 visits per benefit year)</b>	No deductible, \$25	No deductible, \$25
<b>Massage therapy (\$2,500 per benefit year)</b>	No deductible, \$25	No deductible, \$25
<b>Hospital Services</b>		
<b>Inpatient room and board</b>	No deductible, \$300/admit	After deductible, \$600/admit
<b>Inpatient rehabilitation and habilitation services</b>	No deductible, \$300/admit	After deductible, \$600/admit
<b>Skilled nursing facility care</b>	No deductible, \$300/admit	After deductible, \$600/admit
<b>Outpatient Services</b>		
<b>Outpatient surgery/services</b>	No deductible, \$150	After deductible, \$150
<b>Diagnostic imaging – advanced</b>	No deductible, \$100/test	After deductible, 40%
<b>Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced</b>	After deductible, 10%	After deductible, 40%
<b>Urgent and Emergency Services</b>		
<b>Urgent care center visits</b>	No deductible, \$25	After deductible, 40%
<b>Emergency room visits – medical emergency</b>	After deductible, 10%	After deductible, 10%
<b>Emergency room visits – non-emergency</b>	After deductible, 10%	After deductible, 10%
<b>Ambulance, ground</b>	No deductible, \$50/trip	No deductible, \$50/trip
<b>Ambulance, air</b>	No deductible, \$50/trip	No deductible, \$50/trip+
<b>Maternity Services**</b>		
<b>Physician/Provider services (global charge)</b>	After deductible, 10%	After deductible, 40%
<b>Hospital/Facility services</b>	No deductible, \$300 per pregnancy	After deductible, \$600 per pregnancy

<b>Service/Supply</b>	<b>In-network Member Pays</b>	<b>Out-of-network Member Pays</b>
<b>Mental Health and Substance Use Disorder Services</b>		
<b>Office visits</b>	No deductible, \$25	After deductible, 40%
<b>Inpatient care</b>	No deductible, \$300/admit	After deductible, \$600/admit
<b>Residential programs</b>	No deductible, \$300/admit	After deductible, \$600/admit
<b>Other Covered Services</b>		
<b>Allergy injections</b>	After deductible, 10%	After deductible, 40%
<b>Durable medical equipment</b>	After deductible, 20%	After deductible, 40%
<b>Home health services</b>	No deductible, 10%	No deductible, 20%
<b>Transplants</b>	After deductible, 0%	After deductible, 40%
<b>Infertility</b>	After deductible, 50%	After deductible, 50%

**This is a brief summary of benefits. Refer to your 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, copayment, or coinsurance.

+ 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 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.

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, the individual out-of-pocket limit applies for each member only until the family out-of-pocket limit has been met. Be sure to check your handbook, as there are some charges, such as non-essential health benefits, penalties, and balance billed amounts that do not count toward the out-of-pocket limit.

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 at [Authgrid.PacificSource.com](https://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.





## Tier 1, Tier 2, and Tier 3 Member Pays

### Specialty Drugs - In-network Specialty Pharmacy

**Up to a 30 day supply:**

Same as retail

### Specialty Drugs - Out-of-network Specialty Pharmacy

**30 day maximum fill, no more than three fills allowed per year:**

Same as retail

+Formulary prescription insulin will not be subject to a deductible and may not exceed \$75 per 30 day supply.

\*\*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.

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 plan's 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 prior authorization for coverage at no charge.

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



# Value-added extras for you

Our extra tools, benefits, and programs are how we add value to your health plan. 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](https://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<sup>®</sup> 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 mothers learn more about their 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. Visit [PacificSource.com/prenatal](https://PacificSource.com/prenatal) to find out which prenatal vitamins are covered.

### Weight management programs

As a part of your PacificSource medical coverage, participate in a WW<sup>®</sup> (formerly 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<sup>™</sup> gives you access to more than 9,000 fitness facilities nationwide. The program's website offers a gym locator, educational materials, online fitness tracking, and wellness product discounts.

### Email

[CS@PacificSource.com](mailto:CS@PacificSource.com)

### Phone

888-977-9299

TTY: 711

We accept all relay calls.  
En Español 866-281-1464

### [PacificSource.com](https://PacificSource.com)



## Wellness for kids

Six- and nine-year-olds currently covered by a PacificSource medical plan can join HealthKicks!, a children's program that promotes healthy behaviors.

Children enrolling in HealthKicks! will receive age-appropriate, educational activity sheets in the mail with fun information on topics such as nutrition, exercise, and good health habits.

## 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 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.

## 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 [PacificSource.com/members/prescription-drug-information](https://www.pacificsource.com/members/prescription-drug-information).

#### CVS Caremark

**Web:** [Caremark.com](https://www.caremark.com)

**Phone:** 866-329-3051

## Care management

### Condition support program

Personal support is available to members with certain chronic conditions. If you have diabetes, coronary artery disease, heart failure, chronic obstructive pulmonary disease (COPD), or asthma, you might be interested in our free condition support program. It is 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.

### 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.

## Case Management Services

If you have an ongoing medical need, our Nurse Case Managers can help. PacificSource Case Managers—registered nurses with extensive experience—work with you and your healthcare providers to ensure continuity of care and prevent breaks in necessary medical services.

## 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](https://www.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](https://www.pacificsource.com/mobile).

### Health engagement portal

CaféWell is a secure online health engagement portal with personalized information and tools to help you make the most of your health. Log into InTouch, then click Benefits > Wellness – CaféWell.

### 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](https://www.pacificsource.com/find-a-doctor).

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Find more information at [PacificSource.com/extras](https://www.pacificsource.com/extras).

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



# Teladoc<sup>®</sup> – access to doctors via phone, video, or mobile app

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

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



## 1. Set up your Teladoc account

There are three options to get started. Note: when asked to enter the name of your employer or insurance carrier, please use "**PacificSource**" in the field.

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

**Mobile app:** Visit [Teladoc.com/mobile](https://Teladoc.com/mobile) to download the app, then click "Activate account."

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



## 2. Provide medical history

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



## 3. Request an appointment

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

\*Employer group members: to see if Teladoc is available on your plan, check with your employer or contact PacificSource Customer Service at **888-977-9299, TTY 711**, or [CS@PacificSource.com](mailto:CS@PacificSource.com).

See reverse for FAQ >

**Talk to a doctor  
anytime!**

**Web**  
[Teladoc.com](https://Teladoc.com)

**Phone**  
**855-201-7488**

**Mobile App**  
[Teladoc.com/mobile](https://Teladoc.com/mobile)



## Frequently Asked Questions

### What is Teladoc?

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

### Who are the Teladoc doctors?

Teladoc doctors are U.S. board certified in internal medicine, family practice, or pediatrics. They average 20 years 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](http://PacificSource.com), or through the Teladoc website or mobile app. You can also call Teladoc to get started. Note: if setting up your account online, enter "**PacificSource**" for the name of your employer or insurance carrier.

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

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

### How do I request a behavioral health visit?

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

### How quickly can I talk to the doctor?

The median call back time for a general medical request is just 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 for abuse.

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

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

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

The exact amount you will pay is based on your specific plan benefits. The amount for a telehealth visit 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. Your payment method will be set up when you register for Teladoc, and can be changed anytime.

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

Yes. Just like any doctor 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.





## Benefit Limitations: members age 19 and older

- One vision exam every 12 months.
- Lenses: One pair every 12 months.
- Frames: Once every 24 months.
- Contact lenses: Once every 12 months.
- Elective contact lenses are in lieu of frames and lenses.

## Exclusions

- Anti-reflective coatings and scratch resistant coatings.
- Charges for services or supplies covered in whole or in part under any medical or vision benefits provided by an employer.
- Duplication of spare eyeglasses or any lenses or frames for members age 18 and younger.
- Expenses covered under any workers' compensation law.
- Eye exams required as a condition of employment, required by a labor agreement or government body.
- Lens tint.
- Medical or surgical treatment of the eye.
- Nonprescription lenses.
- Plano contact lenses.
- Polycarbonate lenses for members age 19 and older.
- Replacement of lost, stolen, or broken lenses or frames.
- 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.
- Special supplies, such as sunglasses and subnormal vision aids.
- 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.

**Benefit Year:** Calendar Year

This plan covers the following services when performed by a provider 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).

### Payment

**Class I, II, and III Services:** The member pays 30 percent toward all covered services during the first year of eligibility. Payment decreases by 10 percent each successive eligibility year, until they have reached no charge. In order to qualify for each 10 percent decrease, members must visit the provider at least once during each eligibility year. Failure to do so will cause a 10 percent increase in payment for the next eligibility year, although payment will never be more than 30 percent.

Benefit Maximum Per Benefit Year	
\$1,500 per person. Applies to all covered services.	
Exclusion Period	Number of Consecutive Months
All Services	None

**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
<b>Class I Services</b>		
Examinations	30%	30%
Bitewing films, full mouth x-rays, cone beam x-rays, and/or panorex	30%	30%
Dental cleaning (prophylaxis and periodontal maintenance)	30%	30%
Fluoride (topical or varnish applications)	30%	30%
Sealants	30%	30%
Space maintainers	30%	30%
Athletic mouth guards	30%	30%
Brush biopsies	30%	30%

<b>Service/Supply</b>	<b>In-network Member Pays</b>	<b>Out-of-network Member Pays</b>
<b>Class II Services</b>		
<b>Fillings</b>	30%	30%
<b>Simple extractions</b>	30%	30%
<b>Periodontal scaling and root planing</b>	30%	30%
<b>Full mouth debridement</b>	30%	30%
<b>Complicated oral surgery</b>	30%	30%
<b>Pulp capping</b>	30%	30%
<b>Pulpotomy</b>	30%	30%
<b>Root canal therapy</b>	30%	30%
<b>Periodontal surgery</b>	30%	30%
<b>Tooth desensitization</b>	30%	30%
<b>Class III Services</b>		
<b>Crowns</b>	30%	30%
<b>Dentures</b>	30%	30%
<b>Bridges</b>	30%	30%
<b>Replacement of existing prosthetic device</b>	30%	30%
<b>Implants</b>	30%	30%

**This is a brief summary of benefits. Refer to your 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 benefit year.

## What is an exclusion period?

A member must be enrolled under the plan for the period of time stated above before this plan pays benefits. The exclusion period is waived for members who are covered under this plan on the plan's original effective date if the member was continuously covered under a predecessor plan of the employer.

## Prior authorization

Coverage of certain 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. You can search for procedures and services that require prior authorization on our website, [Authgrid.PacificSource.com](https://Authgrid.PacificSource.com) (select Commercial for the line of business).

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**Primary care dentist**

You must select an in-network Essentials dentist as your primary care dentist (PCD) from the plan’s provider directory. The PCD will coordinate all of your dental care needs. See your Dental Handbook for details.

**The member is responsible for the following amounts:**

<b>ADA Code Procedure</b>	<b>Member Pays</b>
<b>General Office Visit Charge</b>	\$15
<b>Specialist Office Visit Charge</b>	\$30
<b>Emergency Office Visit Charge</b>	\$50
<b>Diagnostic and Preventive Services</b>	
<b>D0120 - Periodic oral evaluation</b>	No co-pay
<b>D0140 - Limited oral evaluation – problem focused</b>	No co-pay
<b>D0145 - Oral evaluation – patient under three years old</b>	No co-pay
<b>D0150 - Comprehensive oral evaluation</b>	No co-pay
<b>D0160 - Detailed and extensive oral evaluation</b>	No co-pay
<b>D0170 - Re-evaluation – limited</b>	No co-pay
<b>D0171 - Re-evaluation – post operative office visit</b>	No co-pay
<b>D0180 - Comprehensive periodontal evaluation</b>	No co-pay
<b>D0191 - Assessment of a patient</b>	No co-pay
<b>D0210 - Complete series x-rays</b>	No co-pay
<b>D0220 - Periapical – first film</b>	No co-pay
<b>D0230 - Intraoral – each additional film</b>	No co-pay
<b>D0240 - Intraoral – occlusal film</b>	No co-pay
<b>D0250 - Extraoral – first film</b>	No co-pay
<b>D0251 - Extraoral – posterior dental radiographic image</b>	No co-pay
<b>D0270 - Bitewings – single film</b>	No co-pay
<b>D0272 - Bitewings – two films</b>	No co-pay
<b>D0273 - Bitewings – three films</b>	No co-pay
<b>D0274 - Bitewings – four films</b>	No co-pay
<b>D0277 - Vertical bitewings</b>	No co-pay
<b>D0310 - Sialography</b>	Not covered
<b>D0320 - Temporomandibular joint arthrogram</b>	Not covered

<b>ADA Code Procedure</b>	<b>Member Pays</b>
<b>D0321 - Other Temporomandibular joint films</b>	Not covered
<b>D0322 - Tomographic survey</b>	Not covered
<b>D0330 - Panoramic x-rays</b>	No co-pay
<b>D0340 - Cephalometric film</b>	No co-pay
<b>D0350 - Oral/facial images</b>	No co-pay
<b>D0364 - Cone beam CT, limited view</b>	No co-pay
<b>D0365 - Cone beam CT, full arch – mandible</b>	Not covered
<b>D0366 - Cone beam CT, full arch – maxilla</b>	Not covered
<b>D0367 - Cone beam CT, both jaws</b>	No co-pay
<b>D0368 - Cone beam CT, Temporomandibular joint series</b>	Not covered
<b>D0391 - Interpret and report diagnostic image</b>	Not covered
<b>D0415 - Collection of microorganisms for culture and sensitivity</b>	Not covered
<b>D0425 - Caries susceptibility test</b>	No co-pay
<b>D0460 - Pulp vitality test</b>	No co-pay
<b>D0470 - Diagnostic casts</b>	No co-pay
<b>D1110 - Teeth cleaning (prophylaxis) – adult</b>	No co-pay
<b>D1120 - Teeth cleaning (prophylaxis) – child</b>	No co-pay
<b>D1206 - Topical fluoride – therapeutic application</b>	No co-pay
<b>D1208 - Topical fluoride</b>	No co-pay
<b>D1310 - Nutritional counseling</b>	No co-pay
<b>D1320 - Tobacco counseling</b>	No co-pay
<b>D1330 - Oral hygiene instruction</b>	No co-pay
<b>D1351 - Sealant – per tooth</b>	No co-pay
<b>D1353 - Sealant repair – per tooth</b>	No co-pay
<b>D1354 - Interim caries arresting medicament application</b>	No co-pay
<b>Space Maintainers</b>	
<b>D1510 - Space maintainer – unilateral – fixed</b>	No co-pay
<b>D1516 - Space maintainer – fixed – bilateral, maxillary</b>	No co-pay
<b>D1517 - Space maintainer – fixed – bilateral, mandibular</b>	No co-pay
<b>D1520 - Space maintainer – unilateral – removable</b>	No co-pay
<b>D1526 - Space maintainer – removable – bilateral, maxillary</b>	No co-pay
<b>D1527 - Space maintainer – removable – bilateral, mandibular</b>	No co-pay

<b>ADA Code Procedure</b>	<b>Member Pays</b>
<b>D1551 - Re-cement or re-bond bilateral space maintainer, maxillary</b>	No co-pay
<b>D1552 - Re-cement or re-bond bilateral space maintainer, mandibular</b>	No co-pay
<b>D1553 - Re-cement or re-bond bilateral space maintainer, per quadrant</b>	No co-pay
<b>D1555 - Removal of fixed space maintainer</b>	No co-pay
<b>D1556 - Removal of fixed unilateral space maintainer, per quadrant</b>	No co-pay
<b>D1557 - Removal of fixed unilateral space maintainer, maxillary</b>	No co-pay
<b>D1558 - Removal of fixed unilateral space maintainer, mandibular</b>	No co-pay
<b>Restorative Dentistry - Amalgam Restorations</b>	
<b>D2140 - Fillings – one surface</b>	\$25
<b>D2150 - Fillings – two surfaces</b>	\$25
<b>D2160 - Fillings – three surfaces</b>	\$25
<b>D2161 - Fillings – four or more surfaces</b>	\$25
<b>Restorative Dentistry - Resin Restorations</b>	
<b>D2330 - Resin – one surface – anterior</b>	\$25
<b>D2331 - Resin – two surfaces – anterior</b>	\$25
<b>D2332 - Resin – three surfaces – anterior</b>	\$25
<b>D2335 - Resin – four or more surfaces – anterior</b>	\$25
<b>D2390 - Resin based composite crown</b>	\$25
<b>D2391 - Resin – one surface – posterior</b>	\$25
<b>D2392 - Resin – two surfaces – posterior</b>	\$25
<b>D2393 - Resin – three surfaces – posterior</b>	\$25
<b>D2394 - Resin – four or more surfaces – posterior</b>	\$25
<b>D2950 - Core buildup, including any pins</b>	No co-pay
<b>Restorative Dentistry - Inlay/Onlay (cast restorations)</b>	
<b>D2510 - Inlay – gold – one surface</b>	\$250
<b>D2520 - Inlay – gold – two surfaces</b>	\$250
<b>D2530 - Inlay – gold – three or more surfaces</b>	\$250
<b>D2542 - Onlay – gold – two surfaces</b>	\$250
<b>D2543 - Onlay – gold – three surfaces</b>	\$250
<b>D2544 - Onlay – gold – four or more surfaces</b>	\$250



<b>ADA Code Procedure</b>	<b>Member Pays</b>
<b>D2610 - Inlay – porcelain/ceramic – one surface</b>	\$250
<b>D2620 - Inlay – porcelain/ceramic – two surfaces</b>	\$250
<b>D2630 - Inlay – porcelain/ceramic – three or more surfaces</b>	\$250
<b>D2642 - Onlay – porcelain/ceramic – two surfaces</b>	\$250
<b>D2643 - Onlay – porcelain/ceramic – three surfaces</b>	\$250
<b>D2644 - Onlay – porcelain/ceramic – four or more surfaces</b>	\$250
<b>D2910 - Re-cement inlay, onlay, or partial coverage restoration</b>	No co-pay
<b>Restorative Dentistry - Crowns</b>	
<b>D2710 - Crown – resin laboratory</b>	\$250
<b>D2712 - Crown – ¾ resin-based composite</b>	\$250
<b>D2740 - Crown – porcelain/ceramic – anterior</b>	\$250
<b>D2751 - Crown – porcelain fused to base metal</b>	\$250
<b>D2752 - Crown – porcelain/noble</b>	\$250
<b>D2753 - Crown – porcelain fused to titanium or titanium alloy</b>	\$250
<b>D2782 - Crown – ¾ cast noble</b>	\$250
<b>D2792 - Crown – full cast noble</b>	\$250
<b>D2799 - Provisional crown</b>	No co-pay
<b>D2915 - Re-cement cast or prefabricated post and core</b>	No co-pay
<b>D2920 - Re-cement crown</b>	No co-pay
<b>D2930 - Stainless steel crown – primary</b>	No co-pay
<b>D2931 - Stainless steel crown – permanent</b>	No co-pay
<b>D2932 - Crown – prefabricated resin</b>	No co-pay
<b>D2933 - Crown – prefabricated stainless steel with resin window</b>	No co-pay
<b>D2940 - Sedative filling – temporary</b>	No co-pay
<b>D2950 - Core buildup, including any pins</b>	No co-pay
<b>D2951 - Pin retention – per tooth, in addition to restoration</b>	No co-pay
<b>D2954 - Prefabricated dowel post and core</b>	No co-pay
<b>D2955 - Post removal (no endodontic therapy)</b>	No co-pay
<b>D2957 - Each additional prefabricated post – same tooth</b>	No co-pay
<b>D2980 - Repair crown</b>	No co-pay
<b>Endodontics</b>	
<b>D3110 - Pulp cap – direct excluding final restoration</b>	No co-pay

<b>ADA Code Procedure</b>	<b>Member Pays</b>
D3120 - Pulp cap – indirect excluding final restoration	No co-pay
D3220 - Pulpotomy	No co-pay
D3221 - Gross pulpal debridement – primary and permanent teeth	No co-pay
D3222 - Partial pulpotomy for apexogenesis	Not covered
D3230 - Pulpal therapy – primary anterior	No co-pay
D3240 - Pulpal therapy – primary posterior	No co-pay
D3310 - Root canal therapy – anterior	\$150
D3320 - Root canal therapy – bicuspid	\$225
D3330 - Root canal therapy – molar	\$250
D3331 - Treatment of root canal obstruction – non-surgical access	No co-pay
D3332 - Incomplete endodontic therapy – inoperable or fractured tooth	No co-pay
D3333 - Internal repair of perforation defects	No co-pay
D3346 - Retreatment – anterior	\$150
D3347 - Retreatment – bicuspid	\$225
D3348 - Retreatment – molar	\$250
D3351 - Apexification – initial visit	\$250
D3352 - Apexification – interim visit	No co-pay
D3353 - Apexification – final visit	No co-pay
D3410 - Apicoectomy – anterior	\$150
D3421 - Apicoectomy – bicuspid first root	\$225
D3425 - Apicoectomy – molar first root	\$250
D3426 - Apicoectomy – each additional root	No co-pay
D3430 - Retrograde filling – per root	No co-pay
D3450 - Root amputation per root	\$150
D3920 - Hemisection	\$250
D3950 - Canal prep – preformed dowel/post	No co-pay
<b>Note: The treatment of a root canal or apical surgery performed within 24 months of initial treatment is considered part of the initial treatment charge. Thereafter, re-treatment of a root canal may be subject to an additional charge.</b>	
<b>Periodontics</b>	
D4210 - Gingivectomy or gingivoplasty – four or more teeth	\$150

<b>ADA Code Procedure</b>	<b>Member Pays</b>
<b>D4211 - Gingivectomy – one to three teeth</b>	\$150
<b>D4240 - Gingival flap – four or more teeth</b>	\$150
<b>D4241 - Gingival flap – one to three teeth</b>	\$150
<b>D4249 - Crown lengthening hard tissue</b>	\$150
<b>D4260 - Osseous surgery – four or more teeth</b>	\$150
<b>D4261 - Osseous surgery – one to three teeth</b>	\$150
<b>D4263 - Bone replacement graft – first site in quadrant</b>	\$150
<b>D4264 - Bone replacement graft – each additional site in quadrant</b>	No co-pay
<b>D4270 - Pedicle soft tissue graft procedure</b>	\$150
<b>D4273 - Subepithelial connective graft</b>	\$150
<b>D4274 - Distal wedge procedure</b>	\$150
<b>D4277 - Free soft tissue graft – first tooth or edentulous tooth position</b>	\$150
<b>D4341 - Periodontic scale and root plane – four or more teeth</b>	\$75
<b>D4342 - Periodontic scale and root plane – one to three teeth</b>	\$75
<b>D4355 - Full-mouth debridement</b>	No co-pay
<b>D4381 - Antimicrobial irrigation</b>	No co-pay
<b>D4910 - Periodontal maintenance following therapy</b>	No co-pay
<b>D4920 - Unscheduled dressing change</b>	Not covered
<b>Prosthodontics - Removable</b>	
<b>D5110 - Complete (upper denture)</b>	\$450
<b>D5120 - Complete (lower denture)</b>	\$450
<b>D5130 - Immediate (upper denture)</b>	\$450
<b>D5140 - Immediate (lower denture)</b>	\$450
<b>D5211 - Upper partial resin base</b>	\$450
<b>D5212 - Lower partial resin base</b>	\$450
<b>D5213 - Upper partial cast metal frame</b>	\$450
<b>D5214 - Lower partial cast metal frame</b>	\$450
<b>D5221 - Immediate maxillary partial denture – resin base</b>	\$450
<b>D5222 - Immediate mandibular partial denture – resin base</b>	\$450
<b>D5223 - Immediate maxillary partial denture – cast metal framework with resin denture bases</b>	\$450
<b>D5224 - Immediate mandibular partial denture – cast metal framework with resin denture bases</b>	\$450

<b>ADA Code Procedure</b>	<b>Member Pays</b>
<b>D5225 - Upper partial flexible base</b>	Not covered
<b>D5226 - Lower partial flexible base</b>	Not covered
<b>D5282 - Removable unilateral partial denture – one piece cast metal (including clasps and teeth) – maxillary</b>	\$120
<b>D5283 - Removable unilateral partial denture – one piece cast metal (including clasps and teeth) – mandibular</b>	\$120
<b>D5284 - Removable unilateral partial denture – one piece flexible base (including clasps and teeth) – per quadrant</b>	\$120
<b>D5286 - Removable unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant</b>	\$120
<b>D5410 - Adjustment – complete denture, upper</b>	No co-pay
<b>D5411 - Adjustment – complete denture, lower</b>	No co-pay
<b>D5421 - Adjustment – partial denture, upper</b>	No co-pay
<b>D5422 - Adjustment – partial denture, lower</b>	No co-pay
<b>D5520 - Repair denture – replace missing or broken teeth (each tooth)</b>	No co-pay
<b>D5630 - Repair or replace partial clasp</b>	No co-pay
<b>D5640 - Replace teeth – partial per tooth</b>	No co-pay
<b>D5650 - Add tooth to existing partial</b>	No co-pay
<b>D5660 - Add clasp to existing partial</b>	No co-pay
<b>D5670 - Replace all teeth and acrylic on cast metal framework – maxillary</b>	Not covered
<b>D5671 - Replace all teeth and acrylic on cast metal framework – mandibular</b>	Not covered
<b>D5710 - Rebase complete upper denture</b>	No co-pay
<b>D5711 - Rebase complete lower denture</b>	No co-pay
<b>D5720 - Rebase upper partial</b>	No co-pay
<b>D5721 - Rebase lower partial</b>	No co-pay
<b>D5730 - Reline complete upper denture (chairside)</b>	No co-pay
<b>D5731 - Reline complete lower denture (chairside)</b>	No co-pay
<b>D5740 - Reline upper partial (chairside)</b>	No co-pay
<b>D5741 - Reline lower partial (chairside)</b>	No co-pay
<b>D5750 - Reline upper denture – lab</b>	No co-pay
<b>D5751 - Reline lower denture – lab</b>	No co-pay
<b>D5760 - Reline upper partial – lab</b>	No co-pay
<b>D5761 - Reline lower partial – lab</b>	No co-pay

<b>ADA Code Procedure</b>	<b>Member Pays</b>
D5810 - Interim denture – upper	\$75
D5811 - Interim denture – lower	\$75
D5820 - Interim partial – upper	\$75
D5821 - Interim partial – lower	\$75
D5850 - Tissue conditioning – upper	No co-pay
D5851 - Tissue conditioning – lower	No co-pay
D5986 - Fluoride gel custom tray	No co-pay
<b>Implant Services</b>	
D6010 - Surgical placement of implant body: endosteal implant	\$3,000*
D6056 - Prefabricated abutment – includes placement	\$3,000*
D6057 - Custom abutment – includes placement	\$3,000*
D6058 - Abutment supported porcelain/ceramic crown	\$3,000*
D6059 - Abutment supported porcelain fused to metal crown (high noble metal)	\$3,000*
D6104 - Bone Graft Implant Placement	\$3,000*
<b>Prosthodontics - Fixed</b>	
D6210 - Pontic, cast (per tooth) traditional fixed partial dentures only	\$250
D6240 - Pontic (per tooth); porcelain/metal traditional fixed partial dentures only (bridges)	\$250
D6241 - Pontic (per tooth) Maryland bridge	\$250
D6545 - Cast metal retainer	\$250
D6549 - Resin retainer – for resin bonded fixed prosthesis	Not covered
D6720 - Crown – resin/metal abutment	\$250
D6750 - Crown – porcelain metal abutment	\$250
D6780 - Crown – ¾ cast metal abutment	\$250
D6790 - Crown – full gold abutment	\$250
D6975 - Coping – metal	No co-pay
D6980 - Bridge repair	No co-pay
<b>Oral Surgery</b>	
D7111 - Extraction coronal remnants primary tooth	No co-pay
D7140 - Extraction erupted tooth	\$25
D7210 - Surgical extraction – erupted	\$125
D7220 - Removal of impacted tooth – soft tissue	\$125

<b>ADA Code Procedure</b>	<b>Member Pays</b>
<b>D7230 - Removal of impacted tooth – partial bony</b>	\$125
<b>D7240 - Removal of impacted tooth – complete bony</b>	\$125
<b>D7241 - Removal of impacted tooth – complete bony with complications</b>	\$125
<b>D7250 - Surgical removal residual root</b>	\$125
<b>D7251 - Coronectomy – intentional partial tooth removal</b>	Not covered
<b>D7260 - Oroantral fistula closure</b>	\$150
<b>D7261 - Primary closure of sinus perforation</b>	Not covered
<b>D7270 - Tooth re-implantation</b>	\$150
<b>D7280 - Surgical access unerupted tooth</b>	\$150
<b>D7283 - Ortho bracket to aid eruption if plan covers orthodontia</b>	\$150
<b>D7285 - Biopsy of oral tissue – hard (bone, tooth)</b>	Not covered
<b>D7286 - Biopsy of oral tissue – soft</b>	Not covered
<b>D7287 - Exfoliative cytological sample collection</b>	Not covered
<b>D7288 - Brush biopsy – transepithelial simple collection</b>	No co-pay
<b>D7291 - Transseptal fiberotomy</b>	\$150
<b>D7310 - Alveoloplasty with extractions – per quadrant 4 or more</b>	\$150
<b>D7320 - Alveoloplasty without extractions – per quadrant</b>	\$150
<b>D7321 - Alveoloplasty not with extractions</b>	\$150
<b>D7340 - Vestibuloplasty (secondary epithelialization)</b>	\$150
<b>D7350 - Vestibuloplasty (including soft tissue grafts)</b>	\$150
<b>D7450 - Remove benign odontogenic cyst up to 1.25 cm</b>	\$150
<b>D7451 - Remove benign odontogenic cyst greater than 1.25 cm</b>	\$150
<b>D7465 - Destruction of lesion(s) – physical or chemical method</b>	\$150
<b>D7471 - Remove lateral exostosis</b>	\$150
<b>D7510 - Incision and drainage of abscess – intraoral soft tissue</b>	No co-pay
<b>D7520 - Incision and drainage of abscess – extraoral soft tissue</b>	No co-pay
<b>D7530 - Remove foreign body – soft tissue</b>	No co-pay
<b>D7540 - Remove foreign body – hard tissue</b>	No co-pay
<b>D7550 - Partial ostectomy/sequestrectomy for removal of non vital bone</b>	Not covered
<b>D7560 - Maxillary sinusotomy for removal of tooth fragment</b>	Not covered

<b>ADA Code Procedure</b>	<b>Member Pays</b>
<b>D7670 - Stabilization splint – alveolus</b>	No co-pay
<b>D7770 - Alveolus – open reduction stabilization of teeth</b>	Not covered
<b>D7910 - Suture small wound up to 5 cm</b>	No co-pay
<b>D7911 - Complicated suture up to 5 cm</b>	No co-pay
<b>D7912 - Complicated suture greater than 5 cm</b>	Not covered
<b>D7940 - Osteoplasty</b>	\$150
<b>D7953 - Bone replacement graft for ridge reservation – per site</b>	\$150
<b>D7960 - Frenectomy</b>	\$150
<b>D7963 - Frenuloplasty</b>	Not covered
<b>D7970 - Excision hyperplastic tissue</b>	\$150
<b>D7971 - Excision of pericoronal flap</b>	\$150
<b>D7980 - Sialolithotomy</b>	\$150
<b>D7981 - Excision of salivary gland</b>	Not covered
<b>D7982 - Sialodochoplasty</b>	Not covered
<b>D7983 - Closure of salivary fistula</b>	Not covered
<b>D7990 - Emergency tracheotomy</b>	Not covered
<b>D7997 - Appliance removal (not by dentist who placed appliance)</b>	Not covered
<b>Orthodontia</b>	
<b>D8010 - Limited orthodontic treatment of the primary dentition</b>	Not covered
<b>D8020 - Limited orthodontic treatment of the transitional dentition</b>	Not covered
<b>D8030 - Limited orthodontic treatment of the adolescent dentition</b>	Not covered
<b>D8040 - Limited orthodontic treatment of the adult dentition</b>	Not covered
<b>D8050 - Interceptive orthodontic treatment of the primary dentition</b>	Not covered
<b>D8060 - Interceptive orthodontic treatment of the transitional dentition</b>	Not covered
<b>D8070 - Comprehensive orthodontic treatment of the transitional dentition</b>	\$2,000
<b>D8080 - Comprehensive orthodontic treatment of the adolescent dentition</b>	\$2,000
<b>D8090 - Comprehensive orthodontic treatment of the adult dentition</b>	\$2,000
<b>D8210 - Removable appliance therapy</b>	Not covered
<b>D8220 - Fixed appliance therapy</b>	Not covered

<b>ADA Code Procedure</b>	<b>Member Pays</b>
<b>D8660 - Pre-orthodontic treatment visit</b>	\$150^
<b>D8670 - Periodic orthodontic treatment visit (as part of contract)</b>	No co-pay
<b>D8680 - Orthodontic retention (removal of appliances, construction)</b>	No co-pay
<b>D8681 - Removable orthodontic device adjustment</b>	No co-pay
<b>D8690 - Orthodontic treatment (alternative billing to a contract fee)</b>	Not covered
<b>D8691 - Repair of orthodontic appliance</b>	Not covered
<b>D8698 - Re-cement or re-bond fixed retainer - maxillary</b>	No co-pay
<b>D8699 - Re-cement or re-bond fixed retainer - mandibular</b>	No co-pay
<b>Anesthesia</b>	
<b>D9210 - Local Anesthesia not in conjunction with operative or surgical procedures</b>	No co-pay
<b>D9211 - Regional block anesthesia</b>	Not covered
<b>D9212 - Trigeminal division block anesthesia</b>	Not covered
<b>D9215 - Local anesthesia (Novocain)</b>	No co-pay
<b>D9223 - Deep sedation/general anesthesia – each 15 minute increment</b>	Not covered
<b>D9230 - Nitrous oxide (per visit)</b>	\$40
<b>D9243 - Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment</b>	Not covered
<b>D9248 - Non-intravenous conscious sedation</b>	Not covered
<b>Miscellaneous</b>	
<b>D9110 - Palliative (emergency) minor</b>	\$50
<b>D9120 - Fixed partial denture sectioning</b>	Not covered
<b>D9310 - Consultation – per session</b>	No co-pay
<b>D9410 - House/extended care facility call</b>	Not covered
<b>D9430 - Observation visit</b>	No co-pay
<b>D9440 - Emergency treatment – after office hours</b>	No co-pay
<b>D9610 - Therapeutic parenteral drug – single administration</b>	Not covered
<b>D9612 - Therapeutic parenteral drug – 2 or more</b>	Not covered
<b>D9630 - Other drugs and/or medicaments</b>	Not covered
<b>D9911 - Application of desensitizing medicaments</b>	No co-pay



<b>ADA Code Procedure</b>	<b>Member Pays</b>
<b>D9920 - Behavior management</b>	Not covered
<b>D9930 - Treatment of complications – post surgical</b>	Not covered
<b>D9951 - Occlusal adjustment – simple</b>	No co-pay
<b>D9952 - Occlusal adjustment – complete</b>	No co-pay
<b>Out-of-area emergency reimbursement</b>	Reimbursed up to \$100
<b>Exclusions</b>	
<b>See Exclusion section of the Member Handbook</b>	

^ Fee credited towards comprehensive orthodontic copayment if patient accepts treatment plan.

\* Implant Services benefit accumulates to a \$3,000 co-pay maximum. Remaining amount covered by PacificSource.





# Group Basic Life and Accidental Death and Dismemberment Insurance

Group Basic Life insurance from Standard Insurance Company helps provide financial protection by promising to pay a benefit in the event of an eligible member's covered death. Basic Accidental Death and Dismemberment (AD&D) insurance may provide an additional amount in the event of a covered death or dismemberment as a result of an accident.

The cost of this insurance is paid by Lane County School District #52.

## Eligibility

<b>Definition of a Member</b>	You are a member if you are an active Administrator, Confidential, Supervisory or Certified employee of Lane County School District #52 and regularly working at least 20 hours each week. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
<b>Class Definition</b>	Class 4 - Active Certified Members hired during the calendar months of June, July or August
<b>Eligibility Waiting Period</b>	You are eligible on October 1 that follows the date you become a member.

## Benefits

<b>Basic Life Coverage Amount</b>	Your Basic Life coverage amount is \$30,000.
<b>Basic AD&amp;D Coverage Amount</b>	For a covered accidental loss of life, your Basic AD&D coverage amount is equal to your Basic Life coverage amount. For other covered losses, a percentage of this benefit will be payable.
<b>Life Age Reductions</b>	Basic Life and AD&D insurance coverage amount reduces to 65 percent at age 70 and to 50 percent at age 75.

## Other Basic Life Features and Services

- Accelerated Benefit
- Life Services Toolkit
- Portability of Insurance Provision
- Repatriation Benefit
- Right to Convert Provision
- Standard Secure Access account payment option
- Travel Assistance
- Waiver of Premium

## Other Basic Life Features and Services

- Accelerated Benefit
- Life Services Toolkit
- Portability of Insurance Provision
- Repatriation Benefit
- Right to Convert Provision
- Standard Secure Access account payment option
- Travel Assistance
- Waiver of Premium

## Other Basic AD&D Features

- Expanded AD&D Package
- Family Benefits Package
- Seat Belt Benefit

This information is only a brief description of the group Basic Life/AD&D and Basic Dependents Life insurance policy sponsored by Lane County School District #52. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, reductions in benefits, exclusions and when The Standard and Lane County School District #52 may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For costs and more complete details of coverage, contact your human resources representative.

[SI 13279-D-OR-137212-C2 \(8/18\)](#)

5703636-219857

## Bethel School District Standard Insurance Voluntary Life Plan



<b>Benefit</b>	<b>Outline</b>
Standard Definition of Earnings	Base Salary
Only Benefit Increments	
Employee (active employees)	\$10,000
Spouse	\$10,000
Benefit Maximums	
Employee	\$300,000
Spouse	100% Ee Amt to \$300,000
All benefit elections require evidence of insurability.	

Benefit Reductions	Reduces To: 65% at Age 70; 45% at Age 75; 30% at Age 80 20% at Age 85; 15% at Age 90; 10% at Age 95
--------------------	--

<b>Life Per \$1,000</b>	<b>Employee / Spouse</b>
Under Age 30	\$0.100
30-39	\$0.110
40-44	\$0.220
45-49	\$0.390
50-54	\$0.640
55-59	\$0.990
60-64	\$1.480
65-69	\$2.230
70-74	\$3.430
75-79	\$4.955
80-84	\$7.435
85-89	\$11.150
90-94	\$14.865
95+	\$22.300



# Group Accidental Death & Dismemberment Insurance

## Enhance Your Safety Net With Protection Against Unexpected Loss

Accidental Death & Dismemberment (AD&D) insurance helps protect against the sudden financial loss often brought on by an accidental death. It can also help you pay for unexpected expenses associated with surviving an accident that results in a severe physical loss. You can elect to cover your eligible spouse and children as well.



### This plan offers:

- Competitive group rates
- The convenience of payroll deduction
- Coverage for accidental death and dismemberment

## 🔗 About This Coverage

<b>How Much Can I Apply For?</b>	For You:	<b>\$25,000 – \$250,000</b> in increments of <b>\$25,000</b>
Note: You can't buy more coverage for your spouse and child(ren) than you buy for yourself.	<b>For Your Family:</b>	
	Spouse Only:	50% of your AD&D coverage amount
	Child only:	10% of your AD&D coverage amount for each child
	Spouse and Children:	40% of your AD&D coverage amount 5% of your AD&D coverage amount for each child

See the Important Details section for more information, including requirements, exclusions, age reductions and definitions.

## ☰ Additional Features

Your coverage comes with some added features:

<b>Seat Belt and Air Bag Benefits</b>	The Standard may pay an additional benefit if you die while wearing a seat belt, provided certain conditions are met. If the car's air bags deploy during an accident, an air bag benefit may also be payable.
<b>Family Benefits Package</b>	This package is designed to help surviving family members maintain their standard of living and pursue their dreams. Included in the package are benefits to help with child care, career adjustment for your spouse and higher education for your children.

## 💰 How Much Your Coverage Costs

Because this insurance is offered through Lane County School District #52, you'll have access to competitive group rates. You'll also have the convenience of having your premium deducted directly from your paycheck. How much your premium costs depends on the benefit amount you elect.

### Use this formula to calculate your premium payment:

$$\underline{\hspace{2cm}} \div \$1,000 = \underline{\hspace{2cm}} \times \underline{\hspace{2cm}} = \underline{\hspace{2cm}}$$

Enter the amount of AD&D coverage you're requesting (see benefit amounts in the About This Coverage section).

Enter your rate from the rate table.

This amount is an estimate of how much you would pay each month.

If you buy coverage for your family (spouse and children), your monthly rate is shown in the table below. Use the same formula to calculate the premium that you used for yourself, but use the appropriate rate for the premium you are calculating.

Coverage for...	Cost per \$1,000 of Coverage
You	\$0.04
You and your family	\$0.06



# Group Long Term Disability Insurance

Protect your income when you're coping with a long-lasting disability.

This coverage is designed to replace a portion of your income when you're disabled for an extended period of time due to a qualifying disability and help you get back to work when you're ready. Long Term Disability insurance benefits can help you pay your bills and safeguard your savings when you're unable to work. Whether you're out for a few months or several years, this benefit can help you protect your income — and those who depend on it.



## This plan offers:

- Competitive group rates
- The convenience of payroll deduction
- Benefits for a qualifying disability that occurs on or off the job

## 🔗 About This Coverage

See the Important Details section for more information, including requirements, exclusions and definitions.

### What Your Benefit Provides

This is the amount per month you would receive if you were to suffer a qualifying disability. Eligible earnings are your monthly insured predisability earnings, as defined by the group policy. Your monthly benefit will be reduced by deductible income. Please see the Important Details section for a list of deductible income sources.

**60%** of your eligible earnings, up to a maximum benefit of **\$4,500** per month.

Plan minimum per month: **\$100** or **10 percent** of the Long Term Disability benefit before reduction by deductible income, whichever is greater per month.

### Benefit Waiting Period

If you suffer a qualifying disability, your benefit waiting period is the length of time you must be continuously disabled before you can begin receiving your monthly benefit.

90 days

### How Long Your Benefits Last

This is the maximum length of time you could be eligible to receive disability benefits for a continuous disability.

Until age 65

Depending on your age at the time of disability, your benefits may be subject to a different schedule. Refer to the table in the Important Details section for specifics.





# BETHEL SCHOOL DISTRICT

## Flexible Spending Account Summary

### October 1, 2022 – September 30, 2023

A Flexible Spending Account (FSA) is a type of plan that allows you to receive certain benefits on a pretax basis. Think of it as a tax-free and interest-free loan to yourself. The pretax contributions may be used for qualified healthcare and childcare expenses for you and your tax dependents. They also allow you to pay for your group’s sponsored insurance premiums on a pretax basis.

### Contributing to Your FSA

Component	Maximum Annual Election
General Purpose Health FSA	\$2,850
Dependent Daycare Expenses	\$5,000 if married & filing a joint return or a single parent \$2,500 if married but filing separately

**The Plans:** The following FSA components are available through your employer.

#### Premium Component

- Your employer will deduct your portion of the group-sponsored insurance plans, including premiums for medical, dental, vision, hospitalization, accident insurance, and/or other qualified benefits from your gross salary on a pre-tax basis. This reduces income taxes and results in an increase in take home pay and lower taxable salary.

#### Health FSA Component – includes the following account(s)

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

- If you’re eligible for your employer’s health plan, you can set up an HRE account. With an HRE account, you can save pre-tax money for healthcare expenses, including medical, dental, and vision expenses that are either not covered or only partially covered by your insurance plan.
- These expenses are for your tax dependents. Examples include: you, your spouse, or child(ren), whether or not they are covered on your employer’s group insurance plan.
- No changes in contribution will be allowed during the plan year.

#### Dependent Care Assistance Plan (DCAP) Component

##### Dependent Daycare Expense Account (DCE)

- Our Dependent Daycare Expense Account (DCE) allows you to save pre-tax dollars to pay for dependent care. This is specifically for expenses for a child up to age 13 or disabled taxable dependent who is unable to care for themselves, including elder care expenses.
- 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.
- In many cases, this account will be more beneficial to you than the federal tax credit.

## Claims Reimbursement

### Reimbursement Time Frame

Reimbursements may be requested during the plan year or after it ends. Your claim submission period ends 90 days after the plan year ends. This is known as a run-out period. All eligible reimbursement claims for services you received between **October 1, 2022** and **September 30, 2023** must be submitted by **December 31, 2023** for reimbursement.

### Submitting Claims

Methods for claims submission include manual submission, 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://psa.pacificsource.com/Forms/>

### 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.

- To sign up, fill out and return the EasyPay Enrollment Form, available on our website.

### Funds Remaining After the Plan Ends

If the plan year ends before you've used all of your Health FSA funds, you're allowed to have up to \$570 carry over to the next FSA plan year. If you have more than the \$570 remaining, you'll lose those additional funds, along with all other account balances. You will not be required to make a new election in order to have up to \$570 carryover. Carryover funds will be automatically rolled after the prior plan year, and claims submission period ends. You may request an early roll by contacting Customer Service.

### 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 of termination or on the last day of the pay period in which you have contributed, whichever gives the greatest period of coverage.

You can elect to have a final pre-tax final paycheck salary reduction withheld. In the alternative, you may elect to pay on an after-tax basis any remaining contributions for the Plan Year. The Premium Completion Agreement extends eligibility to incur qualified health related expenses.

You may be eligible to continue the Health FSA under COBRA. Please check with your employer regarding options you may have.

### Questions?

Our Customer Service team is happy to help. For more information about FSA details, please refer to your Plan Document and Summary Plan Description.

### Phone

Direct: (641) 486-7488  
Toll-free: (800) 422-7038

### Email

psacustomerservice@  
pacificsource.com

**PacificSource.com/  
PSA**



## **Forms, Fliers and instructions**

Available online. Examples include:

- FSA Participant Guide (general information)
- Request for Reimbursement Forms
- Direct Deposit Form
- Examples of Eligible Expenses
- Online Claim Submission Instructions
- Prepaid Benefits Card Flier (Benny/Wex)
- Authorization to Disclose PHI

## **PSA Consumer Portal: Online Account Access for Participants**

Manage your FSA from the convenience of your home or office by utilizing our website:

[www.psa.pacificsource.com/PSA](http://www.psa.pacificsource.com/PSA) or <https://psa.consumer.pacificsource.com>

- File a claim online.
- Access information on the most recent reimbursement payments.
- View payment details.
- Check your account balances, annual election, and year-to-date deposits.
- Change your address and other personal information.
- View FAQs and fliers.

# A Helping Hand When You Need It

Rely on the support, guidance and resources of your Employee Assistance Program.











There are times in life when you might need a little help coping or figuring out what to do. Take advantage of the Employee Assistance Program<sup>1</sup> (EAP) which includes WorkLife Services and is available to you and your family in connection with your group insurance from Standard Insurance Company (The Standard). It's confidential — information will be released only with your permission or as required by law.

With EAP, assistance is immediate, personal and available when you need it.

## Connection to Resources, Support and Guidance

You, your dependents (including children to age 26)<sup>2</sup> and all household members can contact master's-degreed clinicians 24/7 by phone, online, live chat, email and text. There's even a mobile EAP app. Receive referrals to support groups, a network counselor, community resources or your health plan. If necessary, you'll be connected to emergency services.

Your program includes up to three face-to-face assessment and counseling sessions per issue. EAP services can help with:

-  Depression, grief, loss and emotional well-being
-  Family, marital and other relationship issues
-  Life improvement and goal-setting
-  Addictions such as alcohol and drug abuse
-  Stress or anxiety with work or family
-  Financial and legal concerns
-  Identity theft and fraud resolution
-  Online will preparation

## WorkLife Services

WorkLife Services are included with the Employee Assistance Program. Get help with referrals for important needs like education, adoption, travel, daily living and care for your pet, child or elderly loved one.

## Online Resources

Visit [workhealthlife.com/Standard3](http://workhealthlife.com/Standard3) to explore a wealth of information online, including videos, guides, articles, webinars, resources, self-assessments and calculators.

<sup>1</sup> The EAP service is provided through an arrangement with Morneau Shepell, which is not affiliated with The Standard. Morneau Shepell is solely responsible for providing and administering the included service. EAP is not an insurance product and is provided to groups of 10–2,499 lives. This service is only available while insured under The Standard's group policy.

<sup>2</sup> Individual EAP counseling sessions are available to eligible participants 16 years and older; family sessions are available for eligible members 12 years and older, and their parent or guardian. Children under the age of 12 will not receive individual counseling sessions.

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

## Contact EAP

888.293.6948

TDD: 800.327.1833

24 hours a day, seven days a week

[workhealthlife.com/Standard3](http://workhealthlife.com/Standard3)

NOTE: It's a violation of your company's contract to share this information with individuals who are not eligible for this service.

Standard Insurance Company  
1100 SW Sixth Avenue  
Portland, OR 97204

[standard.com](http://standard.com)

Employee Assistance Program-3  
SI 17201-D (7/17) EE



# Escalated Claims or Benefit Concerns?

Contact the Benefit Resource Center (“BRC”)!

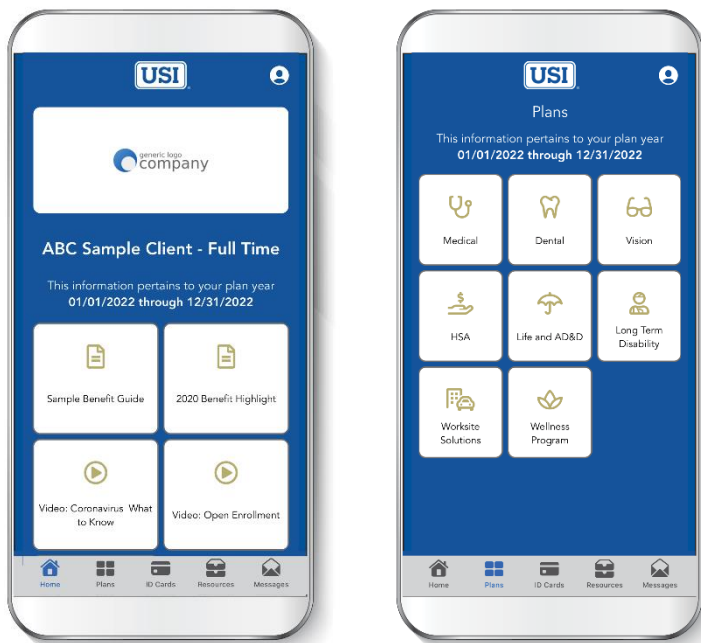
**Toll Free: 866-468-7272**

**[BRCWest@usi.com](mailto:BRCWest@usi.com)**

Our Benefits Specialists can assist you Monday through Friday,  
8am to 5pm MST, PST and AST



# The Usieb App is now MyBenefits2GO!



To access the upcoming plan year information, download the new **MyBenefits2GO** app to view plan contact information, key plan documents and more.

**Bethel School District #52:  
Licensed Staff**

Enter this code when prompted:

**V23102**

## Switching is easy as 1,2,3!

1. Download MyBenefits2GO from the App Store or Google Play store
2. Enter the new access code listed above
3. Start using the new app!

## What's New?

### Easier to Access and Share ID Cards

ID cards can be accessed through the main menu and emailed with the click of a button.

### Updated Navigation

Finding what you need is easier than ever with improved navigation functionality.

### New Look

The design within the app has been updated to be more modern.



Medicare Prescription Drug Coverage and Medicare

Medicare Prescription Drug Coverage and Medicare

Important Notice from Bethel School District About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Bethel School District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- 1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Bethel School District has determined that the prescription drug coverage offered by the Bethel School District health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

Medicare Prescription Drug Coverage and Medicare

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

Bethel School District

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Bethel School District and don't join a Medicare drug plan
NOTE: You'll get this notice each year.
Bethel School District

For More Information About Your Options Under Medicare Prescription Drug Coverage...

Medicare Prescription Drug Coverage and Medicare
Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook)
Medicare Prescription Drug Coverage and Medicare

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

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## 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](http://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](http://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](http://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 is current as of July 31, 2022. If you live in another state, contact your State for more information.**

OREGON – Medicaid	WASHINGTON – Medicaid
Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a> <a href="http://www.oregonhealthcare.gov/index-es.html">http://www.oregonhealthcare.gov/index-es.html</a> Phone: 1-800-699-9075	Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a> Phone: 1-800-562-3022

For more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services  
 Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://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](mailto:ebsa.opr@dol.gov) and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)



## PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

### What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

### Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

### Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.<sup>1</sup>

**Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution – as well as your employee contribution to employer-offered coverage – is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

### How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](http://HealthCare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

<sup>1</sup> An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

**PART B: Information About Health Coverage Offered by Your Employer**

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Bethel School District		4. Employer Identification Number (EIN) 93-600591	
5. Employer address 4640 Barger Drive		6. Employer phone number 541-689-3280	
7. City Eugene	8. State OR	9. ZIP code 97402	
10. Who can we contact about employee health coverage at this job? Remie Calalang			
11. Phone number (if different from above)		12. Email address remie.calalang@bethel.k12.or.us	

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

- As your employer, we offer a health plan to:
  - All employees. Eligible employees are:  
As described in the member handbook.
  - Some employees. Eligible employees are:

- With respect to dependents:
  - We do offer coverage. Eligible dependents are:  
As described in the member handbook.
  - We do not offer coverage.

If checked, this coverage meets the minimum value standard\*, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

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

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• An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

