2024 Employee Benefit Handbook

SPRINGFIELD OREGON

SpringWell
Springfield Employee's Wellness Program

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Important Notice:

The material in this benefits brochure is for informational purposes only and is neither an offer of coverage, medical advice nor legal advice. It contains only a partial description of plan or program benefits and does not constitute a contract. Consult the Summary Plan Descriptions to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plans. In case of a conflict between your plan documents and this information, the plan documents will govern. The availability of a plan or program may vary by geographic service area.

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Sources of Assistance

City of Springfield – Human Resources: 541-726-3705 Springfieldbenefits@springfield.or.gov

Policy	Carrier Name	Group Number	Telephone	Website
Medical & Vision Plan				
All Eligible Employees	PacificSource	G0020720	888-977-9299	www.pacificsource.com
Dental Plans				
All Eligible Employees	Moda Health Plans	10001700	888-217-2365	www.mymoda.com
Additional Lines of Coverage				
Life and AD&D Insurance	Lincoln Financial	09-FL1073	800-423-2765	www.lincolnfinancial.com
Long Term Disability (LTD)				
Voluntary Short Term Disability (STD)				
Health Reimbursement Arrangement (HRA)	PacificSource Administrators	n/a	800-422-7038	www.pacificsource.com/PSA
Flexible Spending Account (FSA)	PacificSource Administrators	n/a	800-422-7038	www.pacficsource.com/PSA
Employee Assistance Program (EAP)	Cascade Health	n/a	541-345-2800	www.cascadehealth.org
Benefits Resource Center (BRC)	USI	n/a	866-468-7272	www.BRCWest@usi.com

Benefits at a Glance

Medical Insurance

The City of Springfield's health plan offers employees a comprehensive medical benefit plan, the Health Incentive (HIP) Plan, through PacificSource Health Plans. This plan has a $1500 single / $3000 family deductible and pays 90% in-network / 80% out-of-network for the cost of most services (except preventive which is paid at 100% by the plan) once you have met the deductible.

Vision Insurance

The medical plan includes vision coverage.

Wellness Center

Springfield Wellness Center provides you and your dependents, who are four (4) years of age or older and enrolled in the City's medical plan, free primary and acute care.

Dental Insurance

The City offers two dental plan options for all benefit-eligible employees. You will have the ability to choose between two plan options through Delta Dental (Moda Health Plans) with over 2000 providers in the state of Oregon to choose from. The Basic Dental Plan has an annual $1,500 benefit maximum with no orthodontia coverage. The Dental Plus Plan has an annual $1,750 benefit maximum and includes orthodontia coverage up to $1,500 lifetime maximum.

Life and AD&D Insurance

Company-Paid Basic Life and AD&D

The City provides eligible full-time employees with Life and Accidental Death & Dismemberment insurance through Lincoln Financial. The benefit is 1 x your annual salary up to $200,000.

Supplemental Life and AD&D

Employees can also purchase additional life and AD&D insurance for themselves and their dependents.

Long Term Disability (LTD)

The LTD plan is designed to provide you with a reasonable level of income replacement in case you can no longer work due to a disability. The disability insurance picks up after 90 days of disability. The benefits are equal to 60% of your monthly base pay up to a maximum monthly benefit of $10,000.

Voluntary Short Term Disability (STD)

The City offers an employee-paid Voluntary Short Term Disability (STD) plan through Lincoln Financial which pays 60 percent of pre-disability earnings after a 14-day waiting period. Maximum weekly benefit not to exceed $1,500.

Health Reimbursement Arrangement (HRA)

The City of Springfield will contribute money toward a Health Reimbursement Arrangement to help reimburse you for you and your dependent(s) eligible medical expenditures throughout the plan year. This can help to minimize your total out-of-pocket expense and help you plan for upcoming procedures.

Flexible Spending Account (FSA)

Another health plan option offered by the City of Springfield is a Section 125 / Flexible Spending Account (FSA). This plan allows employees to set aside pre-tax dollars for qualifying medical and/or dependent care expenses. These funds are deducted from paychecks in equal installments, depending on the amount elected at the beginning of the plan year. You have the option of enrolling in a Health Care FSA or a Dependent Care FSA. The Health Care FSA helps to reimburse eligible medical expenses while the Dependent Care FSA helps to be reimbursed for qualified dependent care expenses. You must enroll each year during open enrollment.

Employee Assistance Program (EAP)

The City of Springfield offers an Employee Assistance Program in order to help employees deal with stressors caused by work and issues outside of the working environment. To use the EAP plan, please contact Cascade Behavioral Health & EAP or visit their website at www.cascadehealth.org.

Questions?

For more information regarding the benefits and coverage offered, you can contact your Benefits Administrator or reach out to the Benefit Resource Center at 866-468-7272, or email at BRCWest@usi.com

Eligibility & Enrollment

Eligibility Provisions

Employees hired as a regular employee and work at least regularly work at least 20 hours per week are eligible to participate in the City of Springfield Benefits Program. For Life / AD&D, your coverage will be effective on Date of Hire. For all other coverages, your coverage will become effective on the first of the month following Date of Hire or Date of Hire if it coincides with the 1st day of the month. You must be actively at work for your coverage to be effective on your eligibility date. You may also enroll your eligible dependents. The following family members are eligible for coverage:

- Your legal spouse or your domestic partner – Declaration of Marriage or Domestic Partnership form required
- Your, your spouse's, or your domestic partner's dependent children under age 26 regardless of the child's place of residence, marital status, or financial dependence on you
- Your, your spouse's, or your domestic partner's unmarried dependent children age 26 or over who are mentally or physically disabled. To qualify as dependents, they must have been continuously unable to support themselves since turning age 26 because of a mental or physical disability

When Can You Enroll?

You can sign up for Benefits at any of the following times:

- After completing your initial eligibility period
- During the annual open enrollment period
- Within 31 days of a qualified family- status change

If you do not enroll at the above times, you must wait for the next annual open enrollment period.

Making Changes

Generally, you can only change your benefit elections during the annual benefits enrollment period. However, you may be able to change some of your benefit elections upon the occurrence of certain change in status events, provided you properly notify Human Resources within 31 days of the event.

Examples of change in status events may include:

- Your marriage or qualified partnership
- Your divorce, legal separation or dissolution of partnership
- Birth or adoption of an eligible child
- Death of your spouse/eligible domestic partner or covered child
- Change in your spouse/registered partner/partner's work status that affects his or her benefits
- Change in your work status that affects your benefits
- Change in residence or work site that affects your eligibility for coverage
- Change in your child's eligibility for benefits
- Receiving a Qualified Medical Child Support Order (QMCSO)

Group Name: City of Springfield
Group Number: G0020720
Provider Network: Navigator
Benefit Year: Calendar Year

Employee Eligibility Requirements

Minimum Hour Requirement: Twenty (20) hours per week

Waiting Period Requirement: First of the month following date of hire. If the date of hire is the first day of the month, coverage will begin that day.

Deductible Per Benefit Year	All Providers	
Individual/Family	$1,500 / $3,000	
Out-of-Pocket Limit Per Benefit Year	**In-network**	**Out-of-network**
Individual/Family	$2,000 / $4,000	$10,000 / NA

Note: In-network out-of-pocket limit accumulates separately from the out-of-network 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 this Plan (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 Fee, please see the Definitions Section of the Plan Document.

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%	No Deductible, 20%
Prostate cancer screening	No Deductible, 0%	No Deductible, 20%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Professional Services		
Office and home visits	First three visits, no Deductible, 0%. Subsequent visits, after Deductible, 10%*	After Deductible, 20%
Naturopath office visits	After Deductible, 10%	After Deductible, 20%
Specialist office and home visits	After Deductible, 10%	After Deductible, 20%
Telehealth visits	First three visits, no Deductible, 0%. Subsequent visits, after Deductible, 10%*	After Deductible, 20%
Office procedures and supplies	After Deductible, 10%	After Deductible, 20%
Surgery	After Deductible, 10%	After Deductible, 20%
Outpatient Rehabilitation and Habilitation Services	After Deductible, 10%	After Deductible, 20%
Chiropractic manipulation/Spinal manipulation (20 visits per Benefit Year)	After Deductible, 10%	After Deductible, 20%
Acupuncture (12 visits per Benefit Year)	After Deductible, 10%	After Deductible, 20%
Massage therapy ($1,200 per Benefit Year)	After Deductible, 10%	After Deductible, 20%
Hospital Services		
Inpatient room and board	After Deductible, 10%	After Deductible, 20%
Inpatient Rehabilitation and Habilitation Services	After Deductible, 10%	After Deductible, 20%
Skilled nursing facility care	After Deductible, 10%	After Deductible, 20%
Outpatient Services		
Outpatient surgery/services	After Deductible, 10%	After Deductible, 20%
Diagnostic imaging – advanced	After Deductible, 10%	After Deductible, 20%
Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced	After Deductible, 10%	After Deductible, 20%
Urgent and Emergency Services		
Urgent care center visits	After Deductible, 10%	After Deductible, 20%
Emergency room visits – medical emergency	After Deductible, 10%	After Deductible, 10%
Emergency room visits – non-emergency	After Deductible, 10%	After Deductible, 20%
Ambulance, ground	After Deductible, 10%	After Deductible, 10%
Ambulance, air	After Deductible, 10%	After Deductible, 10%
Maternity Services**		
Physician/Provider services (Global Charge)	After Deductible, 10%	After Deductible, 20%
Hospital/Facility services	After Deductible, 10%	After Deductible, 20%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Mental Health and Substance Use Disorder Services		
Office visits	First three visits, no Deductible, 0%. Subsequent visits, after Deductible, 10%*	After Deductible, 20%
Inpatient care	After Deductible, 10%	After Deductible, 20%
Residential programs	After Deductible, 10%	After Deductible, 20%
Other Covered Services		
Allergy injections	After Deductible, 10%	After Deductible, 20%
Durable medical equipment	After Deductible, 10%	After Deductible, 20%
Home health services	After Deductible, 10%	After Deductible, 20%
Transplants	After Deductible, 0%	After Deductible, 30%
Temporomandibular joint (TMJ)	After Deductible, 50%	After Deductible, 50%

This is a brief summary of benefits. Refer to the Plan Document for additional information or a further explanation of benefits, limitations, and exclusions.

* First 3 visits per Benefit Year combined for Professional Services – Office and Home Visits, Telehealth Visits, and Mental Health and Substance Use Disorder Services – Office Visits.

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

Additional information

What is the Deductible?

Your Deductible is the amount of money that you pay first, before this Plan starts to pay. You'll see that many services, especially preventive care, are covered by this 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.

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, this 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 the Plan Document, 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 the website, Authgrid.PacificSource.com (select Commercial for the line of business)

Discrimination is against the law

Both the Plan Sponsor and PacificSource Health Plans comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan Sponsor and PacificSource do 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 the PacificSource Customer Service team or visit PacificSource.com/find-a-drug.

The amount you pay for covered prescriptions at in-network pharmacies applies toward this Plan's in-network medical out-of-pocket limit, and the amount you pay for covered prescriptions at out-of-network pharmacies applies toward this Plan's out-of-network medical out-of-pocket limit. The medical out-of-pocket limits are 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 applicable medical out-of-pocket limit.

Medical Deductible

You must meet the medical Deductible, which is shown on the Medical Benefit Summary, before your Prescription Drug benefits begin.

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 90 day supply:	After Deductible, 10%	After Deductible, 10%+	After Deductible, 25%+
In-network Mail Order Pharmacy			
Up to a 90 day supply:	After Deductible, 10%	After Deductible, 10%+	After Deductible, 25%+
Compound Drugs**			
Up to a 90 day supply:	After Deductible, 25%		
Out-of-network Pharmacy			
Regardless of tier up to a 90 day supply:	After Deductible, 50%		
Specialty Drugs – In-network Specialty Pharmacy			
Up to a 30 day supply:	Same as retail pharmacy		

Service/Supply	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays
Specialty Drugs – Out-of-network Specialty Pharmacy			
30 day maximum fill, no more than three fills allowed per Benefit Year:	Same as retail pharmacy		

+ In-network Formulary prescription insulin will not be subject to a Deductible and limited to $85 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 C - Regardless of the reason or Medical Necessity, if you receive a brand name drug or if your Provider prescribes a brand name drug when a generic is available, you will be responsible for the brand name drug's Copayment and/or Coinsurance after the medical Deductible is met. Does not apply to preventive bowel prep kit medications covered under USPSTF guidelines.

If your Provider prescribes a brand name contraceptive due to Medical Necessity it may be subject to prior authorization for coverage at no charge.

See the Plan Document for important information about your Prescription Drug benefit, including which drugs are covered, limitations, and more.

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 Services apply to the medical 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 maximum benefit then Member responsibility
Vision hardware	No Deductible, 0% for one pair per Benefit Year for glasses (lenses and frames) or contacts (lenses and fitting)	No Deductible, 0% up to $75 maximum benefit for one pair per Benefit Year for glasses (lenses and frames) or contacts (lenses and fitting) then Member responsibility
Members Age 19 and Older		
Eye exam	No Deductible, 0%	No Deductible, 0% up to $40 maximum benefit then Member responsibility
Single vision lenses	No Deductible, 0%	No Deductible, 0% up to $56 maximum benefit then Member responsibility
Bifocal lenses	No Deductible, 0%	No Deductible, 0% up to $84 maximum benefit then Member responsibility
Trifocal lenses	No Deductible, 0%	No Deductible, 0% up to $116 maximum benefit then Member responsibility
Lenticular lenses	No Deductible, 0%	No Deductible, 0% up to $236 maximum benefit then Member responsibility
Progressive lenses	No Deductible, 0% up to $116 maximum benefit then Member responsibility	No Deductible, 0% up to $116 maximum benefit then Member responsibility
Frames	No Deductible, 0% up to $150 maximum benefit then Member responsibility	No Deductible, 0% up to $150 maximum benefit then Member responsibility

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Contact Lenses (in lieu of glasses)		
Contact lenses	No Deductible, 0% up to $131 maximum benefit then Member responsibility	No Deductible, 0% up to $131 maximum benefit then Member responsibility

Benefit Limitations: Members age 18 and younger

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

Benefit Limitations: Members age 19 and older

- One vision exam every Benefit Year.
- Lenses: One pair every Benefit Year.
- Frames: Once every two Benefit Years.
- Contact lenses: Once every two Benefit Years.
- 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.
- Non-prescription 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 Services.
- 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 (plain or prescription) and subnormal vision aids.

- Visual analysis that does not include refraction.

Important information about your vision benefits

This 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: This Plan 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: Provider contracts require In-network Providers to bill PacificSource 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 this 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: 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, this Plan's in-network benefits cannot be combined with any other discounts or coupons. You can use this Plan's in-network benefits, or you can use this Plan's out-of-network benefits to take advantage of a sale or coupon offer.

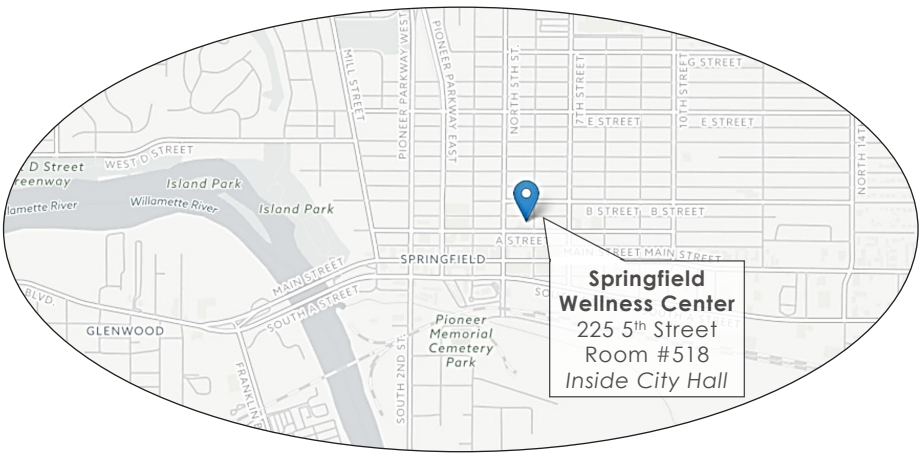
If you do take advantage of a special offer, the In-network Provider may treat you as an uninsured customer and require full payment in advance. You can then send the claim to PacificSource yourself, and this Plan will reimburse you according to this Plan's out-of-network benefits.

Springfield Wellness Center
Overview

Convenient, Quality Healthcare

The Springfield Wellness Center is a medical clinic for eligible City of Springfield and Springfield School District employees, retirees and their families. We specialize in individualized, comprehensive care, health coaching and follow up resources. Working with your Pacific Source health plan, we provide you free, high quality primary and acute care.

Our partnership with Cascade Health allows us to provide a full range of primary health care, diagnostic tests, minor surgery and preventive care while maintaining strict confidentiality. School, sports, camp and annual physicals also available: *See reverse for a list of additional services.*



Using Springfield Wellness Center

It's easy! Just call us for an appointment:

541.242.2816

Appointments are available Monday through Friday.

The Springfield Wellness Center is brought to you through a partnership between Cascade Health, City of Springfield and the Springfield School District.

Springfield Wellness Center | 541.242.2816 p

Springfield Wellness Center

Services Provided

cascade HEALTH

Preventive Care/Management/Screening

- Breast exams/ cancer screening
- Sports physicals; age 4 years and older
- Complete male annual/prostate exam
- Complete female annual/gynecological exams; Pelvic/ Pap smear/HPV testing
- Diabetic wellness exams & management
- Medication review/prescription initiation and management (i.e. hypertension, dyslipidemia, birth control, etc.)
- Seasonal allergy management
- Asthma management
- Infectious disease/outbreak management (whooping cough, lice, impetigo, shingles, norovirus, influenza)
- Tobacco cessation treatment
- Migraine preventive management
- Biometric screening

Injury Treatment*

- Burn and wound care
- Animal bites/scratches
- Lesion /mole and wart removal; biopsy of skin if indicated
- Splinting
- Abscess incision and drainage
- Suturing of lacerations
- Suture removal
- Nail removal
- Foreign object removal (i.e. splinters/glass)
- Muscle strains/sprains (non-emergency)

Work related injuries *are treated at the Wellness Center partner, Cascade Health on Suzanne Way in Eugene - please call 541.228.3100 for more info.*

Illness

- Acute illness care (i.e. sore throat, colds, influenza, rash, sinusitis, ear infections)
- Abdominal disorders
- Sleep disturbance
- Depression
- Anxiety
- Urinary concerns and infections
- Sexually transmitted disease testing
- Rapid strep tests
- Mono testing

Other Services

- Health Coaching
- Follow-up emergency room, urgent care, and specialist visits
- Pregnancy tests
- IUD removal
- Nebulizer treatment
- PPD Tests (Tuberculosis/TB)
- Ordering and interpretation of lab testing
- Ear lavage

Referrals for

- Diagnostic imaging
- Specialist visits
- Physical therapy
- Mental health therapy/on-site counseling

Vaccinations

- Tetanus, diphtheria, pertussis
- Hepatitis A
- Hepatitis B
- Influenza
- Pneumococcal
- Meningitis

Springfield Wellness Center by Cascade Health | 541.242.2816 p
225 5th Street Room #518 | 541.242.2817 f

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.**

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.

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.

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.

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.

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.

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.

Delta Dental Premier Plan Benefit Summary

Delta Dental of Oregon & Alaska

City of Springfield - Basic Dental Plan

Group ID: 10001700

Calendar year costs	
Calendar year maximum, per member (ages 19 and over)	$1,500
Calendar year deductible, per member	$0
Class 1	
Periodic Examinations / X-rays	*1st year - 70% 2nd year - 80% 3rd year - 90% 4th year - 100%
Prophylaxis (cleanings) / Periodontal Maintenance	
Sealants	
Space Maintainers	
Topical Application of Fluoride	
Class 2/3	
Restorative Fillings	*1st year - 70% 2nd year - 80% 3rd year - 90% 4th year - 100%
Oral Surgery (extractions & certain minor surgical procedures)	
Endodontics (treatment of teeth with diseased or damaged nerves)	
Periodontics (treatment of diseases of the gums and supporting structures of the teeth)	
Crowns and other cast restorations	
Class 4	
Implants	50%
Dentures and bridges (construction or repair of fixed bridges, partial, and complete dentures)	

*Under this plan, payments increase by 10% each eligibility year provided the individual has visited the dentist at least once during the year. Failure to do so will cause a 10% reduction in payment the following year, although payment will never fall below 70%.

This is a benefit summary only. For a more detailed description of benefits, refer to your member handbook.

How to use this dental plan

When you visit your dental provider, tell him or her you are a Delta Dental member.

When the member visits:

Delta Dental Premier Dentist:
Members are held harmless from balance billing (will not be billed for the difference between the dentist's billed charge and the Delta Dental negotiated fee).

Non Participating Dentists:
Members may be held liable for the difference between the dentist's billed charge and the non-participating allowable.

Limitations

If a more expensive treatment than is functionally adequate is performed, Delta Dental Plan of Oregon will pay the applicable percentage of the maximum plan allowance for the least costly treatment.

Preventive (Class 1 services)

- **Diagnostic** Routine or comprehensive examinations or consultations covered twice per calendar year. Supplementary bitewing x-rays are covered once in any 12-month period. Complete series x-rays or a panoramic film are covered once in any 5-year period.
- **Preventive** Prophylaxis (cleaning) or periodontal maintenance is covered up to twice per calendar year. Additional periodontal maintenance is covered for members with periodontal disease, up to a total of 2 additional periodontal maintenances per year. Topical application of fluoride is covered twice per calendar year for members until age 19. For members age 19 and older, topical application of fluoride is covered twice per calendar year if there is a recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant, per tooth, during any 5-year period.

Basic (Class 2/3 services)

- **Oral Surgery** Limited to extractions and other minor surgical procedures.
- **Restorative** A separate charge for general anesthesia and/or IV sedation is not covered when used for non-surgical procedures.
- **Periodontic** Scaling and root planing is limited to once per quadrant in any twenty-four (24) month period.

Major (Class 4 services)

- **Prosthodontic** A bridge or denture (full or partial, including alternate benefits) will be covered once in a seven (7) year period only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the past seven (7) years. Specialized or personalized prosthetics are limited to the cost of standard devices.
- **Implants** and implant removal are limited to once per lifetime per tooth space. A crown over an implant is covered once per lifetime of the implant.
- **Night Guard** (occlusal guard) covered at 100% once in a five year period, up to $200 maximum. Over-the-counter night guards are excluded.
- **Athletic mouth guard** covered at 50%, once in any 12-month period for members age 15 and under and once in any 24-month period age 16 and over. Over-the-counter athletic mouth guards are excluded.

Exclusions

- Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
- Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis and disturbance of the temporomandibular joint.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth.
- Services started prior to the date the individual became eligible for services under the program.
- Hypnosis, prescribed drugs, premedications or analgesia (e.g. nitrous oxide) or any other euphoric drugs.
- Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
- General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office.
- Plaque control and oral hygiene or dietary instructions.
- Experimental procedures.
- Missed or broken appointments.
- Precision attachments.
- Services for cosmetic reasons.
- Claims submitted more than 12 months after the date of service are not covered.
- All other services or supplies, not specifically covered.
- Orthodontia.

Delta Dental Premier Plan Benefit Summary

Delta Dental of Oregon & Alaska

City of Springfield - Dental Plus+(with ortho)

Group ID: 10001700

Calendar year costs	
Calendar year maximum, per member (ages 19 and over)	$1,750
Calendar year deductible, per member	$0
Class 1	
Periodic Examinations / X-rays	*1st year - 70% 2nd year - 80% 3rd year - 90% 4th year - 100%
Prophylaxis (cleanings) / Periodontal Maintenance	
Sealants	
Space Maintainers	
Topical Application of Fluoride	
Class 2/3	
Restorative Fillings	*1st year - 70% 2nd year - 80% 3rd year - 90% 4th year - 100%
Oral Surgery (extractions & certain minor surgical procedures)	
Endodontics (treatment of teeth with diseased or damaged nerves)	
Periodontics (treatment of diseases of the gums and supporting structures of the teeth)	
Crowns and other cast restorations	
Class 4	
Implants	50%
Dentures and bridges (construction or repair of fixed bridges, partial, and complete dentures)	
Orthodontia	
Subscribers and their eligible dependents	50% up to a lifetime maximum of $1500

*Under this plan, payments increase by 10% each eligibility year provided the individual has visited the dentist at least once during the year. Failure to do so will cause a 10% reduction in payment the following year, although payment will never fall below 70%.

This is a benefit summary only. For a more detailed description of benefits, refer to your member handbook.

How to use this dental plan

When you visit your dental provider, tell him or her you are a Delta Dental member.

When the member visits:

Delta Dental Premier Dentist:
Members are held harmless from balance billing (will not be billed for the difference between the dentist's billed charge and the Delta Dental negotiated fee).

Non Participating Dentists:
Members may be held liable for the difference between the dentist's billed charge and the non-participating allowable.

Limitations

If a more expensive treatment than is functionally adequate is performed, Delta Dental Plan of Oregon will pay the applicable percentage of the maximum plan allowance for the least costly treatment.

Preventive (Class 1 services)

- **Diagnostic** Routine or comprehensive examinations or consultations covered twice per calendar year. Supplementary bitewing x-rays are covered once in any 12-month period. Complete series x-rays or a panoramic film are covered once in any 5-year period.
- **Preventive** Prophylaxis (cleaning) or periodontal maintenance is covered up to twice per calendar year. Additional periodontal maintenance is covered for members with periodontal disease, up to a total of 2 additional periodontal maintenances per year. Topical application of fluoride is covered twice per calendar year for members until age 19. For members age 19 and older, topical application of fluoride is covered twice per calendar year if there is a recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant, per tooth, during any 5-year period.

Basic (Class 2/3 services)

- **Oral Surgery** Limited to extractions and other minor surgical procedures.
- **Restorative** A separate charge for general anesthesia and/or IV sedation is not covered when used for non-surgical procedures.
- **Periodontic** Scaling and root planing is limited to once per quadrant in any twenty-four (24) month period.

Major (Class 4 services)

- **Prosthodontic** A bridge or denture (full or partial, including alternate benefits) will be covered once in a seven (7) year period only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the past seven (7) years. Specialized or personalized prosthetics are limited to the cost of standard devices.
- **Implants** and implant removal are limited to once per lifetime per tooth space. A crown over an implant is covered once per lifetime of the implant.
- **Night Guard** (occlusal guard) covered at 100% once in a five year period, up to $200 maximum. Over-the-counter night guards are excluded.
- **Athletic mouth guard** covered at 50%, once in any 12-month period for members age 15 and under and once in any 24-month period age 16 and over. Over-the-counter athletic mouth guards are excluded.

Exclusions

- Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
- Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis and disturbance of the temporomandibular joint.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth.
- Services started prior to the date the individual became eligible for services under the program.
- Hypnosis, prescribed drugs, premedications or analgesia (e.g. nitrous oxide) or any other euphoric drugs.
- Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
- General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office.
- Plaque control and oral hygiene or dietary instructions.
- Experimental procedures.
- Missed or broken appointments.
- Precision attachments.
- Services for cosmetic reasons.
- Claims submitted more than 12 months after the date of service are not covered.
- All other services or supplies, not specifically covered.

Life / AD&D Insurance - this coverage is through Lincoln Financial

Company-Paid Basic Life and Accidental Death & Dismemberment (AD&D)

Although we don't like to think about it, should death occur, the survivors left behind could face serious financial hardship s. Your family might need an alternative source of income to pay off your bills and meet their ongoing financial responsibilities. That is the purpose of life insurance–to provide funds for those left behind. It is also possible that an accident could cause serious injury–the loss of limbs or eyesight, for example. There is special insurance coverage which pays benefits if an accident causes the loss of life, limb, or sight–it is called Accidental Death and Dismemberment (AD&D) insurance. AD&D pays an amount equal to your life insurance benefit in the event of your accidental death. It also provides benefits for certain accidental injuri es. City of Springfield offers a company paid basic life / AD&D benefit to eligible members of the following classifications at no cost to you;

1 times your annual earnings, subject to a maximum of $200,000 rounded to the next higher $1,000 if not already a multiple of $1,000

Supplemental Life & Supplemental Dependent Life

City of Springfield allows you to purchase additional amounts of individual term life insurance through Lincoln Financial for yourself, your eligible spouse/registered domestic partner and your eligible children. Employees may purchase amounts of life insurance up to the following maximum benefits:

Employee: In increments of $10,000 up to 6 times your annual earnings, to a maximum of $500,000 (guarantee issue amount is $100,000)

Spouse: If you elect supplemental life insurance for yourself, you may choose to purchase spouse supplemental life insurance in increments of $5,000, to a maximum of $100,000 (guarantee issue amount is $10,000). You may not elect coverage for your spouse if they are in active fulltime military service or already covered as an employee under this policy

Child(ren): If you elect supplemental life insurance for yourself, you may choose to purchase child(ren) supplemental life insurance coverage in increments of $2,000, to a maximum of $10,000 for each child – no medical information is required. Your child(ren) must be at least 15 days old but not yet age 26 to be covered. Child(ren) age 26 or older may be covered if they were disabled prior to attaining age 26

Supplemental AD&D

The City of Springfield allows you to also purchase additional amounts of AD&D coverage through Lincoln Financial. You may elect to have the additional AD&D coverage in the following amounts at a cost of $0.048 per $1,000 of benefit for employee coverage and $0.067 per $1,000 of benefit for family coverage:

Employee: In increments of $10,000 up to a maximum of $300,000

Family Coverage

- **Spouse Benefit:** 50% of the Employee amount
- **Spouse/Dependent Child(ren) Benefit:** 60% of the Employee amount
- **Dependent Child(ren) Benefit:** 25% of the Employee amount

Cost calculation example for employee wanting $20,000 of AD&D coverage: 20 x $0.048 = $.96 per month

Benefit reductions apply for Basic and Supplement Life/AD&D at age 70

Mandatory Life Insurance

- Covers Police Officers/Detention & Firefighters as defined by state law
- $10,000 covering death caused by injury sustained during working hours or death resulting from such an injury within 65 days

Disability Insurance – this coverage is through Lincoln Financial

Long Term Disability Insurance (LTD)

The greatest threat to your earning power is illness or injury. If you are disabled due to a non-occupational illness or injury, the City of Springfield offers a Long Term Disability benefit. The LTD plan is designed to provide you with a reasonable level of income replacement in case you can no longer work due to a disability.

The City provides Long Term Disability insurance coverage through Lincoln Financial to eligible employees.

Highlights of the Long Term Disability plan include the following:

- Benefits begin for employees after the 90-day waiting period
- Benefits are equal to 60% of monthly base pay up to a maximum monthly benefit of $10,000
- Benefits are payable for total disability until your Social Security Normal Retirement Age
- Pre-existing conditions apply. If you have had an illness, injury or are pregnant within three months before enrolling in the plan, that condition will not be covered for the first 12 months you are enrolled

Voluntary Short Term Disability Insurance

The Voluntary Short Term Disability (STD) plan is administered by Lincoln Financial and provides disability income benefits for short-term disabilities resulting from non-work-related injury, an illness, or pregnancy.

Highlights of the Voluntary Short Term Disability plan include:

- Benefits commence for Disability caused by Injury or Sickness on the 15th day of Total Disability or Disabled and Working
- Benefits are equal to 60% of weekly base pay, to a maximum of $1,500 per week
- The benefit period is 90 days
- STD benefits cease when LTD benefits begin
- Benefits are voluntary, and members are required to pay the premium

Health Reimbursement Arrangement (HRA)

For employees enrolled in the employer-sponsored medical plan, City of Springfield offers an additional option to help reimburse health insurance premiums throughout the year. This option, the Health Reimbursement Arrangement (HRA), is available to set aside pre-tax savings to pay for reimbursement of eligible medical expenses for you and your dependents, regardless of whether or not your tax dependents are enrolled in a group health plan. The funds contributed to this account are employer contributed, meaning that you do not add your own money to the account. If you terminate, the funds will remain in your account until there is a zero balance (you will be responsible for the administration fee). This account is administered by PacificSource Administrators.

All money contributed to the HRA can either be used during the same plan year that it was contributed or rolled over to the following plan year.

Your employer will contribute the following amounts to the HRA account for those enrolled:

Single Coverage	**$1,200**
Family Coverage	**$2,400**

Comparing the FSA & HRA

	FSA	HRA
Who is eligible?	Any employee eligible for benefits, regardless of whether they are enrolled in the City's medical plan	Employees who are enrolled in the medical plan offered by the City of Springfield
Who can contribute?	Employee may contribute money to the FSA	Employer Only
What medical expenses are eligible for reimbursement?	All qualified medical expenses listed in IRS section 213(d) for employee, legal spouses and children to age 26, regardless of whether they are enrolled in the medical plan. Expenses of tax dependent domestic partners are allowed. Cannot reimburse insurance premiums Cannot reimburse qualified long-term care services	All qualified medical expenses listed in IRS section 213(d) for employee, spouse and children to age 26 as long as they are enrolled in a group health plan Can reimburse premiums for eligible health insurance
What happens to funds left in the account that are unused for the plan year?	Any funds in excess of $640 are forfeited. Any balance up to $640 can be rolled over to the next plan year to be spent for qualifying medical expenses	Money in the account at the end of the plan year can roll over to the next plan year, regardless of how much is left
What is the maximum amount that can be contributed to the account?	$3,200 for the Health Care FSA and $5,000 for the Dependent Care FSA	Because this is an employer-only contribution account, the maximum amount contributed depends on the amount City of Springfield will contribute to this account. For the 2024 plan year, the City will contribute $1,200 for employees enrolled as employee-only and $2,400 for employees who enroll their dependents

PacificSource ADMINISTRATORS

CITY OF SPRINGFIELD
Flexible Spending Account Summary
January 1, 2024 – December 31, 2024

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	Minimum Annual Election	Maximum Annual Election
General Purpose Health FSA	$ NA	$3,200
Supplemental Premium Account	$ NA	No limit
Dependent Daycare Expenses	$ NA	$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.

Supplemental Premium Account (SPA) Component

Supplemental Premium Account (SPA)

- The Supplemental Premium Account (SPA) allows you to save pre-tax dollars to pay for supplemental insurance premiums (excluding employer-sponsored health insurance). Examples include Firemed, or personal dental or vision policies.

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 **January 1, 2024** and **December 31, 2024** must be submitted by **March 31, 2025** for reimbursement.

Submitting Claims

There are several ways you can submit expenses for reimbursement. These methods include manual submission, using your Prepaid Benefit Card, or enrolling in the EasyPay program. If you're reimbursed for a claim and it is later determined that the expense was not eligible for reimbursement, you will be liable for repaying the money to your FSA. Additional information is listed below.

Manual Claims

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

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

Prepaid Benefit Card

A Prepaid Benefits Debit Card gives you an easy, automatic way to pay for qualified healthcare expenses. When you enroll in the health FSA, you will automatically receive two benefits cards. Simply swipe your benefits card as you would a credit/debit card (and select "credit" rather than "debit"). When you use the card to make a purchase or payment, it deducts funds directly from your FSA. Date of service is important! It's assumed the date of service is the day the card is swiped. If you are paying for a prior service, only use your card if the service date is within your current plan year. Prior year services need to be submitted as manual claims for reimbursement. Replacements or additional cards can be purchased for $10 per set of two cards.

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

EasyPay

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

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

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

Funds Remaining After the Plan Ends

If the plan year ends before you've used all of your Health FSA funds, you're allowed to have up to $640 carry over to the next FSA plan year. If you have more than the $640 remaining, you'll lose those additional funds, along with all other account balances., You will not be required to make a salary reduction contribution in the new Plan Year in order to have up to $640 carryover.

Carryover funds will be automatically rolled after the prior plan year and claims submission period ends(90 day runout). 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, by default your participation in the plan will end on the last day of the month in which you have contributed. Expenses incurred after participation ends will not be reimbursable.

You may elect to participate in a Premium Completion Agreement by electing to have a final pre-tax deduction withheld from your final paycheck equal to the remaining account balance. If your final paycheck will not cover the remaining balance, 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 to the end of the current Plan Year.

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.

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

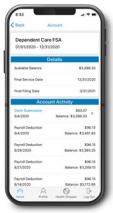
Manage your reimbursement accounts with the PSA mobile app

Check reimbursement account balances, submit receipts, and get the information you need on the go.

One app for many types of accounts

You can use the PacificSource Administrators, Inc. (PSA) app to manage:

- Flexible Spending Accounts (FSA)
  - Health and Dependent Care Accounts
- Health Reimbursement Arrangements (HRA)
- Transportation Benefits
- Premium Reimbursement Plans



Check your balances

Wondering whether you can pay for an elective procedure or cover an upcoming bill? Your accounts and their balances are easily viewable, right at the top of the main screen. And you can tap on any account to get a detailed list of activity.

File a claim, submit a receipt

Filing a claim is almost as easy as depositing a check using a bank app. Just fill in the claim details and use your mobile device to take a photo of the receipt. If you prefer to upload receipts and submit claims later, there's a handy receipt organizer for that, too.

Questions?

Contact PSA Customer Service

Email

PSACustomerService@PacificSource.com

Phone

800-422-7038

Web

PacificSource.com/PSA

PacificSource ADMINISTRATORS

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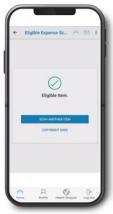


Does it qualify?

If you have an FSA, you have likely wondered whether a particular item is eligible or not. Prescription sunglasses? Over-the-counter medicine? And, recent changes via the CARES Act have expanded the list of qualified items. You can use the app while at the pharmacy to scan a product's bar code to see if it qualifies as a medical expense.

Add your bank account for faster reimbursement

You can add or update information to have reimbursements deposited directly into your bank account. Direct deposit information added through the PSA mobile app goes through a real-time verification process and becomes effective the next business day.

Download it today

The PSA app is available for download from your device's app store. You'll find it by searching "myPacificSource Admin (PSA)." Note that there are two apps with similar names. The other one, called "myPacificSource," is for PacificSource Health Plans, and includes a member ID, a doctor or hospital finder, benefits information, and more.

Once you've downloaded the app, you'll need your username and password from the PSA web page: PSA.Consumer.PacificSource.com. The app also enables you to use your fingerprint to log in, if your device supports that function.

PacificSource ADMINISTRATORS

Sick Leave Reserve

The Sick Leave Reserve Program may provide income replacement through a sick leave bank when:

1. The employee or their family member has a serious illness or injury as defined by OFLA/FMLA, and

2. The employee has depleted all available paid time off benefits, and

3. The employee is a current member of the Sick Leave Reserve program

For complete program details refer to the Administrative Regulation Policy # 03-02-07

Here to Help

Get the Most Our of Your Employee Assistance Program.

Congratulations! Your employer has partnered with Cascade Health Counseling & Employee Assistance Program to give you and all members of your household access to free, confidential counseling services.

Counseling can be a good way to combat stress, develop new skills, learn more about yourself and help you make changes to improve your life. Whether your goals are personal, professional or relationship-focused, our counselors can provide guidance, support and action plans to help you live your happiest, healthiest life.

We serve individuals, couples and families ages 6 and up. Give us a call today and get started on your path to self-discovery.

cascadehealth.org | (541) 345-2800

To Schedule
Call (541) 345-2800
Monday - Friday
8:30 a.m. - 5 p.m.

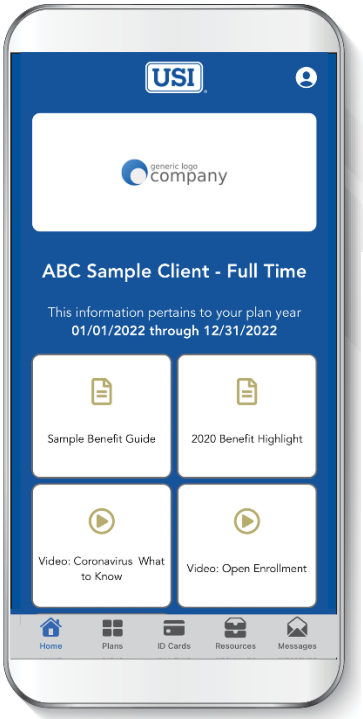
Appointments Available
Monday - Thursday
8 a.m. - 7 p.m.

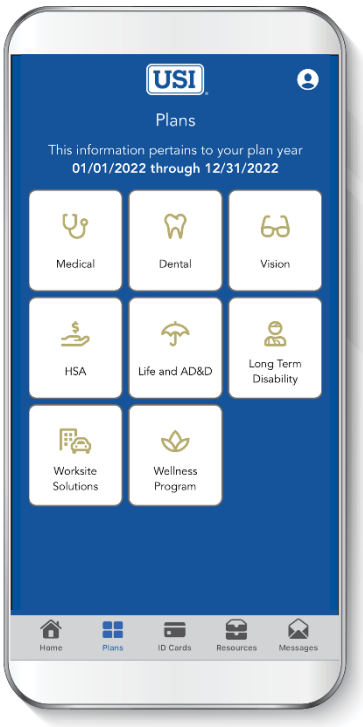
Friday
8 a.m. - 5 p.m.

If you are having a mental health emergency, call us 24 hours a day for assistance.

Location
2650 Suzanne Way, Ste. 120
Eugene, OR 97408

cascade HEALTH
Counseling & EAP





Download **MyBenefits2GO** from the app store and access your benefits details and contact information when you need it.

City of Springfield

Enter this code when prompted:

U66877

Benefits Information When You Need It Most

Available for iPhone and Android

Getting In Touch
The app provides employees and their enrolled dependents single-point contact information for benefits resources and insurance carriers.

Lightening Wallets
The app allows you to store and share images of your ID cards, freeing up space and giving you access when you need it.

Keeping Up-to-Date
The app automatically connects you with the most updated plan information and allows for message reminders from your employer.

Staying Organized
The app gives you access to benefit plan information and ID cards—all in one place.

Call the Benefit Resource Center ("BRC"), We're Here To Help!

We speak insurance. Our Benefits Specialists can help you with:

- Deciding which plan is the best for you
- Benefit plan & policy questions
- Eligibility & claim problems with carriers
- Information about claim appeals & process
- Allowable family status election changes
- Transition of care when changing carriers
- Claim escalation, appeal & resolution
- Medicare basics with your employer plan
- Coordination of benefits
- Finding in-network providers
- Access to care issues
- Obtaining case management services
- Group disability claims
- Filing claims for out-of-network services

USI®

Benefit Resource Center

BRCWest@usi.com | Toll Free: 866-468-7272

Monday through Friday 8:00am to 5:00pm Mountain, Pacific and Alaska Standard Time

Important Legal Notices Affecting Your Health Plan Coverage

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. See your Summary Plan Description for details.

NEWBORNS ACT DISCLOSURE - FEDERAL

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

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Questions regarding any of this information can be directed to:

- springfieldbenefits@springfield.or.gov

MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

If you are receiving this electronically, you are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who are covered under the group health plan.

Important Notice from City of Springfield **Regarding 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 City of Springfield 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 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. City of Springfield has determined that the prescription drug coverage offered by the City of Springfield 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?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City of Springfield coverage will not be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D. If you do decide to join a Medicare drug plan and drop your current City of Springfield coverage, be aware that you and your dependents will only be able to get this coverage back by satisfying the plan's eligibility criteria.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with City of Springfield and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join. Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Springfield changes. You also may request a copy of this notice at any time.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Note: Please provide a copy of this Notice to your Medicare-eligible dependents covered under this plan.

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).

Date: January 1, 2024
Name and Address of Sender: City of Springfield, Inc. 225 N Fifth Street, Springfield, OR 97477
Contact and Phone Number: Human Resources, 541-726-3705

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:
    - Marketing purposes
    - Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice
- Effective Date of this Notice – 1/1/2024
- springfieldbenefits@springfield.or.gov

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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. City of Springfield	4. Employer Identification Number (EIN) 93-6002258	
5. 225 North Fifth Street	6. Employer phone number: 541-726-3700	
7. Springfield	8. OR	9. 97477
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above)	12. springfieldbenefits@springfield.or.gov	

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:

    The plan's eligibility requirements are stated in the Member Benefits Handbook. All employees who meet those requirements are eligible for coverage

  - [ ] Some employees. Eligible employees are:
- With respect to dependents:
  - [x] We do offer coverage. Eligible dependents are:

    The plan's eligibility requirements are stated in the Member Benefits Handbook. All dependents who meet those requirements are eligible for coverage

  - [ ] 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)

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, please contact the PacificSource customer service team at 1-888-246-1370. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at Healthcare.gov/sbc-glossary/ or call 1-888-246-1370 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	All providers: $1,500 individual/ $3,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and other services listed below with 'deductible does not apply'.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at Healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network provider: $2,000 individual/ $4,000 family | Out-of-network providers: $10,000 individual	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See providerdirectory.PacificSource.com/?nPlan or call 1-888-246-1370 for a list of network providers. Please refer to your member id card for the name of your network.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	First 3 visits no charge, deductible does not apply. Subsequent visit, deductible then 10% coinsurance	Deductible then 20% coinsurance	First 3 visits/benefit year combined for primary care, mental health, behavioral health, and substance abuse visits.
	Specialist visit	Deductible then 10% coinsurance		None
	Preventive care/screening/ immunization	No charge, deductible does not apply	20% coinsurance, deductible does not apply	Preventive Physicals: 13 visits ages 0-36 months, annually ages 3 and older. Well Woman Visits: annually. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible then 10% coinsurance	Deductible then 20% coinsurance	None
	Imaging (CT/PET scans, MRIs)			Prior authorization required. If not received, you will be responsible for the expense.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **PacificSource.com/drug-list/PDL/.**	Generic drugs - Tier 1	Retail and Mail: Deductible then 10% coinsurance	Deductible then 50%	Prescription benefit includes certain outpatient drugs as a preventive benefit at no charge, deductible does not apply. In-network formulary prescription insulin is not subject to a deductible and may not exceed $85 per 30 day supply. Retail and mail are limited to a 90 day supply. Prior authorization is required for certain drugs. If not received, you will be responsible for the expense.
	Preferred drugs - Tier 2			
	Non-preferred drugs - Tier 3	Retail and Mail: Deductible then 25% coinsurance		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
	Specialty drugs – Tier 4	Same as retail		In-network specialty drugs are limited to 30 day supply. Out-of-network specialty drugs are limited to a 30-day supply, up to 3 fills per benefit year. Prior authorization required for certain drugs. If not received, you will be responsible for the expense.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then 10% coinsurance	Deductible then 20% coinsurance	Prior authorization required for some surgeries. If not received, you will be responsible for the expense.
	Physician/surgeon fees			None
If you need immediate medical attention	Emergency room care	Medical Emergency: Deductible then 10% coinsurance Non-Emergency: Deductible then 10% coinsurance	Medical Emergency Deductible then 10% coinsurance Non-Emergency: Deductible then 20% coinsurance	None
	Emergency medical transportation	Ground/Air: Deductible then 10% coinsurance		Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate.
	Urgent care	Deductible then 10% coinsurance	Deductible then 20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 10% coinsurance	Deductible then 20% coinsurance	Limited to semi-private room, except when a private room is determined to be necessary. Prior authorization required for some inpatient services. If not received, you will be responsible for the expense.
	Physician/surgeon fees			None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	First 3 visits no charge, deductible does not apply. Subsequent visit, deductible then 10% coinsurance	Deductible then 20% coinsurance	First 3 visits/benefit year combined for primary care, mental health, behavioral health, and substance abuse visits.
	Inpatient services	Deductible then 10% coinsurance		Prior authorization required for some inpatient services. If not received, you will be responsible for the expense.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you are pregnant	Office visits	Deductible then 10% coinsurance	Deductible then 20% coinsurance	Cost sharing does not apply to certain preventive services. Delivery and hospital visits are covered under prenatal and postnatal care. Facility is covered the same as any other hospital services.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	Deductible then 10% coinsurance	Deductible then 20% coinsurance	No coverage for private duty nursing or custodial care.
	Rehabilitation services			Inpatient: Limited to 60 days/benefit year. Outpatient: Limited to 60 visits/benefit year. No coverage for recreation therapy.
	Habilitation services			Inpatient: Limited to 60 days/benefit year. Outpatient: Limited to 60 visits /benefit year. No coverage for recreation therapy.
	Skilled nursing care			Limited to 60 days/benefit year. No coverage for custodial care.
	Durable medical equipment			Limited to: one pair/benefit year for glasses or contact lenses; one breast pump/pregnancy; $150/benefit year for wig for chemotherapy or radiation therapy. Prior authorization is required if equipment is over $2,500 and for power-assisted wheelchairs. If not received, you will be responsible for the expense.
	Hospice services			No coverage for private duty nursing. Respite care limited to 5 consecutive days and 30 days/lifetime.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge, deductible does not apply	No charge up to $40 maximum, then 100% coinsurance, deductible does not apply	For age 18 or younger, one preventive eye exam/benefit year.
	Children's glasses	No charge, deductible does not apply	No charge up to $75 maximum, then 100% coinsurance, deductible does not apply	For age 18 or younger, one pair of glasses (frames and lenses) or contacts (lenses and fitting) in lieu of glasses per benefit year. Additional coatings not covered.
	Children's dental check-up	Not covered		

Excluded Services & Other Covered Services:

Services Your plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery (except in certain situations)
- Custodial care
- Dental care (Adult)
- Dental check-up (Child)
- Hearing aids (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care, other than with diabetes mellitus

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Acupuncture
- Chiropractic care
- Hearing aids (Child)
- Routine eye care (Adult)
- Weight loss programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: The PacificSource Customer Service team at 1-888-246-1370 or the Division of Financial Regulation at 1-888-877-4894 or at dfr.oregon.gov.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-281-1464.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-281-1464.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-281-1464.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,060**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Summary provided by the Broker of Record for
City of Springfield:

USI Insurance Services
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