BETHEL
SCHOOL DISTRICT

2022-2023
Employee Benefits Guide
Administrative 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
Flexibile 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

Eligibility & Enrollment

Eligibility Rules

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When Can You Enroll?

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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

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- Change in your child's eligibility for benefits
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Benefits at a Glance

Medical / Rx Insurance

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Dental Insurance

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Vision Insurance

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

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Voluntary Additional Insurance

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Long Term Disability (LTD)

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Flexible Spending Account (FSA)

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Employee Assistance Program (EAP)

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Benefit Year: Calendar Year

Provider Network: Navigator

Deductible Per Benefit Year	In-network	Out-of-network
Individual/Family	$250/$750	$750/$2,250
Out-of-Pocket Limit Per Benefit Year	**In-network**	**Out-of-network**
Individual/Family	$2,000/$12,700	$2,650/Not applicable

Note: In-network deductible and out-of-pocket limit accumulate separately from the out-of-network deductible and out-of-pocket limit. Even though you may have the same benefit for in-network and out-of-network, your actual costs for services provided out-of-network may exceed this plan's out-of-pocket limit for out-of-network services. In addition, out-of-network providers may in certain circumstances bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company (called balance billing). Balance billing amounts are not counted toward the out-of-network out-of-pocket limit. For additional information about balance billing or allowable fees, see your handbook.

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

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Preventive Care		
Well baby/Well child care	No deductible, 0%	No deductible, 20%
Preventive physicals	No deductible, 0%	No deductible, 20%
Well woman visits	No deductible, 0%	No deductible, 20%
Preventive mammograms	No deductible, 0%	No deductible, 20%
Immunizations	No deductible, 0%	No deductible, 20%
Preventive colonoscopy	No deductible, 0%	After deductible, 40%
Prostate cancer screening	No deductible, 0%	No deductible, 20%
Professional Services		
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, 0%	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, 10%	After deductible, 40%
Outpatient rehabilitation and habilitation services	No deductible, $25	After deductible, 20%
Chiropractic manipulation/Spinal manipulation (20 visits per benefit year)	No deductible, $25	No deductible, $25
Acupuncture (12 visits per benefit year)	No deductible, $25	No deductible, $25
Massage therapy ($2,500 per benefit year)	No deductible, $25	No deductible, $25
Hospital Services		
Inpatient room and board	No deductible, $300/admit	After deductible, $600/admit
Inpatient rehabilitation and habilitation services	No deductible, $300/admit	After deductible, $600/admit
Skilled nursing facility care	No deductible, $300/admit	After deductible, $600/admit
Outpatient Services		
Outpatient surgery/services	No deductible, $150	After deductible, $150
Diagnostic imaging – advanced	No deductible, $100/test	After deductible, 40%
Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced	After deductible, 10%	After deductible, 40%
Urgent and Emergency Services		
Urgent care center visits	No deductible, $25	After deductible, 40%
Emergency room visits – medical emergency	After deductible, 10%	After deductible, 10%
Emergency room visits – non-emergency	After deductible, 10%	After deductible, 10%
Ambulance, ground	No deductible, $50/trip	No deductible, $50/trip
Ambulance, air	No deductible, $50/trip	No deductible, $50/trip+
Maternity Services**		
Physician/Provider services (global charge)	After deductible, 10%	After deductible, 40%
Hospital/Facility services	No deductible, $300 per pregnancy	After deductible, $600 per pregnancy

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

Formulary Preferred Drug List (PDL)

Benefit Year: Calendar Year

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

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

Affordable Care Act Standard Preventive No-cost Drug List

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

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

Service/ Supply	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays
In-network Retail Pharmacy			
Up to a 34 day supply:	No deductible, $15	No deductible, $25+	No deductible, $50+
35 - 68 day supply:	No deductible, $30	No deductible, $50+	No deductible, $100+
69 - 102 day supply:	No deductible, $45	No deductible, $75+	No deductible, $150+
In-network Mail Order Pharmacy			
Up to a 30 day supply:	No deductible, $15	No deductible, $25+	No deductible, $50+
31 - 90 day supply:	No deductible, $30	No deductible, $50+	No deductible, $100+
Compound Drugs**			
Up to a 34 day supply:		No deductible, $50	
35 - 68 day supply:		No deductible, $100	
69 - 102 day supply:		No deductible, $150	
Out-of-network Pharmacy			
30 day maximum fill, no more than three fills allowed per year:		No deductible, 25%	

	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.

Wellness programs

24-Hour NurseLine

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

Tobacco cessation

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

Health and wellness education

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

Prenatal Program

Our Prenatal Program helps expectant 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 to find out which prenatal vitamins are covered.

Weight management programs

As a part of your PacificSource medical coverage, participate in a WW® (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™ 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

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

PacificSource.com

PacificSource HEALTH PLANS

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.

CVS Caremark
Web: 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 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.

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.

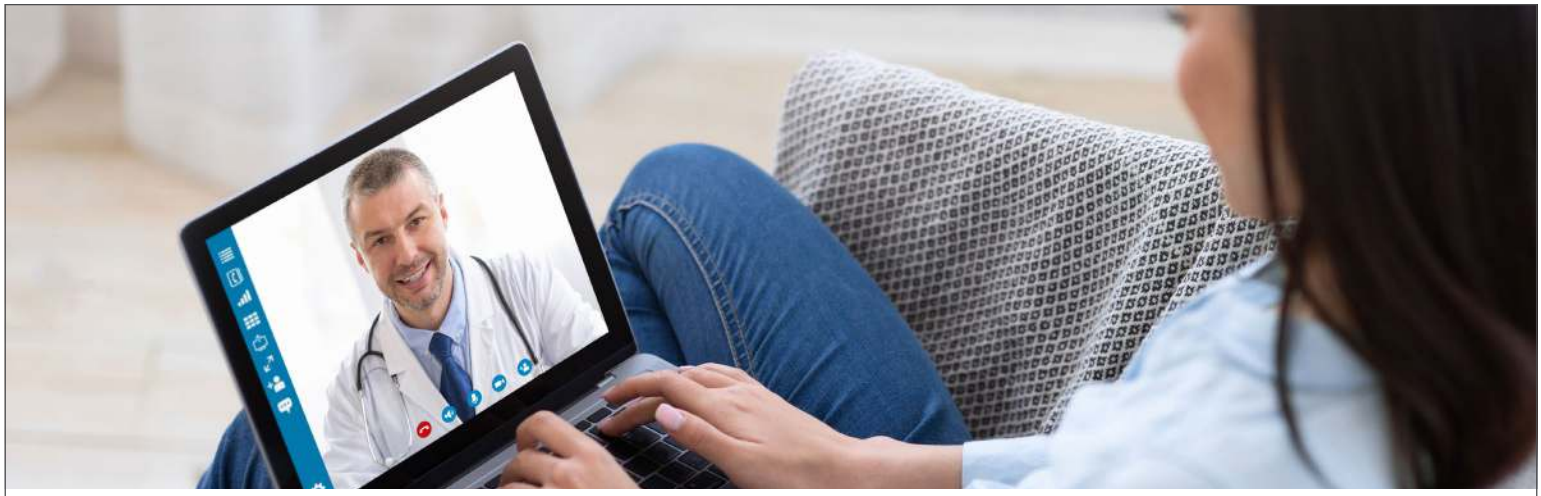
Provider directory

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.

Find more information at PacificSource.com/extras.

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



Teladoc®—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. Find the "Teladoc - Remote Care" link under "Tools" to set up your account.

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

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

2. Provide 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.

See reverse for FAQ >

Talk to a doctor anytime!

Web
Teladoc.com

Phone
855-201-7488

Mobile App
Teladoc.com/mobile

PacificSource HEALTH PLANS

Frequently Asked Questions

What is Teladoc?

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

Who are the Teladoc doctors?

Teladoc doctors are U.S. board certified in internal medicine, family practice, or pediatrics. They average 20 years 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. 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.

PacificSource HEALTH PLANS

Benefit Year: Calendar Year

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

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Members Age 18 and Younger		
Eye exam	No deductible, 0%	No deductible, 0% 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
Members Age 19 and Older		
Eye exam	No deductible, 0%	No deductible, 0% up to $201 then 100%
Single vision lenses	No deductible, 0%	No deductible, 0% up to $115 then 100%
Bifocal lenses	No deductible, 0%	No deductible, 0% up to $142 then 100%
Trifocal lenses	No deductible, 0%	No deductible, 0% up to $182 then 100%
Lenticular lenses	No deductible, 0%	No deductible, 0% up to $236 then 100%
Progressive lenses	No deductible, 0%	No deductible, 0% up to $182 then 100%
Frames	No deductible, 0%	No deductible, 0% up to $150 then 100%
Contact Lenses (in lieu of glasses)		
Contact lenses	No deductible, 0%	No deductible, 0% up to $830 then 100%

Benefit Limitations: members age 18 and younger

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

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
Class I Services		
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%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Class II Services		
Fillings	30%	30%
Simple extractions	30%	30%
Periodontal scaling and root planing	30%	30%
Full mouth debridement	30%	30%
Complicated oral surgery	30%	30%
Pulp capping	30%	30%
Pulpotomy	30%	30%
Root canal therapy	30%	30%
Periodontal surgery	30%	30%
Tooth desensitization	30%	30%
Class III Services		
Crowns	30%	30%
Dentures	30%	30%
Bridges	30%	30%
Replacement of existing prosthetic device	30%	30%
Implants	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 (select Commercial for the line of business).

Discrimination is against the law

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

Benefit Year: Contract Year

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

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

Lifetime Benefit Maximum	All Providers Member Pays
$1,500 per person	20%

Benefit Limitations

Benefits for cosmetic orthodontic covered services will be paid monthly on a pro-rated basis over the length of the treatment. If the cosmetic orthodontic treatment began before the member was eligible for this plan, this plan will continue to make payments toward the remaining balance due, as of the member's initial eligibility date. The benefit maximum listed above will apply fully to this amount. PacificSource's obligation to make payment for cosmetic orthodontic treatment ends when the member'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.
- Mail order or Internet/web based providers are not eligible providers.

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:

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

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

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

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

ADA Code Procedure	Member Pays
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
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.	
Periodontics	
D4210 - Gingivectomy or gingivoplasty – four or more teeth	$150

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

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

ADA Code Procedure	Member Pays
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
Implant Services	
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*
Prosthondontics - Fixed	
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
Oral Surgery	
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

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

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

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

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

^ 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.

Standard Insurance Company
Lane County School District #52
Group Policy #137212
Effective Date October 1, 2005

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, or his or her dependent'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, except for the cost of your dependent's insurance, which is paid by you through payroll deduction. Enrollment materials needed to elect coverage will be provided.

Eligibility

Definition of a Member	You are a member if you are an active Administrator, Condfidential, 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.
Class Definition	Active Administrators, Confidential and Supervisory Members
Eligibility Waiting Period	See Certificate of Coverage for details

Benefits

Basic Life Coverage Amount	Your Basic Life coverage amount is $50,000.
Basic AD&D Coverage Amount	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.
Life Age Reductions	Basic Life and AD&D insurance coverage amount reduces to 65 percent at age 70 and to 50 percent at age 75.

Standard Insurance Company
Lane County School District #52
Group Policy #137212
Effective Date October 1, 2005

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Class Definition	Active Administrators, Confidential and Supervisory Members
Eligibility Waiting Period	See Certificate of Coverage for Details

Benefits

Basic Life Coverage Amount	Your Basic Life coverage amount is $50,000.
Basic AD&D Coverage Amount	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.
Life Age Reductions	Basic Life and AD&D insurance coverage amount reduces to 65 percent at age 70 and to 50 percent at age 75.
Basic Dependents Life Coverage Amount	The Basic Dependents Life coverage amount for your eligible spouse is $5,000. Your spouse is the person to whom you are legally married, or your domestic partner as recognized by law or by your employer's domestic partnership policy, if applicable. The Basic Dependents Life coverage amount for each of your eligible children is $1,000. Child means your child from live birth through age 25.

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

Benefit	Outline
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

Life Per $1,000	Employee / Spouse
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

Standard Insurance Company
Lane County School District #52
Group Policy #137212

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

How Much Can I Apply For? Note: You can't buy more coverage for your spouse and child(ren) than you buy for yourself.		
	For You:	**$25,000** – **$250,000** in increments of **$25,000**
	For Your Family:	
	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:

Seat Belt and Air Bag Benefits	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.
Family Benefits Package	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:

_____ ÷ $1,000 = _____ x _____ = _____

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

Standard Insurance Company
Lane County School District #52
Group Policy #137212

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 **$6,250** 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.

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: (541) 486-7488
Toll-free: (800) 422-7038

Email
psacustomerservice@pacificsource.com

PacificSource.com/PSA

PacificSource ADMINISTRATORS

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.

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 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[1] (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.

Connection to Resources, Support and Guidance

You, your dependents (including children to age 26)[2] 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** to explore a wealth of information online, including videos, guides, articles, webinars, resources, self-assessments and calculators.

Contact **EAP**

888.293.6948
TDD: 800.327.1833
24 hours a day, seven days a week

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.

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

[1] 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.

[2] Individual EAP counseling sessions area 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.

Standard Insurance Company
1100 SW Sixth Avenue
Portland, OR 97204

standard.com

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

Escalated Claims or Benefit Concerns?

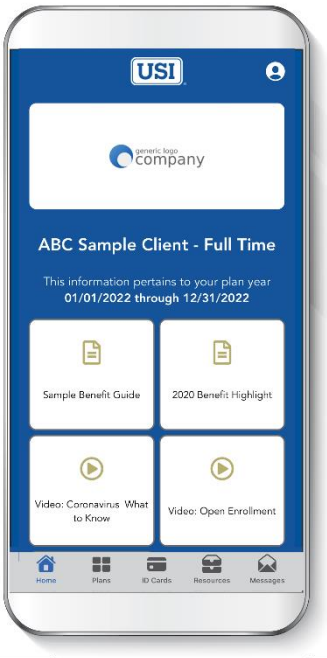
Contact the Benefit Resource Center ("BRC")!

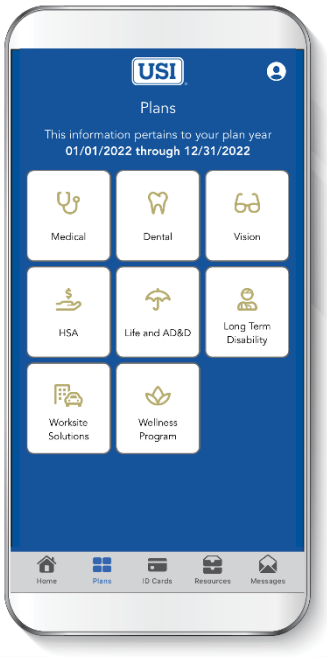
Toll Free: 866-468-7272

BRCWest@usi.com

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: Administrative Staff

Enter this code when prompted:

H82836

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.

Important Legal Notices

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Please contact your medical customer service representative or refer to your benefits booklet for additional information.

CONTACT INFORMATION

Questions regarding all of this information can be directed to:
Review Calculating
review@calculating.net

If □o□ are receivi□g t□is electro□icall□□ □o□ are res□o□si□le for □rovidi□g a co□□ of t□is □otice to a□□ Medicare □art D □eligi□le de□e□de□ts □ □o are covered □□der t□e gro□□ □ealt□ □la□□

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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?
□o□ ca□ □oi□ a Medicare dr□g □la□ □ □e□□o□ first □eco□e eligi□le for Medicare a□d eac□ □ear fro□ Octo□er □□t□to Dece□□er □t□□ □o□ ever if □o□ lose □o□r c□rre□t credita□le □rescri□tio□ dr□g coverage□t□ro□g□ □o fa□lt of □o□r o□ □□□o□ □ ill also □e eligi□le for a t□ o□□□ □o□t□ S□ecial □□roll□e□t □eriod □S□□□ to □oi□ a Medicare dr□g □la□□

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If □o□ decide to □oi□ a Medicare dr□g □la□□ □o□r c□rre□t **Bethel School District** coverage □ ill □ot□□e affected□

If □o□ do decide to □oi□ a Medicare dr□g □la□ a□d dro□ □o□r c□rre□t **Bethel School District** coverage□□e a□ are t□at □o□ a□d □o□r de□e□de□ts □ ill □e a□le to get t□is coverage □ac□□

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
□o□ s□o□ld also □□o□ t□at if □o□ dro□ or lose □o□r c□rre□t coverage □ it□ **Bethel School District** and don't join a Medicare drug plan □ it□i□ □□ co□ti□□o□s da□s after □o□r c□rre□t coverage e□ds□□o□ □a□ a□ a □ig□er □re□i□□ □a □e□alt□□ to □oi□ a Medicare dr□g □la□ later□ If □o□ go □□ co□ti□□o□s da□s or lo□ger □ it□o□t credita□le □rescri□tio□ dr□g coverage□□o□r □o□t□l□ □re□i□□ □a□ go □□ □□at le□st □□ of t□e Medicare □ase □e□eficiar□ □re□i□□ □er □o□t□ for ever□ □o□t□ t□at □o□ did □ot □ave t□at coverage□For e□a□□le□ if □o□ go □i□etee□ □o□t□s □ it□o□t credita□le coverage□□o□r □re□i□□ □a□ co□siste□tl□ □e at le□st □□□□ □ig□er t□a□ t□e Medicare □ase □e□eficiar□ □re□i□□□ □o□ □a□ □ave to □a□t□is □ig□er □re□i□□ □a □e□alt□□as lo□g as □o□ □ave Medicare □rescri□tio□ dr□g coverage□l□ additio□□ □o□ □a□ □ave to □ait □□til t□e follo□ i□g Octo□er to □oi□□Co□tact t□e □erso□ listed □elo□ for f□rt□er i□for□atio□ **NOTE:** You'll get this notice each year. □o□ □ill also get it □efore t□e □e□t □eriod □o□ ca□ □oi□ a Medicare dr□g □la□□a□d if t□is coverage t□ro□g□ **Bethel School District** c□a□ges□□o□ also □a□ re□□est a co□□ of t□is □otice at a□□ ti□e□

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a co□□ of t□e □a□d□oo□ i□ t□e □ail ever□ □ear fro□ Medicare□ □o□ □a□ also □e co□tacted directl□ □□ Medicare dr□g □la□s□

For □ore i□for□atio□ a□o□t Medicare □rescri□tio□ dr□g coverage□
- Visit □ □ □ □edicare□gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for t□eir tele□□o□e □□□□er□for □erso□ali□ed □el□
- Call □□□□□□M□DIC□R□ □□□□□□□□□□□□□□□□□□□□TT□ □sers s□o□ld call □□□□□□□□□□□□□□□□

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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**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following is current as of July 31, 2022. If you live in another state, contact your State for more information.

OREGON – Medicaid	WASHINGTON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ 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
1-866-444-EBSA (3272)

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

Paperwork Reduction Act Statement

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

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

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.1

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 for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 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	4. Employer Identification Number (EIN)	
Bethel School District	93-600591	
5. Employer address	6. Employer phone number	
4640 Barger Drive	541-689-3280	
7. City	8. State	9. ZIP code
Eugene	OR	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:
  - [x] All employees. Eligible employees are:

    As described in the member handbook.
  - [ ] Some employees. Eligible employees are:
- With respect to dependents:
  - [x] We do offer coverage. Eligible dependents are:

    As described in the member handbook.
  - [ ] We do not offer coverage.

[x] 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.

* 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)

This procedure summarizes the benefit plans that are available to Bethel School District employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions and limitations of benefits. These documents govern benefits programs. If there is a conflict the official documents prevail. These documents are available for review at the Resources Department. Information provided in this procedure is not a guarantee of benefits.