WHA INSURANCE

Western Lane Fire & EMS Authority
Benefits Resource Guide





PLAN YEAR | **2024 / 2025**

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YOUR SERVICE TEAM

BENEFITS

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

PRIMARY CONTACTS

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Wilsonville Office – 29100 SW Town Center Loop, Suite 160, Wilsonville, OR 97070

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Contact Information

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

Eligibility Information

Who is Eligible and When:

All full-time employees are eligible for benefits the first of the month following date of hire. Eligibility also includes a weekly minimum of 30 hours worked.

Employer Pays:

Western Lane Fire & EMS Authority pays 95% of the employee and dependent premiums for Medical, Dental, Group Life and AD&D, Short Term Disability and Long Term Disability. Employees are responsible for 5% of the premium funded through pre-tax payroll deduction. In addition, WLFEA contributes $1,500 for employee-only and $3,000 for all other employees in the health insurance plan every July into their Health Reimbursement Arrangement. For new hires, the individual's employer contribution is pro-rated based on their specific date of hire.

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MEDICAL

Regence

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Oregon Fire Chiefs Association

Medical Plan 1V

Effective July 1, 2024 through June 30, 2025

Cost Share Details		In-Network	Out-of-Network
Annual Deductible	The total deductible you pay per calendar year	$500 Individual $1,500 Family	$500 Individual $1,500 Family
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance and copays per calendar year	$2,500 Individual $5,000 Family	$4,000 Individual $8,000 Family

Be aware that your actual costs for Covered Services provided by an Out-of-Network provider may exceed the Out-of-Pocket Maximum amount. In addition, Out-of-Network providers can bill you for the difference between the amount charged and our allowed amount and that amount does not count toward any Out-of-Pocket Maximum.

Medical Benefits (unless stated otherwise, a deductible applies)		What You Pay	
Primary Care Visits (for Illness or Injury)	First 3 upfront visits combined for primary care and behavioral health services.	$5 copay, deductible waived/ first 3 visits $20 copay per visit, after 3 upfront visits, deductible waived	40%
Specialist Visits		$20, deductible waived	40%
Urgent Care Visits		$20, deductible waived	40%
Other Professional Services		20%	40%
Preventive Care/Immunizations	• Preventive services and immunizations are covered according to guidelines set forth by the United States Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA)	0%, deductible waived	40%
Acupuncture	• 30 visits per calendar year	$20, deductible waived	$20, deductible waived
Ambulance Services	• 6 trips per calendar year	20%	20%
Biofeedback	• 10 visits per lifetime	$20, deductible waived	40%
Durable Medical Equipment & Prosthetics		20%	40%
Emergency Room (Including Professional Charges)		$100 copay per visit, deductible waived	$100 copay per visit, deductible waived
Hearing Aids & Evaluations	• 1 hearing aid per ear, every calendar year	20%	40%
Hospice Care	• 30 days of respite care per lifetime	20%	40%
Hospital Care		20%	40%
Massage Therapy	• 12 visits per calendar year • Licensed Massage Therapists only	$20, deductible waived	40%
Maternity Care		20%	40%
Behavioral Health – Inpatient	• Mental health, behavioral health, or substance abuse services.	20%	40%
Behavioral Health - Outpatient	First 3 upfront visits combined for primary care and behavioral health services. • Mental health, behavioral health, or substance abuse services.	$5 copay, deductible waived/ first 3 visits $20 copay per visit, after 3 upfront visits, deductible waived	40%
Neurodevelopmental Therapy	• 30 visits per calendar year • Children under the age of 18	$20, deductible waived	40%

Newborn Home Visits	• Within 6 months of age, at least one visit during first 3 months, with up to 3 more available	0%, deductible waived	Not covered
Nutritional Counseling	• 5 visits per lifetime	20%	40%
Palliative Care	• 30 visits per calendar year	20%	40%
Radiology and Laboratory - Outpatient		20%, deductible waived	40%
Advanced Imaging	• CT, PET, MRA, SPECT, Bone Density, MRI	20%	40%
Rehabilitation Services - Inpatient	• 30 days per calendar year	20%	40%
Rehabilitation Services - Outpatient	• 30 visits per calendar year	$20, deductible waived	40%
Skilled Nursing Facility (SNF) Care	• 60 days per calendar year	20%	40%
Spinal Manipulations		$20, deductible waived	$20, deductible waived
Virtual Care - Telehealth		**Vendor: MDLive** $0 copay per session, deductible waived **In-Network non-Vendor Provider:** $0 copay per visit, deductible waived	N/A 40%
Therapeutic Injections		20%	40%

VSP Vision Benefits		**What You Pay**	
Routine Eye Exam	• 1 per calendar year	$20 copay, deductible waived	No charge up to $45
Contact Lens Fitting	• Limit: 1 per calendar year	No charge	Applies to the hardware limit
Hardware		No charge up to $300 maximum per year	No charge up to $40

This benefit summary provides a brief description of your plan benefits, limitations and/or exclusions under your plan and is not a guarantee of payment. Once enrolled, you can view your benefits booklet online at regence.com. **PLEASE REFER TO YOUR BENEFITS BOOKLET OR SUMMARY PLAN DESCRIPTION FOR A COMPLETE LIST OF BENEFITS, THE LIMITATIONS AND/OR EXCLUSIONS THAT APPLY, AND A DEFINITION OF MEDICAL NECESSITY**. Regence is providing this benefit summary for illustrative purposes only. Regence makes no warranties or representations regarding compliance with applicable federal, state, or local laws, or the accuracy of the benefit summary. This document is not the legally required Summary of Benefits and Coverage that an employer is required to provide to employees and members under Federal law, and the group must provide a legally compliant Summary of Benefits and Coverage to its employees and members.

1 (866) 240-9580 - TTY: 711 | 100 SW Market Street, Portland, OR 97201 | regence.com

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Oregon Fire Chiefs Association

Pharmacy Plans

Effective July 1, 2024 through June 30, 2025

Option 1

Prescription Medication Benefits		What You Pay
Annual Deductible	The total deductible you pay per calendar year	$0
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance and copays per calendar year	Shared with medical
Tier 1	90-day supply for retail or mail order	$2 retail prescription* / $3 mail order prescription / $10 for each self-administrable Cancer Chemotherapy medication
Tier 2	90-day supply for retail or mail order	$10 retail prescription* / $15 mail order prescription / $10 for each self-administrable Cancer Chemotherapy medication
Tier 3	90-day supply for retail or mail order	$20 retail prescription* / $30 mail order prescription / $50 for each self-administrable Cancer Chemotherapy medication
Tier 4	90-day supply for retail or mail order	$50 retail prescription* / $75 mail order prescription / $50 for each self-administrable Cancer Chemotherapy medication
Tier 5	30-day supply for retail	$50 participating pharmacy retail prescription / $100 for each self-administrable Cancer Chemotherapy medication
Tier 6	30-day supply for retail	$50 participating pharmacy retail prescription / $100 for each self-administrable Cancer Chemotherapy medication
Compound Medications	30-day supply for retail	50% coinsurance

**1 copay per 30 day supply*
$85 cap on member cost share per 30 day retail supply insulin, deductible waived
$255 cap on member cost share for up to 90 day supply of mail order insulin, deductible waived
More information about prescription drug coverage is available at https://regence.com/go/2024/OR/6tierLG

Find doctors and understand your costs

Get the most out of your coverage with the Find a Doctor and Cost Estimator tools

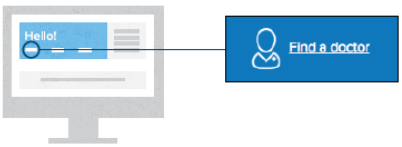
Find providers and get cost estimates at regence.com and on our mobile app.

How to search for an in-network provider

Knowing your network can save you money, and we want you to get the most value out of your coverage. That's why we've made it easy to search for in-network doctors, specialists, clinics and pharmacies with our **Find a Doctor** tool. Here's how to use it:

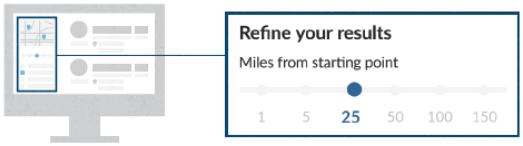
Step 1: Sign in to regence.com.

Step 2: Click **Find a Doctor**, then select the type of care you're looking for.

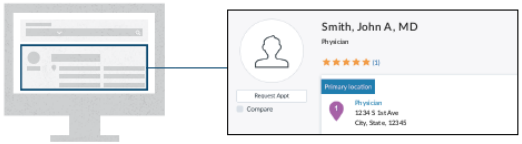


Step 3: Choose a search category (such as *Doctors by name*, *Doctors by specialty*, *Places by name*, etc.). Type in your search term, then hit *Enter* or click the magnifying glass.

Step 4: Choose a filter to narrow the results, including distance, gender, languages spoken and more.



Step 5: Select a provider or location name to review comments from other patients and see more details about the provider.



How to get a cost estimate

Where you receive care and who you see can have a big impact on your bill. So, take advantage of our handy **Cost Estimator** tool for common medical procedures and care, such as: office visits, imaging services, surgeries, immunizations, physical therapy and more. The Cost Estimator is only available to Regence members, so make sure you're signed in. Here's how to use it:

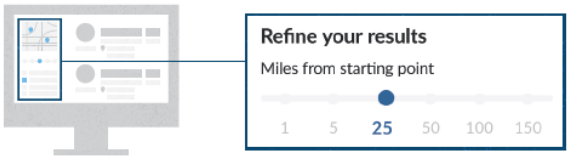
Step 1: Sign in to regence.com.

Step 2: Click **Find a Doctor** or **Cost Estimator**, then select the type of care you're looking for.

Step 3: Choose *Estimate your costs* from the options shown and then type in the service you want an estimate for.

Step 4: Hit *Enter* or select the magnifying glass to see your results.

Step 5: Choose a filter to narrow the results, including distance, gender, languages spoken and more.



Step 6: Select the blue cost to see a price breakdown.

To see regional cost averages and treatment timelines, start at Step 3 and select *Treatment Timelines*.

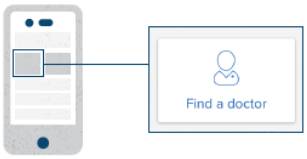
Cost estimates are calculated with your benefits in mind, including your deductible and out-of-pocket maximums, so you see only what you would be estimated to pay.

Find doctors and costs on the Regence mobile app

Tap into your health—anywhere, anytime—with the Regence app for iPhone and Android. With features like **Find a Doctor** and **Cost Estimator**, you can easily manage your benefits and make quick health care decisions on the go.

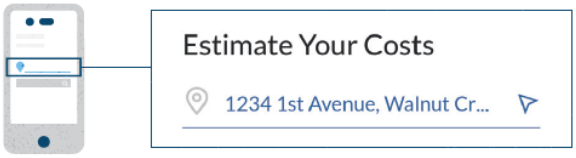
Step 1: Sign into the Regence mobile app. Your username and password are stored after the first use, so you can use biometric sign-in (such as face recognition or thumbprint ID) for faster access.

Step 2: Tap the **Find a Doctor** icon on the Member Dashboard, then select the type of care you're looking for.

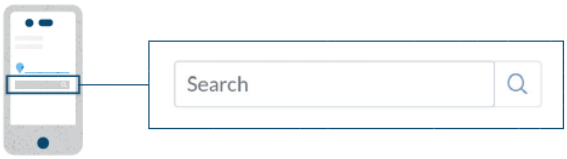


Step 3: Choose your search category, including *Estimate your costs* if you're looking for cost results.

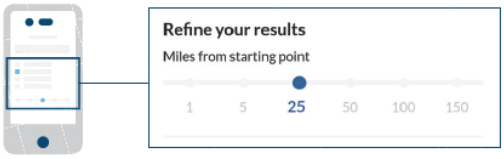
Step 4: Make sure the right search location is selected (home, work or somewhere else).



Step 5: Type in your search term and click the blue magnifying glass to view your results.



Step 6: Filter your results and review provider/ location information.



Preventive care

In-network services covered at 100%

Most Regence members have 100% coverage for preventive services—care that detects an issue before it becomes a problem. You'll pay nothing for the care listed here when you see an in-network provider. We follow recommendations from three government agencies to determine which services we cover.[1]

You may have to pay for covered preventive care if:

- You see an out-of-network provider
- Your doctor provides preventive care outside the guidelines
- Your provider doesn't obtain any required pre-authorization (for example, physical therapy for fall prevention, genetic testing for BRCA 1 and 2 and lung cancer screening)

Also, diagnostic services are different from preventive. Diagnostic care looks at a problem you're already having. So ask your doctor if services are preventive or diagnostic. It's important to know because you may have to pay out of pocket for diagnostic care.

Check the list below to see which preventive services most of our plans cover. Some plans may have limitations or not cover all of these services. Check your plan benefits or call Customer Service at the number on the back of your member ID card if you have questions.

1. These scientifically supported guidelines are created by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), and Health Resources and Services Administration (HRSA).

Members of all ages

The following services are provided as appropriate to need and age.*

Lab tests

- Cholesterol screening (if high risk)
- BRCA 1 and 2 testing and counseling (if high risk and meet criteria)
- Hepatitis B screening (if increased risk)
- Hepatitis C screening (if high risk or age 18-79)
- HIV screening (15–65 or high risk)
- Sexually transmitted disease counseling during wellness exams
- Screening for gonorrhea, syphilis and chlamydia
- Tuberculosis screening
- Type 2 diabetes screening and counseling (40–70 if overweight or obese)

Procedures

- Abdominal aortic aneurysm screening (men only, 65+ and have ever smoked)
- Cervical cancer screening (Pap) (21+)
- Colon cancer screening (45+)
- Lung cancer screening (55–80 with history of smoking)
- Osteoporosis screening (women 65+ or at risk)
- Physical therapy to prevent falls (in community-dwelling adults 65+ and at high risk)
- Screening mammogram (40+ or at high risk)
- Sterilization (tubal ligation)

Examinations/counseling

- Annual wellness (physical) exam (18+)
- Blood pressure monitoring (18+)
- Breast cancer prevention counseling (if high risk)
- Depression screening during wellness exams
- Diabetes counseling (40–70 if overweight or obese)
- Diet behavior counseling (for those with hyperlipidemia)
- Heart disease prevention counseling (18+ and overweight or obese)
- HIV counseling (15–65 or at high risk)
- HPV screening every three years (30+)
- Interpersonal and domestic violence screening and counseling during wellness exams
- Obesity screening and counseling (6+)
- Sexually transmitted disease counseling during wellness exams
- Tobacco-use counseling (not programs or classes)
- Unhealthy alcohol and/or drug use screening and behavioral counseling (18+)

Immunizations

- Chicken pox (varicella)
- Diphtheria, pertussis (whooping cough), tetanus (DPT)
- Hemophilus influenzae type b (Hib)
- Hepatitis A and B
- Herpes zoster (shingles) (50+)
- HPV (up to 45)
- Influenza (flu)
- Measles, mumps, rubella (MMR)
- Meningitis
- Pneumonia

* When an age range is listed, such as 15-18, your coverage includes the first age through the second.

Pregnant members

During pregnancy, members may receive preventive services described under "Members of all ages," plus the following:

Lab tests

- Anemia screening
- Gestational diabetes screening
- Hepatitis B screening
- HIV screening and counseling
- Rh(D) incompatibility screening
- UTI screening

Breastfeeding / chestfeeding supplies and support

- Breast pump / lactation pump (non–hospital-grade)
- Lactation support and counseling

Children

Children may receive age-appropriate* preventive services described under "Members of all ages," plus the following:

Newborns (up to 62 days of age)

- Congenital hypothyroidism screening
- Gonorrhea medication for the eyes
- Jaundice (bilirubin) screening
- Metabolic screening
- PKU screening
- Sickle cell anemia screening

Youths (up to 21)

- Anemia screening
- Dyslipidemia (high cholesterol and fat in blood)
- Lead poisoning screening

Examinations/counseling

- Dental caries (up to age 6, starting when first tooth appears)
- Eye exam (3–5)
- Fluoride varnish (up to age 6 when applied by primary care clinician)
- Newborn hearing screening (up to 62 days)
- Skin cancer counseling (6 months–24 years for those with fair skin type)
- Well-child exams (up to age 18)

Immunizations

Children may receive age-appropriate immunizations described under "Members of all ages," plus the following:

- Polio
- Rotavirus

* When an age range is listed, such as 15-18, your coverage includes the first age through the second.

Contraception for women

- Birth control education and training

Our prescription drug benefit covers all forms of FDA-approved birth control. For a complete list, visit https://regence.myprime.com/v/RBO/COMMERCIAL/en/forms.html. Religious exemption: Birth control coverage may not be available if the group you have coverage through has a religious exemption.

Prescription drugs

Your preventive care benefits cover many over-the-counter and prescription drugs. To learn more, visit https://regence.myprime.com/v/RBO/COMMERCIAL/en/forms.html and go to the ACA Preventive Medications, Covered Contraceptive Products and Tobacco Cessation coverage lists.

Oregon reproductive health care services

The following services are also covered at 100% under the reproductive health care services benefit:

- Abortion**
- Breast cancer chemoprevention counseling for all ages at high risk
- Breast cancer screening for age 40+ or all ages if at high risk
- Contraceptives for a medical diagnosis**
- Osteoporosis screening for age 65+ or all ages if at risk
- Patient education and counseling on contraception and sterilization
- Screening to determine whether counseling related to the BRCA1 or BRCA2 genetic mutations is indicated, and counseling related to the BRCA1 or BRCA2 genetic mutations if indicated; risk assessment; also BRCA counseling and testing (requires pre-authorization and must meet guidelines for medical necessity) for all ages if you have a family risk of breast, ovarian, tubal and peritoneal cancer
- Screening for chlamydia
- Screening for gonorrhea
- Screening for pregnancy**
- Voluntary vasectomy**

Administration of contraceptive coverage is mandated with no pre-authorization, step therapy or other utilization techniques.

**High-deductible health plans (HDHP) and health savings account (HSA) plans: Due to Internal Revenue Service (IRS) guidelines, the deductible must be met prior to the benefit paying at 100%.

To learn more, go to **regence.com.** For your plan benefits, see your benefit booklet or call us at the number on the back of your member ID card.

Primary care telehealth

MDLIVE® puts health care at your fingertips

Visit a doctor over the phone, video or app

We all have times when we need to see a doctor, but it's inconvenient—there's no time, the office is closed, or we're on the road. You know that feeling: "I wish I could just talk to someone over the phone and get what I need fast!" **Now you can.**

Your health plan includes a telehealth benefit, powered by MDLIVE, a national leader in telehealth. You can talk to any of MDLIVE's board-certified doctors any time by phone, video or through the app–**24 hours a day, 7 days a week, 365 days a year.***

Care you can count on

You can consult board-certified doctors who will diagnose and treat non-emergency medical conditions, prescribe medications and send prescriptions to your pharmacy.

Regence

Idaho regulations require telehealth services be video-enabled.
By law, additional restrictions in other states may apply.

On average, MDLIVE doctors have 15 years of experience practicing medicine and are licensed in the state where patients are located. Their specialties include primary care, pediatrics, emergency medicine and family medicine.

Common ailments treated via telehealth include:

All ages		Kids
Allergies	Pink eye	Cold & flu
Cold & flu	Rashes	Constipation
Ear infections	Sinus infection	Ear infections
Headache	Sore throat	Nausea
Infections	Sunburn	Pink eye

What you need to know

MDLIVE is easy to use. Here are some basic things to know:

- MDLIVE can be a great option when your child isn't feeling good outside business hours; dependents will need a parent present during the visit.
- The average wait to connect with a physician is less than 15 minutes.
- You can use MDLIVE as often as you need to.
- We process each visit as a claim, and your costs count toward your deductible.
- This is more than a nurse advice line. With MDLIVE, a doctor can diagnose, treat and prescribe medications.
- You will work with an MDLIVE doctor, not your regular doctor.
- With your permission, the MDLIVE doctor will share your treatment information with your regular doctor.

Go to MDLIVE.com/regence-or and register today. You'll want to create your online account in advance so when you need care, you will already be set.

Behavioral health is important too!

Your MDLIVE benefit includes a behavioral health program. It gives you access to mental health specialists for a wide variety of concerns—from grief counseling, family stress and marital problems, to other issues that impact your quality of life, as well as management of some psychiatric medications.

What you need to know

- Behavioral health visits are offered as video visits.
- Per-visit rates for behavioral health vary depending on your needs and the type of provider you access.
- Behavioral health visits are scheduled in advance, and are not offered "on-demand" like primary care, but you can usually schedule a counseling visit within a few days.

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MDLIVE is a separate and independent company that does not provide Blue Cross Blue Shield products or services, and is solely responsible for its products or services.

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100 SW Market Street | Portland, OR 97201

REG-129998-18/08-OR-BEHrep20333

Get the most from your pharmacy benefit

Have a prescription to fill? Wondering if you should switch to a generic or use our home delivery service? Here are some quick tips and programs you need to know about.

How to fill your prescription

Whether you have a new prescription or need to refill an existing one, our network of more than 65,000 participating pharmacies has you covered—across the country and around your corner.

Show your member ID card to your pharmacist so they can file your claim with us online and tell you how much you owe.

Programs to stretch your pharmacy dollar

Our programs are designed to put valuable medication and health support into your hands, while also saving you money.

Covered-drug list

When it comes to choosing medications, it's important to know how the list of covered drugs—or formulary—works.

The covered-drug list divides medications into multiple tiers, each with its own cost share. Before we add a medication to the list, our team of doctors and pharmacists carefully evaluate how safe and effective it is while assessing whether it will improve health.

To see if your medication is covered and how much it will cost, visit **regence.com/pharmacy**, sign in or select your type of coverage, and click on **Find a Drug**.

Generics

Generic and brand-name medications have the same strength, quality and purity. But, generics can cost up to 80% less. So, ask your doctor if there is a generic drug that will work for you.

Home delivery

You can get some medications—like the ones you take for a chronic condition—mailed to you at the location of your choice. That means fewer trips to the pharmacy, and it can even save you a copay or lower your out-of-pocket costs if you have coinsurance.

90-day fills

You can pick up 90-day supplies of most long-term medications at one of our Extended Supply Network (ESN) retail pharmacies or have our Home Delivery Program ship it to the location of your choice. Visit **regence.com/pharmacy**, select your type of coverage or simply sign in, and click on **Find a Pharmacy** to locate an ESN retail pharmacy or register for home delivery.

Clinical programs

Our pharmacists work behind the scenes to help you get the medications you need when you need them. We also look out for safety concerns, such as potential drug interactions or duplicate prescriptions, that could affect you.

Specialty Pharmacy

We know that living with a complex health condition can be stressful and sometimes confusing. Our specialty pharmacy services are here to support you with the care and medications you need, every step of the way. In some cases, your plan may require that you use our Specialty Pharmacy.

To assist you with the complexities of your condition and its treatment, our Specialty Pharmacy services will help you coordinate refills, monitor side effects, and give you 24-hour access to clinical specialists. You'll even get injectable supplies for free—and everything can be delivered to your home or location of your choice.

Blood Glucose Meter Program

If you have diabetes, you're eligible to receive a new LifeScan OneTouch® glucose meter at no cost. Order your meter directly from LifeScan by calling 1 (855) 306-2278.

Understanding pre-authorization

To ensure you're getting an effective drug at an affordable price, we review prescriptions for some medications before we cover them. Drugs on the pre-authorization list include many for which equal or more effective and lower-cost options exist.

If your drug needs pre-authorization, you'll want to do one of two things:

1. Talk with your doctor to see if there's an alternative treatment that does not require pre-authorization.

OR

2. Have your doctor or pharmacist request pre-authorization for your medication. You may need to get that authorization before you can get your prescription filled.

Stay connected

Visit **regence.com** to find drug coverage, pricing, network pharmacies and more.

Questions? Call the Customer Service number on your member ID card.

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100 SW Market Street | Portland, OR 97201

REG-378412-20/08-ORRxServrep378412-19

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711).

DENTAL

2024 Delta Dental Premier Plan Benefit Summary

Delta Dental of Oregon & Alaska

Oregon Fire Chiefs Association

Option 2 with Ortho

Calendar year costs	
Calendar year maximum, per member (age +19)	$1,500
Calendar year deductible, per member	$25
Calendar year maximum deductible, per family	$75
Calendar year out-of-pocket maximum, one member (under age 19)	$400
Calendar year out-of-pocket maximum, two or more members (under age 19)	$800
Class 1* (Services do not apply to the calendar year max)	
Periodic examinations / X-rays	100%
Prophylaxis (cleanings) / periodontal maintenance	100%
Sealants	100%
Space maintainers	100%
Topical application of fluoride	100%
Class 2**	
Restorative fillings	80%
Oral surgery (extractions & certain minor surgical procedures)	80%
Endodontics (treatment of teeth with diseased or damaged nerves)	80%
Periodontics (treatment of diseases of the gums and supporting structures of the teeth)	80%
Class 3**	
Implants	50%
Crowns and other cast restorations	50%
Dentures and bridges (construction or repair of fixed bridges, partial, and complete dentures)	50%

* Deductible waived for preventive services.

** Class 2 and 3 services apply to the calendar year maximum.

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 them 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 once in any 6-month period. Supplementary bitewing x-rays are covered once in any 12-month period. Complete series x-rays or a panoramic film are covered once in any 5-year period.
- **Preventive** Prophylaxis (cleaning) or periodontal maintenance is covered once in any six-month period. Additional periodontal maintenance is covered for members with periodontal disease, up to a total of 2 additional periodontal maintenances per year. Topical application of fluoride is covered once in any 6-month period for members until age 19. For members age 19 and older, topical application of fluoride is covered once in any 6-month period if there is a recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant, per tooth, during any 5-year period.

Basic (Class 2 services)

- **Oral Surgery** Limited to extractions and other minor surgical procedures.
- **Restorative** Amalgam and composite fillings are covered for all teeth. A separate charge for general anesthesia and/or IV sedation is not covered when used for non-surgical procedures.
- **Periodontic** Scaling and root planing is limited to once per quadrant in any 2-year period.

Major (Class 3 services)

- **Implants** and implant removal are limited to once per lifetime per tooth space. A crown over an implant is covered once per lifetime of the implant.
- **Restorative** Cast restorations (including pontics) are covered once in a seven (7) year period on any tooth.
- **Prosthodontic** A bridge or denture (full or partial, including alternate benefits) will be covered once in a seven (7) year period only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the past seven (7) years. Specialized or personalized prosthetics are limited to the cost of standard devices.
- **Occlusal Guard** (night guard) covered at 100% once in a five year period, up to $200 maximum. Over-the-counter night guards are excluded.
- **Athletic mouthguard** 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 mouthguards are excluded.

Exclusions

- Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
- Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis and disturbance of the temporomandibular joint.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth except for occlusal guards.
- Services started prior to the date the individual became eligible for services under the program.
- Hypnosis, prescribed drugs, premedications or analgesia (e.g. nitrous oxide) or any other euphoric drugs.
- Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
- General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in 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.

Delta Dental orthodontia rider

Delta Dental of Oregon & Alaska

Oregon Fire Chiefs Association

Adult & Child Ortho 1500	
Lifetime maximum	$1,500
	What members pay
Members age 19+	50%
Members under age 19	50%

How to use this dental plan

When you visit your dental provider, tell them you are a Delta Dental member.

Pre-determination

Your dental office can submit a pre-treatment plan to Delta Dental of Oregon on your behalf. We will return it to them indicating the dollar allowance which will be covered by your plan before you go forward with treatment.

Group Life

Standard Insurance Company
Special Districts Insurance Services
Group Policy #136382 (Option 3D)
Effective Date July 1, 2016

Group Basic Life and Accidental Death and Dismemberment Insurance

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

The cost of this insurance is paid by your employer.

Eligibility

Group Basic Life and Accidental Death and Dismemberment Insurance	This benefit is available to eligible employees. Contact your human resources representative or review your benefit certificate for specific eligibility requirements.

Benefits

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

Other Basic Life Features and Services

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

Other Basic AD&D Features

- Expanded AD&D Package
- Family Benefits Package
- Seat Belt and Air Bag Benefits

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

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 13279-D-OR-136382-OP3D (5/22)
7079908-858921

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Group Disability Policies

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Standard Insurance Company
Special Districts Insurance Services
Group Policy #136382 (Option 5)
Effective Date July 1, 2016

Group Short Term Disability Insurance

Group Short Term Disability insurance from Standard Insurance Company helps provide financial protection for insured members by promising to pay a weekly benefit in the event of a covered disability.

The cost of this insurance is paid by your employer.

Eligibility

Group Short Term Disability Insurance	This benefit is available to eligible employees. Contact your human resources representative or review your benefit certificate for specific eligibility requirements.

Benefits

Weekly Benefit	60 percent of the first $1,500 of weekly predisability earnings as of the date of disability, reduced by deductible income (e.g., work earnings, workers' compensation, state disability, etc.)
Maximum Weekly Benefit	$900
Minimum Weekly Benefit	$15
Benefit Waiting Period	Your weekly benefit becomes payable the first day you are disabled for disability caused by accidental injury and after 7 days for disability caused by physical disease, pregnancy or mental disorder.
Definition of Disability	For the benefit waiting period and while the Short Term Disability benefits are payable, you are considered disabled if you: • Are unable – as a result of physical disease, injury, pregnancy or mental disorder – to perform with reasonable continuity the material duties of your own occupation, and • Suffer a loss of at least 20 percent of your predisability earnings when working in your own occupation You are not considered disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license. You will no longer be considered disabled when your earnings from any occupation meet or exceed 80 percent of your predisability earnings.
Maximum Benefit Period	90 days

Other Features and Services

- Reasonable Accommodation Expense Benefit
- Temporary Recovery Provision

This information is only a brief description of the group Short Term Disability insurance policy sponsored by Special Districts Insurance Services. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, reduction in benefits, exclusions and when The Standard and Special Districts Insurance Services may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For more complete details of coverage, contact your human resources representative.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 13275-D-OR-136382-OP5 (5/22)
7079908-858931

Standard Insurance Company
Special Districts Insurance Services
Group Policy #136382 (Option 1)
Effective Date July 1, 2016

Group Long Term Disability Insurance

Group Long Term Disability insurance from Standard Insurance Company helps provide financial protection for insured members by promising to pay a monthly benefit in the event of a covered disability.

The cost of this insurance is paid by your employer.

Eligibility

Group Long Term Disability Insurance	This benefit is available to eligible employees. Contact your human resources representative or review your benefit certificate for specific eligibility requirements.

Benefits

Monthly Benefit	60 percent of the first $8,333 of monthly predisability earnings, reduced by deductible income (e.g., work earnings, workers' compensation, state disability, etc.)
Maximum Monthly Benefit	$5,000
Minimum Monthly Benefit	$100
Benefit Waiting Period	90 days
Definition of Disability	For the benefit waiting period and the first 24 months that Long Term Disability benefits are payable, you will be considered disabled if, as a result of physical disease, injury, pregnancy or mental disorder: • You are unable to perform with reasonable continuity the material duties of your own occupation, and • You suffer a loss of at least 20 percent of your predisability earnings when working in your own occupation. You are not considered disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license. After the own occupation period of disability, you will be considered disabled if, as a result of a physical disease, injury, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of any occupation.

Maximum Benefit Period

If you become disabled before age 62, Long Term Disability benefits may continue during disability until age 65 or to the Social Security Normal Retirement Age (SSNRA) or 3 years 6 months, whichever is longest. If you become disabled at age 62 or older, the benefit duration is determined by the age when disability begins:

Age	Maximum Benefit Period
62	To SSNRA, or 3 years 6 months, whichever is longer
63	To SSNRA, or 3 years, whichever is longer
64	To SSNRA, or 2 years 6 months, whichever is longer
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69+	1 year

Other Features and Services

- 24 hour coverage, including coverage for work-related disabilities
- Employee Assistance Program
- Reasonable Accommodation Expense Benefit
- Rehabilitation Plan Provision
- Return to Work Incentive
- Survivors Benefit
- Temporary Recovery Provision
- Waiver of Premium while Long Term Disability benefits are payable

This information is only a brief description of the group Long Term Disability insurance policy sponsored by Special Districts Insurance Services. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, reduction in benefits, exclusions and when The Standard and Special Districts Insurance Services may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For more complete details of coverage, contact your human resources representative.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 13271-D-OR-136382-OP1 (5/22)
7079908-858933

A&H Provident Policy

POLICY SCHEDULE OF BENEFITS
SUMMARY OF COVERAGE

This Policy provides coverage for the following benefits that indicate that they are "Included" or that provide a specified amount opposite the name of the benefit. Benefits indicated as "Not Included" are not provided under this Policy.

SECTION I: DEATH BENEFITS

	Class I	Class II
I.A. COVERED INJURY DEATH BENEFIT		
Principal Sum	$25,000	$25,000
I.B. COVERED ILLNESS DEATH BENEFIT		
Principal Sum	$25,000	$25,000
I.C. HIV POSITIVE DIAGNOSIS LUMP SUM BENEFIT		
Benefit Amount	$25,000	$25,000
I.D. BEREAVEMENT BENEFIT		
Maximum Benefit Amount	$2,500	$2,500
I.E. DEPENDENT CHILD BENEFIT		
Benefit Amount (for each Dependent Child)	$10,000	$10,000
I.F. SEATBELT AND AIRBAG BENEFIT		
Seatbelt Benefit Amount	$6,250	$6,250
Airbag Benefit Amount	$6,250	$6,250
I.G. FINAL EXPENSES BENEFIT		
Maximum Benefit Amount	$2,500	$2,500
I.H. SPOUSAL BENEFIT		
Benefit Amount	$15,000	$15,000

SECTION II: IMPAIRMENT BENEFITS

	Class I	Class II
II.A. DISMEMBERMENT, LOSS OF SPEECH OR HEARING BENEFIT		
Impairment Principal Sum	$25,000	$25,000
II.B. VISION IMPAIRMENT BENEFIT		
Vision Impairment Principal Sum	$25,000	$25,000
II.C. COSMETIC DISFIGUREMENT FROM BURNS BENEFIT		
Cosmetic Disfigurement from Burns Principal Sum	$25,000	$25,000
II.D. PERMANENT PHYSICAL IMPAIRMENT BENEFIT		
Permanent Physical Impairment Principal Sum	$25,000	$25,000
II.E. FELONIOUS ASSAULT BENEFIT		
Benefit Amount	50% of the total amount payable under the following benefits: Covered Injury Death Benefit, Dismemberment, Loss of Speech or Hearing Benefit, Vision Impairment Benefit, Cosmetic Disfigurement from Burns Benefit, Permanent Physical Impairment Benefit, Paralysis Benefit, or Weekly Total or Partial Disability Benefits, subject to an overall maximum benefit of $12,500	50% of the total amount payable under the following benefits: Covered Injury Death Benefit, Dismemberment, Loss of Speech or Hearing Benefit, Vision Impairment Benefit, Cosmetic Disfigurement from Burns Benefit, Permanent Physical Impairment Benefit, Paralysis Benefit, or Weekly Total or Partial Disability Benefits, subject to an overall maximum benefit of $12,500
II.F. IMPAIRMENT MODIFICATION BENEFIT		
Maximum Benefit Amount	actual expenses up to $50,000	actual expenses up to $50,000
II.G. PARALYSIS BENEFIT		
Paralysis Benefit Principal Sum	$25,000	$25,000
Paralysis must occur within	365 days of the Covered Injury or onset of Covered Illness	365 days of the Covered Injury or onset of Covered Illness

SECTION III: INCOME PROTECTION BENEFITS

	Class I	Class II
III.A. WEEKLY TOTAL DISABILITY BENEFITS		
III.A.i. COVERED INJURY MINIMUM WEEKLY TOTAL DISABILITY BENEFIT		
Minimum Weekly Benefit Amount	$100	$100
Maximum Benefit Period	Lifetime	2 Years
III.A.ii. COVERED ILLNESS MINIMUM WEEKLY TOTAL DISABILITY BENEFIT		
Minimum Weekly Benefit Amount	$100	$100
Maximum Benefit Period	Later of Age 67 or Five Years	2 Years
III.A.iii. COVERED INJURY WEEKLY EARNED INCOME REPLACEMENT BENEFIT		
Maximum Weekly Benefit Amount	$200	$200
Maximum Benefit Period	Lifetime	2 Years
III.A.iv. COVERED ILLNESS WEEKLY EARNED INCOME REPLACEMENT BENEFIT		
Maximum Weekly Benefit	$200	$200
Maximum Benefit Period	Later of Age 67 or Five Years	2 Years
III.B. PARTIAL DISABILITY BENEFIT		
Maximum Weekly Benefit	$300	$300
Maximum Benefit Period	Later of Age 67 or Five Years	2 Years
III.C. COST OF LIVING ADJUSTMENT		
Maximum Benefit Amount	$900	$900
III.D. FIRST WEEK TOTAL DISABILITY BENEFIT		
Maximum Benefit Amount	Weekly Earned Income up to $1,000	Weekly Earned Income up to $1,000
III.E. TRANSITION BENEFIT		
Benefit Amount	$300	$300
Maximum Benefit Period	26 Weeks	26 Weeks
III.F. RETRAINING BENEFIT		
Maximum Benefit Amount	$20,000	$20,000

SECTION IV: MEDICAL EXPENSE BENEFITS

IV.A. MEDICAL EXPENSE BENEFIT

Any benefits limits apply, unless otherwise specified, on a per Insured Person per Covered Injury or Covered Illness basis.

Medical Expense Benefit Options

The shaded box below indicates the Policyholder's selection:

- ☒ Primary Medical Expense other than Workers' Compensation or No-Fault Auto Insurance
- ☐ Full Excess Medical Expense
- ☐ Primary Medical Expense

	Class I	Class II
Maximum Medical Expense Benefit Amount	$2,500	$2,500

IV.B. PLASTIC SURGERY EXPENSE BENEFIT

Maximum Benefit Amount	An additional 25% of the Maximum Medical Expense Benefit Amount for Covered Injury but not less than $25,000	An additional 25% of the Maximum Medical Expense Benefit Amount for Covered Injury but not less than $25,000

SECTION V: ADDITIONAL BENEFITS

	Class I	Class II
V.A. DAILY HOSPITAL CONFINEMENT AND OUTPATIENT TREATMENT BENEFIT		
Daily Benefit Amount	$10	$10
Maximum Benefit Period for Hospital confinement	730 days	730 days
Maximum Benefit Period for treatment after discharge	730 days	730 days
Maximum Benefit Period for treatment without Hospital confinement	365 days	365 days
V.B. DAILY CRITICAL CARE BENEFIT		
Daily Benefit Amount	$20	$20
Maximum Benefit Period	730 days	730 days
V.C. FAMILY EXPENSE BENEFIT		
Maximum Benefit Amount	$10,000	$10,000
V.D. OCCUPATIONAL REHABILITATION BENEFIT		
Maximum Benefit Amount	$10,000	$10,000
V.E. MENTAL STRESS MANAGEMENT BENEFIT		
Maximum Benefit Amount	$10,000	$10,000
V.F. TRAUMATIC INCIDENT BENEFIT		
Traumatic Incident Aggregate Maximum Benefit Amount	$5,000	$5,000
V.G. HEALTH INSURANCE PREMIUM BENEFIT		
Maximum Benefit Amount	$12,000	$12,000
V.H. SURVIVING SPOUSE EDUCATION BENEFIT		
Maximum Benefit Amount	$10,000	$10,000
Maximum Benefit Period	4 years	4 years
V.I. DEPENDENT CHILD EDUCATION BENEFIT		
Maximum Benefit Amount	$10,000	$10,000
Maximum Benefit Period	4 years	4 years

AD&D Provident Policy

SCHEDULE OF BENEFITS

This Policy is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, PLEASE READ ALL THE POLICY PROVISIONS CAREFULLY.

The *Schedule of Benefits* provides a brief outline of the coverage and benefits provided by this Policy. Please read the Conditions of Coverage and Description of Benefits sections for full details.

Eligible Persons: An Eligible Person is an individual who meets all of the requirements of one of the covered classes shown below:

Class A	**Principal Sum**
All Active Volunteer & Part-time Members of the Policyholder	$25,000

Class B	
All Active Volunteer & Part-time Members of the Policyholder	$50,000

CONDITIONS OF COVERAGE
The benefits provided by this Policy will be paid, subject to applicable conditions, limitations and exclusions, under the following coverages:

Class A

24-HOUR BUSINESS AND PLEASURE COVERAGE

Class B

LINE OF DUTY OCCUPATIONAL COVERAGE

Additional Participating Organizations (if applicable)
Siuslaw Valley Fire & Rescue; Western Lane Ambulance District

BENEFITS

Aggregate Limit of Indemnity

Applies to:	**Benefit Amount**
Accidental Death and Dismemberment, Coma, Paralysis	Ten times the Class A Principal Sum, not to exceed $1,000,000.

Not more than the Aggregate Limit of Indemnity specified above will be paid for all Covered Losses, Covered Accidents and Covered Injuries suffered by all Insured Persons as the result of any one Covered Accident that occurs under one of the Conditions of Coverage, as specified above. This Aggregate Limit of Indemnity is payable only once, should more than one Condition of Coverage apply, We will pay the greater amount. If this amount does not allow all Insured Persons to be paid the amounts this Policy otherwise provides, the amount paid will be the proportion of the Insured Person's loss to the total of all losses, multiplied by the Aggregate Limit of Indemnity.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Covered Loss must occur within 365 days of the Covered Accident

Covered Loss	**Benefit Amount**
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Principal Sum
Loss of Use of Two or More Hands or Feet	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of Speech and Hearing (in Both Ears)	100% of the Principal Sum
Loss of One Hand or Foot and Sight in One Eye	100% of the Principal Sum
Loss of One Hand or Foot	50% of the Principal Sum
Loss of Use of One Hand or Foot	50% of the Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing (in Both Ears)	50% of the Principal Sum
Severance and Reattachment of One Hand or Foot	50% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum
Loss of all Four Fingers of the Same Hand	25% of the Principal Sum
Loss of all Toes of the Same Foot	25% of the Principal Sum
Loss of Thumb	25% of the Principal Sum
Loss of Index Finger	25% of the Principal Sum
Loss of any Joint on Either Hand	6.25% of the Principal Sum
Loss of 2nd, 3rd, or 4th Finger on Either Hand	12.5% of the Principal Sum
Loss of Large Toe of Either Foot	5% of the Principal Sum
Loss of a Joint of a Toe	1% of the Principal Sum

Exposure and Disappearance Benefit	**Included**

ACCIDENTAL SEVERE BURN AND DISFIGUREMENT BENEFIT

Benefit Amount	
75%-100% Body Disfigurement	100% of the Principal Sum subject to a Maximum Benefit of $100,000
50%-74% Body Disfigurement	75% of the Principal Sum subject to a Maximum Benefit of $100,000
25%-49% Body Disfigurement	50% of the Principal Sum subject to a Maximum Benefit of $100,000
10%-24% Body Disfigurement	25% of the Principal Sum subject to a Maximum Benefit of $100,000
Burn Classification	Third Degree

BEREAVEMENT AND TRAUMA COUNSELING BENEFIT

Counseling must occur within	30 days of the Loss of Life or Covered Loss.
Benefit Amount	$100 per session
Maximum Number of Sessions	10
Maximum Benefit per Covered Loss	$1,000

BURIAL AND CREMATION BENEFIT

Benefit Amount	$2,500

COMA BENEFIT

Coma must occur within	30 days of the Covered Accident
Benefit Amount	1% of the Principal Sum for the first 11 months, 100% in the 12th Month.

FELONIOUS ASSAULT AND VIOLENT CRIME BENEFIT

Covered Loss must occur within	365 days of the Covered Accident
Benefit Amount	10% multiplied by the portion of the Benefit Amount applicable to a Covered Loss for Accidental Death and Dismemberment, Coma, Paralysis, as shown in the Schedule of Benefits subject to a maximum of $10,000.

HEPATITIS OCCUPATIONAL OR ASSIGNED DUTIES ACCIDENT BENEFIT

Benefit Amount	50% of the Principal Sum subject to a maximum of $50,000

HOME ALTERATION AND VEHICLE MODIFICATION EXPENSE BENEFIT

Benefit Amount	10% multiplied by the portion of the Benefit Amount applicable to a Covered Loss for Accidental Death and Dismemberment, Coma, Paralysis, as shown in the Schedule of Benefits subject to a maximum of $10,000.

MEDICAL EVACUATION BENEFIT

Benefit Amount	100% of Usual & Customary Charges
Includes Traveling Companion	
Includes Emergency Sickness	

PARALYSIS BENEFIT

Paralysis must occur within	365 days of the Covered Accident
Benefit Amount	
Quadriplegia	100% of the Principal Sum
Paraplegia	75% of the Principal Sum
Hemiplegia	50% of the Principal Sum
Uniplegia	25% of the Principal Sum

PROSTHESIS APPLIANCE BENEFIT

Covered Loss must occur within	365 days of the Covered Accident
Benefit Amount	$1,000 per Covered Loss

REHABILITATION BENEFIT

Covered Treatment must occur within	365 days of the Covered Accident
Benefit Amount	10% multiplied by the portion of the Benefit Amount applicable to a Covered Loss for Accidental Death and Dismemberment, Coma, Paralysis, as shown in the Schedule of Benefits subject to a maximum of $10,000.

REPATRIATION BENEFIT

Benefit Amount	100% of Usual & Customary Expenses
Includes Emergency Sickness	

SEATBELT AND AIRBAG BENEFIT

Seatbelt Benefit Amount	25% multiplied by the Principal Sum applicable to the Covered Loss subject to a maximum of $50,000
Airbag Benefit Amount	10% multiplied by the Principal Sum applicable to the Covered Loss subject to a maximum of $25,000
Default Benefit Amount	$1,000

Employee Assistance Program

Public Safety EAP
A division of ESI

Information Resources:

A vital benefit to help with everyday issues

Public safety professionals face daunting challenges: budget crises, rapidly changing technology and the impact of social media are just a few emerging issues. Public Safety EAP offers extensive links, tools, discounts, and resources to help public safety personnel deal with these and other professional challenges.

- **Challenges of Military Deployment & Homecoming**
- **Budget Helpers, Grants & More for Public Safety Personnel**
- **CISM, Stress, Depression & Other Mental Health Issues**

To access this benefit, you can call the EAP or log on to the website, **www.PublicSafetyEAP.com**, for thousands of articles, videos and tools to help you resolve personal problems. Find information on thousands of topics including:

- **Adoption & Childcare**
- **Financial Planning**
- **Consumer Rights**
- **Mental Health**
- **Divorce**
- **Home Ownership**
- **Legal Issues**
- **Loss and Grief**
- **Stress**
- **Elder Care & Childcare Locators**
- **Family Violence**
- **Work-Life Balance**
- **Wills and Other Legal Forms**
- **Training & Education**

More benefits than any other EAP.

www.PublicSafetyEAP.com • 1-888-327-1060

TO ACCESS THE WEBSITE AND RESOURCES FOR EMPLOYEES

1. Log on to **PublicSafetyEAP.com**
2. Click **Employee & Family Login**
3. If you've already created a User Name and Password, simply enter that information in the appropriate boxes. **If you have not registered, complete steps 4 - 7.**
4. Click on REGISTER HERE
5. Enter your employer's name and click Continue
6. Your employer's name will appear; select the button and click Continue
7. Fill out the Registration Form and create your own User Name and Password, then click Continue. **You only need to register once.**

SDAO Special Districts Association of Oregon

SDIS Special Districts Insurance Services

You'll find an entire library of problem-solving resources including assessments, trainings, videos, tools and calculators such as 2,000+ Harvard Medical School articles • Thousands of Legal articles • 800,000 Child/Elder care providers • Personal Growth programs • Mental and Physical Health assessments • Financial tools and calculators • Career Development information • 900 Health videos • Plus, important new resources that include:

CAREGIVER CENTER

A vast array of tools designed to help those providing care for a chronically ill, disabled, or aging family member or friend.

TRAINING CENTER

Access hundreds of personal and professional development trainings and courses.

LOCATORS

Search for childcare and eldercare resources in your local area.

RESILIENCE JOURNEY

An interactive new benefit to help you develop your maximum potential, experience less stress, less depression and improve physical and emotional health.

ESI WELLNESS CENTER

Articles, health assessments, courses, videos, and FAQs related to dieting, nutrition, stress, smoking, and physical fitness.

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Emergency Medical Transport

MASA Medical Transport Solutions™

Any Ground. Any Air. Anywhere.™

MASA MTS CLAIM INSTRUCTIONS AND BENEFIT GUIDE

If You Have A Medical Emergency, Please Call 911

GLOBAL TRANSPORT HOTLINE

24 Hour – Access to Services

800-643-9023

ACCESS OF SERVICES

- Services rendered under Non-Emergent Air Transportation (HOSPITAL TO HOSPITAL) and Repatriation/Recuperation must be coordinated and/or provided directly by MASA MTS.
- In the event that such Services are not rendered directly by MASA MTS, all requests for post-service payment and/or reimbursement will be denied for violation of the "Access of Services" provision of this Agreement.

INTERFACILITY-TRANSFERS (HOSPITAL TO HOSPITAL)

- Contact MASA's Transport Department to schedule all hospital to hospital transfers.
- MASA's Transport Department will coordinate with the provider.

REPATRIATION/RECUPERATION

- MASA will arrange Member's non-emergent, Repatriation/Recuperation transportation, in the event Member is hospitalized in a Medical Facility more than one hundred (100) statute miles from Member's Residence and Member's treating physician and MASA MTS's Medical Director determines it is feasible and medically appropriate to transfer Member to a Medical Facility nearer to Member's Residence for recuperation. ***(Said benefit MUST be coordinated by MASA).***

NOTE: All Services under this Agreement are limited to the continental United States, Alaska, Hawaii and Canada, and must originate and conclude therein.

Dependents must be under the age of 26 and live with the Member to qualify for coverage under the Emergent Plus plan.

Email: claims@masaglobal.com

Fax: 817-769-2755

Mail:
MASA
ATTN: *Transport Department*
1250 South Pine Island Road Suite #500
Plantation, FL 33324

Transport Dept 800-643-9023

MASA Medical Transport Solutions™

Any Ground. Any Air. Anywhere.™

SUBMITTING CLAIMS ONLINE

- Go to www.masamts.com
- Click on “Member Login” located in top right hand corner. Click on Register and enter your member ID number and birthdate and create a password.
- Once you have signed-in then click on the Claims Tab, and then click on “Submit New Claim”.
- Upload the Bill/Invoice and the EOB, if available. Be sure to include your Member number on the bill/invoice.

NEW CLAIM INSTRUCTIONS

- Submit the bill from the ambulance company to MASA with Member’s MASA number clearly displayed.
- Submit the bill via E-Mail, Fax or Mail.
- Attach the EOB and run notes, if readily available.
- Contact the claims department directly with any questions.

DOCUMENTS NEEDED BY MASA TO PROCESS A CLAIM

- Bill/Health Insurance Claim Form a/k/a “HICFA”.
- Run notes/Trip notes from provider.
- Explanation of Benefits a/k/a “EOB”.

NOTE: ***All claims must be submitted to MASA within 180 days of the date of service***

Email: ambulanceclaims@masaglobal.com

Fax: 877-681-2399

Mail:
MASA
ATTN: *Claims Dept*
1250 South Pine Island Road Suite #500
Plantation, FL 33324

Claims Dept 800-643-9023

Get the MASA Global App

MASA Global

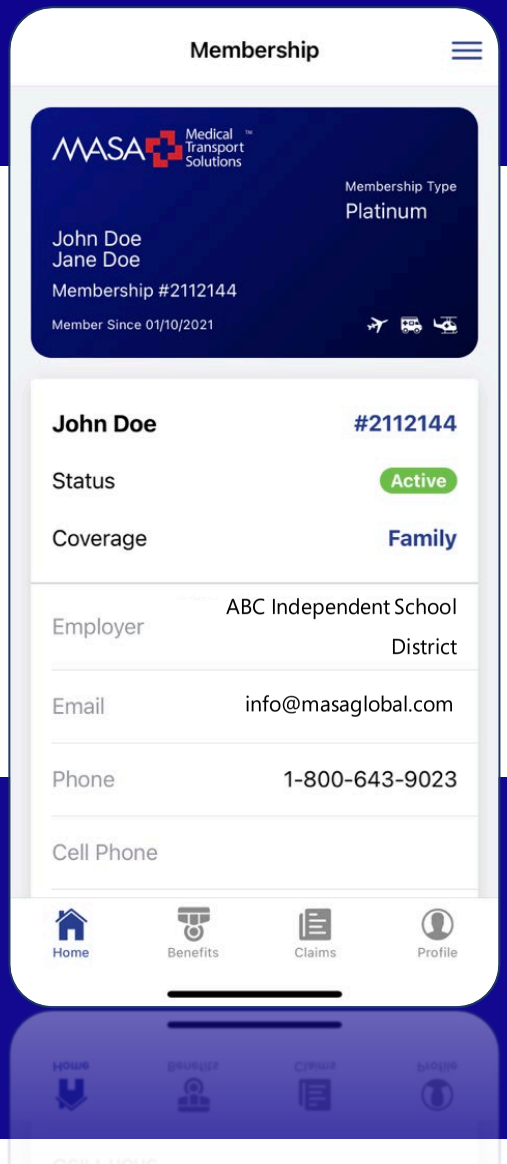
MASA Global

GET IT ON Google Play

DOWNLOAD ON THE App Store

Register today with your Member ID!

- Access your Digital ID Cards
- View Plan Documents and Benefits
- Get your Claim History



DOWNLOAD FOR **ANDROID**
Scan the WR code to get the MASA Global App from the play store.

DOWNLOAD FOR **IPHONE**
Scan the WR code to get the MASA Global App from itunes.

Health Reimbursement Arrangement

HRA Basics

Health Reimbursement Arrangement

An HRA is a **tax-free account** that **puts you in control** of your family's healthcare spending[1]. It's easy to use, and it's a smart way to save up for medical bills, including retiree insurance premiums. Plus, you never pay any taxes on the money going in or coming out. That's the **best tax advantage** there is—even better than tax-deferred 457, 403(b), and 401(k) plans!

- Pay no income or FICA taxes
- Choose your investments
- Get your money fast
- No use-or-lose or carryover limits

> *I didn't have enough money to purchase my contact lenses and my prescription medication. I was able to use my HRA money. What a relief!*
>
> HRA Participant

How It Works

1. Your employer **sends tax-free money** to your HRA[2]. Often, these funds would have otherwise been paid to you as taxable income. Your employer might also contribute funds in place of some other tax-free employee benefit.

2. You choose how you want to **invest your HRA funds** using the available fund lineup.

3. Depending on your plan[3], you can **use your money right away or save it up for later**, such as during retirement.

4. If you pass away, your HRA can transfer to your surviving spouse, children, or other survivors. Most other HRA plans can't offer this.

[1] Your HRA covers you, your spouse, and dependents, including your adult children through the end of the calendar year in which they turn age 26. [2] IRS rules require all eligible employees to participate (no individual elections). [3] Your HRA may be subject to post-separation benefits only or other limitations depending on your employer's plan design or any limited HRA coverage elections you may make. Note, domestic partners are not eligible for reimbursements.

How It Helps

> *This plan helped me retire a few years early and pay insurance premiums until Medicare kicks in.*
>
> HRA Participant

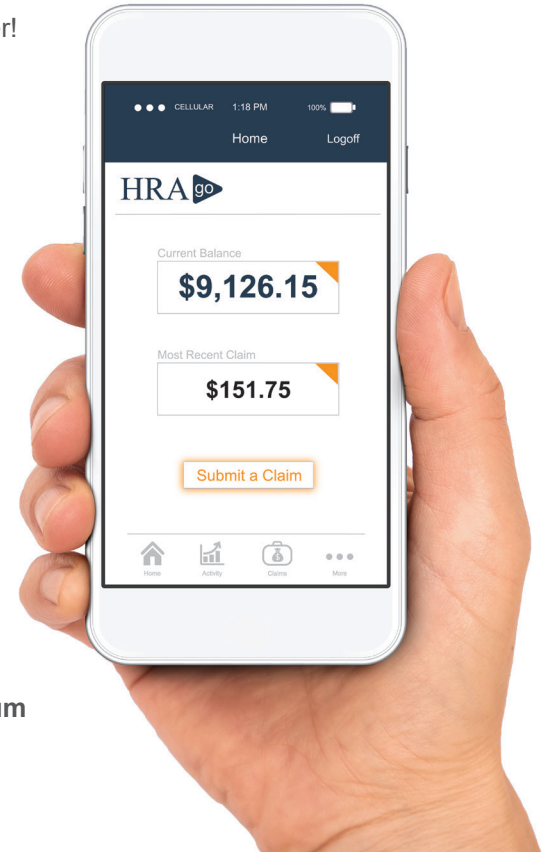
Are you struggling to cope with the cost of **doctor visits, prescriptions, new glasses or contacts, or braces for the kids?** Will you and your spouse be able to afford medical premiums up to **$1,000 or more per month** if you want to retire before age 65?

Many participants use their HRAs to reimburse **retiree insurance premiums** and the cost of medical care items and services they wouldn't be able to afford otherwise, like **power chairs, hearing aids, expensive vision and dental care, and emergency medical bills**.

Using Your HRA

Managing and using your HRA is now easier than ever!

- Fast online and mobile claims
- Handy mobile app (HRAgo®)
- Free debit card (upon request)
- Secure e-statements



Ready to file a claim? Log in online and click **Claims**, or use **HRAgo** and do it "on the go." With HRAgo, you can quickly snap pics of supporting documentation and submit claims right from your mobile device. We'll process your claim in about five to seven business days.

Are you a retiree? We can automatically reimburse your monthly insurance premiums, including Medicare premiums. Log in online and, click **Claims**. Then, click the **Set up an Automatic Premium Reimbursement** button.

MORE INFO?
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1-888-659-8828
customercare@hraveba.org

HRAveba.

The HRA VEBA Plan is a group health plan. Plan administrative fees are $1.50 (if claims-eligible) or $0.75 (if not claims eligible) per month, plus an annualized asset-based fee of about 1.00%. The monthly fee is waived if your account balance is more than $5,000. In addition, a 0.25% asset-based fee discount applies to any portion of your account balance in excess of $10,000. Please refer to the HRA VEBA Plan Summary for more details.

How to File a Claim

Your health reimbursement arrangement (HRA) is tax-free. The IRS requires us to verify that all reimbursement amounts are for qualified medical care expenses. This means we need you to submit proper supporting documentation for every expense listed on your claim. The below information will help you understand this process. You'll also learn how to submit "clean" claims for quick and hassle-free processing.

To find out what types of medical care expenses are eligible for reimbursement and who is eligible for coverage, refer to your **HRA VEBA Plan Summary**. To get a current copy, log in at **HRAveba.org** and click **Resources**.

Can I submit my claim online?

Yes, most participants submit their claims and documentation online. Log in at **HRAveba.org** and click **Claims**. You can also use our handy mobile app, **HRAgo®**.

What if I would rather use a paper form?

You can download and print a paper **Claim Form** online. Go to **HRAveba.org** and click **Forms**. Submit your completed Claim Form and documentation to the email or mailing address shown on the form.

How long will it take to process my claim and get my reimbursement?

Standard claims processing time is **five to seven business days** from the day we receive your claim.

To get your money back faster, submit your claim online. Also, sign up for direct deposit. It's faster and more convenient than waiting to receive paper checks in the mail. If you're not signed up for direct deposit, remember to allow adequate mail delivery time for paper checks.

You can check the status of your claim online. Log in at **HRAveba.org** and click **Claims**.

What documentation do I need to include?

The documentation you submit should contain these five things:

1. **Name** (you, your spouse, or dependent);
2. **Date** service was received or item was purchased;
3. **Service provider** name (doctor, pharmacy, clinic, hospital, etc.)
4. **Description** of service received or item purchased; and
5. **Amount** of out-of-pocket expense.

You can help avoid the hassle of denied claims by making sure the documentation you submit clearly contains all five of the above. Missing, incomplete, or illegible forms of documentation are the most common reasons claims are denied.

What's the best kind of documentation?

The **explanation of benefits (EOB)** from your insurance company usually works best. If you don't have one of those, get an itemized statement or detailed receipt from your healthcare provider or merchant. Make sure it

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Add mobile access. Search and download our handy mobile app, **HRAgo®**, from the App Store or Google Play. Snap and submit pics of your documentation—even submit claims.

contains all five pieces of information listed earlier. Here are some more good examples:

1. **Itemized statement** of services from your doctor or other service provider;
2. **Stub or "bag tag"** from a prescription (not the cash register receipt); or
3. **Detailed receipt** for over-the-counter (OTC) medicines and drugs.

What common types of expenses require different or additional documentation?

Certain types of expenses require documentation that is a bit different from the basic requirements. Here are a few of the most common examples.

- **Vitamins and supplements**

  Claims for vitamins and supplements require a prescription or letter of medical necessity from your doctor. Among other things, this documentation must show the product is being prescribed or recommended to treat a specific (diagnosed) medical condition.

  Read our **What is a Letter of Medical Necessity?** handout for more information. To get a current copy, log in at **HRAveba.org** and click **Resources**.

- **Orthodontia**

  We can usually reimburse full or partial pre-payment of orthodontia services if you submit proof of payment and a copy of the treatment plan with costs.

- **Insurance premiums**

  Proof of qualified insurance premiums must include:

  1. Policyholder name;
  2. Premium amount;
  3. Policy period (coverage months); and
  4. Insurance provider name and address.

  This information is typically contained on your premium billing notice, statement of insurance, open enrollment notice, pension benefit direct deposit stub, or similar form of documentation.

  For long-term care insurance premiums, include a copy of the policy's Declarations page, which should contain proof that the policy is tax-qualified.

Can you reimburse my insurance premiums automatically?

Yes, automatic premium reimbursement is available. To set this up, log in at **HRAveba.org** and click **Claims**.

How will I know when my claim has been processed?

We'll send you an email or a paper **Claim Notice** as soon as we process your claim. If we can't fully reimburse your claim, log in at **HRAveba.org** or from **HRAgo®** and click **Claims** to find out why.

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Medical Care Expenses

You can use your health reimbursement arrangement (HRA) to pay or reimburse hundreds of eligible medical, dental, or vision expenses and premiums. Your HRA covers you, your spouse, and dependents. IRS-qualified "medical care" expenses and premiums are outlined in Section 213(d) of the Internal Revenue Code. Examples include, but are not limited to, those listed below.

When you're ready to file a claim, log in at **HRAveba.org** and click **Claims**, or use our handy mobile app, **HRAgo®**. We'll process your claim in about five to seven business days.

With our free **Benefits Card**, you don't have to file claims and wait to get reimbursed. Just swipe your card and save the explanation of benefits (EOB) or detailed invoice from your provider. We'll let you know when we need a copy.

General Expenses

Acupuncture
Alcoholism and drug treatment center costs
Birth control (male and female)
Blood pressure monitor
Chiropractic
Christian Science office visits
Contact lenses
Copays
Coinsurance
Deductibles
Dental
Flu shots
Fertility treatments
Gynecology/Obstetrics
Hearing aids and batteries
Immunizations
Lactation aids, consultation
Laser eye surgery
Massages*
Medical supplies and equipment
Naturopathic office visits
Organ transplants
Orthodontia
Orthotics
Osteopathy
Physical therapy
Physicals (annual, DOL)
Prescription medicines
Preventive care
Psychiatric
Retirement home (medical care costs)
Stem cell therapy
Stop smoking programs
Transportation
Vaccines
Vasectomy
Vision (exams, glasses, prescription sunglasses)
Wheelchair

*Letter of medical necessity required.

Premiums

IRS-qualified premiums deducted from your paycheck <u>after</u> taxes are eligible, unless your employer offers a pre-tax option. Premiums deducted from your spouse's paycheck <u>after</u> taxes may be eligible.

Medical*
Dental
Vision
Qualified long-term care
Medicare Part B
Medicare Part D
Medicare Supplement

*Includes marketplace exchange premiums that are not or will not be subsidized by the Premium Tax Credit.

The OneBridge Visa® Benefits Card is issued by The Bancorp Bank, Member FDIC, pursuant to a license from Visa U.S.A. Inc. and may be used for qualified expenses wherever Visa debit cards are accepted. See Cardholder Agreement for details.

Over-the-counter (OTC)

Medicines and Drugs*

Acne medications
Allergy and sinus medicines
Antacids
Aspirin
Cold medicines
Cough syrup
Eye drops
First aid creams/liquids
Nasal sprays or drops
Nicotine gum/patches
Pain relievers
Sinus medications
Sleep aids
Stomach remedies
Supplements**

Miscellaneous Items
(no prescription required)

Bandages
Birth control products and devices
Contact lens solution
Crutches
Insulin
Diagnostic devices (blood sugar kits)
Menstrual products (starting 01/01/2020)

*Prescription or letter of medical necessity required if purchased before January 1, 2020. This requirement does not apply to purchases made on or after January 1, 2020. **Supplements require a prescription or letter of medical necessity.

Medicare

Copays
Coinsurance
Deductibles
Home health care
Hospice care
Hospital stay
Medicare Part B premiums
Medicare Part D premiums
Medicare Supplement premiums
Outpatient hospital services
Skilled nursing facility stay

Military Retirees

Copays
Deductibles
Medicare Part B Premiums
Medicare Part D Premiums
Miscellaneous medical, dental, and vision expenses
TRICARE premiums (medical and dental plans)

Ineligible Expenses

Aromatherapy
Cosmetic products and procedures
Counseling (marriage, general wellbeing)
Facelifts
Food
Gym memberships*
Hair regrowth supplies and services
Hair transplants
Health sharing premiums
Late fees
Marijuana, marijuana-derived CBD products
Massages*
Protein drinks
Shampoo (including medicated)
Tips
Tooth brushes (including electronic)
Vitamins (most cases)
Warranties, protection plans

*May be reimbursed with a letter of medical necessity.

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customercare@hraveba.org

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Certain restrictions may apply. Read our **HRA VEBA Plan Summary** for details. To get a copy, log in online and click Resources. Expenses solely for cosmetic reasons are not qualified medical care expenses. Expenses for items or services intended to maintain good health and not treat a diagnosed medical condition are usually not eligible. Certain “dual-purpose” expenses, such as massages, may require a letter of medical necessity from your licensed healthcare provider. If you’re covered by a healthcare flexible spending account (FSA), it must be used up before submitting claims to your HRA.

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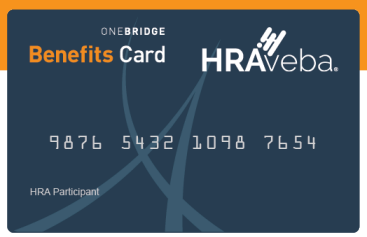
Benefits Card Frequently Asked Questions



Easy to Use. Saves you time.

Use your **OneBridge Visa® Benefits Card** to instantly pay medical care expenses directly from your health reimbursement arrangement (HRA). No filing claims and waiting to get reimbursed!

- No monthly card fee
- Spend up to 90% of your HRA balance every day ($3,000 daily limit)
- Request separate cards for your spouse or dependents

Save your supporting documentation.

Your HRA is tax-free. The IRS requires us to make sure every transaction is for a qualified medical care expense. Sometimes the electronic transaction data we receive isn't enough. We'll let you know when we need a copy of the **explanation of benefits (EOB)** from your insurance company or **detailed invoice** from your medical provider.

Scan for Video:
"Using Your Benefits Card"
▼▼

How can I get a Benefits Card?

You can request a Benefits Card at any time. You must have at least $50 in your account and a valid U.S. mailing address on file.

Is there a monthly fee?

No, there is no monthly fee.

What types of expenses can be paid with my card?

You can use your card to pay for qualified medical care expenses and premiums. This includes amounts you pay for office visits, prescriptions, over-the-counter (OTC) medicines and drugs, lab work, hospital stays, dental and vision services, etc.

Can I use my card for my spouse or dependents?

Yes, you can use your card to pay medical care expenses for you, your spouse, and qualified dependents. If you want, you can request separate cards for your spouse or dependents.

How much can I spend each day?

You can spend up to 90% of your HRA balance every day ($3,000 daily limit).

Do I need to keep a minimum balance in my HRA to use my card?

Yes, you must keep at least $50 in your HRA. Your card will not work if your HRA balance is less than $50.

→

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customercare@hraveba.org

1/22 PRC

Benefits Card
Frequently Asked Questions

Can I use my card to purchase vitamins or supplements?
Yes, but you'll need to submit a prescription or letter of medical necessity from your doctor if we don't already have one on file.

Should I save my supporting documentation?
Yes, you should always save your documentation in case we need copies.

Why might you need copies of my documentation?
Your HRA is tax free, and the IRS has some pretty strict rules we have to follow. We're required to make sure every amount paid or reimbursed from your HRA is for a qualified medical care expense. So, when the electronic transaction data we receive isn't enough, we have to ask you for documentation.

When using your card, it's always a good idea to request and hang on to supporting documentation in case we need it. Your provider should be familiar with what's required.

What types of transactions are usually verified automatically without documentation?
Most flat-dollar copays (in increments of $5) and prescription purchases are verified automatically. This means we usually don't need you to provide documentation for these types of transactions.

What happens if I don't provide documentation when you ask me for it?
IRS rules will require us to eventually suspend your card, but don't worry! We'll give you plenty of time before that happens. We understand you might have to wait until you get your final EOB or other form of proper documentation.

What if my card gets suspended?
We'll turn your card back on after all unsupported transactions have been resolved. To make that happen, you can either submit the documentation we need or pay back your HRA.

How will I know if you need documentation, and how do I submit it?
We'll notify you by email or regular mail within about 10 days if we need documentation.

You can submit documentation online or from our handy mobile app, HRAgo®. Either option is quick and easy. We'll give you instructions when we need you to send us something.

Can I submit documentation just once for an expense I pay all the time?
Yes, you can use our convenient "recurring payment" feature. You'll need to submit documentation once up front, but not every time after that. To set this up, simply check the Recurring Payment box when uploading documentation. We can then automatically verify future transactions for the same dollar amount from the same provider or merchant.

What's the best kind of supporting documentation?
As you might have guessed, the IRS requires more than just a receipt. The explanation of benefits (EOB) from your insurance provider usually works best. If you don't have one of those, get a detailed invoice from your merchant or provider. Make sure it contains these five things:

1. Name of patient or covered individual;
2. Date item was purchased or service was received;
3. Service provider name (doctor, pharmacy, clinic, hospital, etc.);
4. Description of the item purchased or service received; and
5. Amount paid.

If these options don't work, we'll have to note an "overpayment" on your account equal to your unsupported transaction amounts.

What is an "overpayment," and how can I resolve it?
An "overpayment" is an expense amount paid from your HRA for which we have not yet received proper documentation. If an "overpayment" is noted on your account, it will remain there until resolved.

To resolve an "overpayment," you can either submit the documentation we need or pay back your HRA. You can also submit regular claims. But, instead of approved claim amounts being paid to you, they will be used to reduce your outstanding "overpayment" until it has been resolved.

What if my card gets lost or stolen?
You should immediately call us at 1-888-659-8828. Our friendly customer care team is available to assist you during normal business hours. If calling after hours, follow the recorded instructions.

How can I cancel my card?
Just give us a call at 1-888-659-8828 during normal business hours and ask us to cancel your card. You will need to resolve any unsupported transactions before we can cancel your card.

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HRAveba.org

QUESTIONS?
1-888-659-8828
customercare@hraveba.org

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Flexible Spending Account

Western Lane Fire and EMS Authority
Flexible Spending Account Summary
September 1, 2023 – August 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	Maximum Pay Period Election	Maximum Annual Election
General Purpose Health FSA	$ 208.33	$2,500
Dependent Daycare Expenses	$ 416.66	$5,000 if married & filing a joint return or a single parent $2,500 if married but filing separately

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

Premium Component

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

Health FSA Component – includes the following account(s)

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

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

Dependent Care Assistance Plan (DCAP) Component

Dependent Daycare Expense Account (DCE)

- Our Dependent Daycare Expense Account (DCE) allows you to save pre-tax dollars to pay for dependent care. This is specifically for expenses for a child up to age 13 or disabled taxable dependent who is unable to care for themselves, including elder care expenses.
- When you have a qualified change in status—such as if your spouse's employment changes—you can increase or decrease how much you put into your account.
- In many cases, this account will be more beneficial to you than the federal tax credit.

Claims Reimbursement

Reimbursement Time Frame

Reimbursements may be requested during the plan year or after it ends. Your claim submission period ends 90 days after the plan year ends. This is known as a run-out period. All eligible reimbursement claims for services you received between **September 1, 2023** and **August 31, 2024** must be submitted by **November 30, 2024** for reimbursement.

Submitting Claims

The method for claims reimbursement is manual submission. 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/

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 $610 carry over to the next FSA plan year. If you have more than the $610 remaining, you'll lose those additional funds, along with all other account balances. In order to have up to $610 carryover, you will be required to make a salary reduction contribution in the new Plan Year. Carryover funds will be automatically rolled after the prior plan year, and claims submission period ends. You may request an early roll by contacting Customer Service.

What Happens if I Terminate Employment during the Plan Year?

If you terminate employment or lose eligibility, your participation in the plan will end on the date of termination or on the last day of the pay period in which you have contributed, whichever gives the greatest period of coverage.

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

You may be eligible to continue the Health FSA under COBRA or by making an additional pre-tax contribution out of your last paycheck. Please check with your employer regarding options you may have.

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

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

Email
psacustomerservice@pacificsource.com

PacificSource.com/PSA

PacificSource ADMINISTRATORS

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.

Aflac Policies

Scan the QR Code below to see the Aflac Insurance Plans

Aflac helps with expenses health insurance doesn't cover, so you can care about everything else.

Or, visit your benefits page at: www.aflacenrollment.com/WesternLaneFireandEMSAuthority/PWB243734468

Aflac's family of insurers American Family Life Assurance Company of Columbus and/or American Family Life Assurance Company of New York, and/or Continental American Insurance Company (CAIC) and/or Continental American Life Insurance Company.

Aflac | WWHQ | 1932 Wynnton Road | Columbus, GA 31999

Aflac New York | 22 Corporate Woods Boulevard, Suite 2 | Albany, NY 12211

Continental American Insurance Company | Columbia, SC

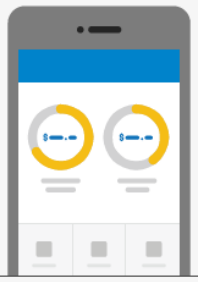
Z2300116QR EXP 1/25

REGENCE EXTRAS

Get on-the-go access with the Regence app

The Regence mobile app gives you easy and secure access to all your health information. It's iPhone and Android ready, and waiting for you to download.

Just sign in with your existing Regence account or create a new one from the app—then use biometric security to sign in. That means you won't need a password after setup!



Personalized dashboard

See your deductibles and out-of-pocket max.

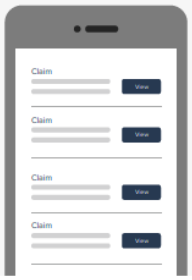
Find in-network doctors, hospitals and urgent care.

Use Live Chat to send secure messages to Customer Service or tap to call.

Member ID card

View your card on the app and it's stored for anytime access—even without an internet connection.

Show your digital member ID card at the doctor's office for easy check-in.



Claims and benefits

View your claims and detailed EOB statements.

See your copay, deductible and coinsurance amounts.

Download your benefits booklet.

REGISTER TODAY FOR ONLINE RESOURCES

REGENCE.COM

Get everything you need to know about your plan

- ***Access your Explanation of Benefits***
- ***Download a copy of your insurance cards***
- ***Review information about your benefit coverage***
- ***Route to MDLIVE website***

Looking for a claim or a doctor? Want to compare treatment costs?
Visit regence.com for all that and more.

Your complete source of health and wellness information

You can find everything you need to know about your health plan and ways to take care of yourself all in one place: **regence.com**.

Consider health care decisions and explore treatment options to help you plan your budget:

- Compare cost and quality of hospitals, clinics and providers.
- Research treatment options and out-of-pocket cost estimates.
- Learn about medical conditions and medications.
- Explore health articles and videos.

Discover tools that help you track your coverage and make informed decisions about your health care:

- Review details about your coverage.
- Manage your claims online and eliminate paper Explanation of Benefits.
- Find a doctor or specialist and read patient reviews.

Healthy living has its own rewards, but Regence Rewards points can help:

- Earn points for completing a General Health Assessment.
- Receive points for healthy everyday activities—such as eating fruits and veggies and walking the dog, or joining an online wellness program.
- Redeem points for a $25 gift card.

To get started, just follow these steps:

1. Go to **regence.com** and click Register.
2. Complete the required Plan Information fields. The name, member ID and group numbers you enter must match your member card.
3. Complete the Account Information fields.
4. Create a user name and secure password.
5. Review your information, accept the User Agreement and click Approve.

You're automatically enrolled for Rewards after you register. You get Rewards points for the following:

Taking a confidential General Health Assessment. Learn how you've been managing your health to date, and get practical tips on how to improve your health and well-being.

Managing stress and getting into shape. Reach for a healthy lifestyle with wellness programs on weight loss, nutrition, stress relief, smoking cessation and more.

MDLIVE®

Virtual Care, Anywhere.

24/7/365 on-demand access to affordable, quality healthcare. Anytime, Anywhere.

With MDLIVE, you can visit with a doctor 24/7 from your home, office or on the go. Our network of Board Certified doctors is available by phone or secure video to assist with non-emergency medical conditions.

Who are our doctors?

MDLIVE has the nation's largest network of telehealth doctors. On average, our doctors have 15 years of experience practicing medicine and are licensed in the state where patients are located. Their specialties include primary care, pediatrics, emergency medicine and family medicine. Our doctors are committed to providing convenient, quality care and are always ready to take your call.

Are my children eligible?

Yes. MDLIVE has pediatricians on call 24/7/365. Please note, a parent or guardian must be present during any interactions involving minors.We ask parents to establish a child record under their account. Parents must be present on each call for children 18 or younger.

When should I use MDLIVE?

- Instead of going to the ER or an urgent care center for a non-emergency issue
- During or after normal business hours, nights, weekends and even holidays
- If your primary care doctor is not available
- To request prescription refills (when appropriate)
- If traveling and in need of medical care

How much does it cost?

Signing up is free, you only pay per visit. If you're receiving MDLIVE as part of a group benefit, you may not be required to pay at all.

Costs per consult do vary. Sign up to find out your consult fee.

Common Conditions We Treat

- Allergies
- Asthma
- Bronchitis
- Cold & Flu
- Diarrhea
- Ear Infections
- Fever
- Headache
- Infections
- Insect Bites
- Joint Aches
- Rashes
- Respiratory Infections
- Sinus Infections
- Skin Infections
- Sore Throat
- Urinary Tract Infections
- And More!

Behavioral Health

- Marital Problems
- Child Behavior & Learning Issues
- Financial Hardship
- Coping with Loss & Grief
- Parenting Counseling & Advice
- Problems at Work
- Stresses & Challenges of Everyday Life

MD Download the App

Doctor visits are easier and more convenient with the MDLIVE App. Be prepared. Download today.

Download on the App Store | Google play | Download from Windows Store

Virtual Care, Anywhere. | MDLIVE.com/regence-or | 1-888-725-3097

Regence

Prescription *Benefit Summary*

Home Delivery
Express Scripts® Pharmacy

Introducing Express Scripts® Pharmacy, your home delivery pharmacy

Home delivery through Express Scripts® Pharmacy is a safe, convenient, contactless way to get your long-term medicines delivered right to your door. It may even help you save money.

Savings and convenience

- Free standard delivery
- Refill reminder notices through your phone or email, whichever you prefer
- Optional automatic refill program for eligible prescriptions, so your medicine is processed and sent to you when you need it*
- Save time – no waiting in line at the pharmacy

Support and service

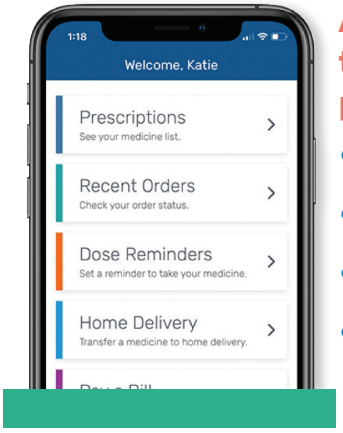
- 24/7 access to a team of knowledgeable pharmacists and support staff
- Multiple locations across the United States for fast processing and dispensing
- Pharmacists check each prescription multiple times before they send it to you

It's easy to get started

Create an online profile to manage your medicines

1. Go to express-scripts.com/rx
2. Register and create a profile
3. See your active medicines and/or send your refill order

If you haven't used home delivery yet, you can also call 1 (833) 599-0451 to get started.



A mobile app to manage your prescriptions

- Refill prescriptions
- Track your order
- Make payments
- Set reminders to take medicine and more

*Check to see if your health plan offers automatic refills and prescription renewal.

Regence

OREGON

Get the most from your pharmacy benefit

Have a prescription to fill? Wondering if you should switch to a generic or use our home delivery service? Here are some quick tips and programs you need to know about.

How to fill your prescription

Whether you have a new prescription or need to refill an existing one, our network of more than 65,000 participating pharmacies has you covered—across the country and around your corner.

Show your member ID card to your pharmacist so they can file your claim with us online and tell you how much you owe.

Programs to stretch your pharmacy dollar

Our programs are designed to put valuable medication and health support into your hands, while also saving you money.

Covered-drug list

When it comes to choosing medications, it's important to know how the list of covered drugs—or formulary—works.

The covered-drug list divides medications into multiple tiers, each with its own cost share. Before we add a medication to the list, our team of doctors and pharmacists carefully evaluate how safe and effective it is while assessing whether it will improve health.

To see if your medication is covered and how much it will cost, visit regence.com/pharmacy, sign in or select your type of coverage, and click on **Find a Drug**.

Generics

Generic and brand-name medications have the same strength, quality and purity. But, generics can cost up to 80% less. So, ask your doctor if there is a generic drug that will work for you.

Home delivery

You can get some medications—like the ones you take for a chronic condition—mailed to you at the location of your choice. That means fewer trips to the pharmacy, and it can even save you a copay or lower your out-of-pocket costs if you have coinsurance.

90-day fills

You can pick up 90-day supplies of most long-term medications at one of our Extended Supply Network (ESN) retail pharmacies or have our Home Delivery Program ship it to the location of your choice.

Visit regence.com/pharmacy, select your type of coverage or simply sign in, and click on **Find a Pharmacy** to locate an ESN retail pharmacy or register for home delivery.

Clinical programs

Our pharmacists work behind the scenes to help you get the medications you need when you need them. We also look out for safety concerns, such as potential drug interactions or duplicate prescriptions, that could affect you.

Specialty Pharmacy

We know that living with a complex health condition can be stressful and sometimes confusing. Our specialty pharmacy services are here to support you with the care and medications you need, every step of the way. In some cases, your plan may require that you use our Specialty Pharmacy.

If you're on a non-HSA plan and are prescribed certain specialty drugs, you may have the opportunity to reduce your out-of-pocket costs by enrolling in the FlexAcess program, which helps you identify manufacturer copay assistance coupon programs to make your medication(s) more affordable.

To assist you with the complexities of your condition and its treatment, our Specialty Pharmacy services will help you coordinate refills, monitor side effects and give you 24-hour access to clinical specialists. You'll even get injectable supplies for free—and everything can be delivered to your home or location of your choice.

Blood Glucose Meter Program

If you have diabetes, you're eligible to receive a new LifeScan OneTouch® glucose meter at no cost. Order your meter directly from LifeScan by calling 1 (855) 306-2278.

Understanding pre-authorization

To ensure you're getting an effective drug at an affordable price, we review prescriptions for some medications before we cover them. Drugs on the pre-authorization list include many for which equal or more effective and lower-cost options exist.

If your drug needs pre-authorization, you'll want to do one of two things:

Talk with your doctor to see if there's an alternative treatment that does not require pre-authorization.

OR

Have your doctor or pharmacist request pre-authorization for your medication. You may need to get that authorization before you can get your prescription filled.

Stay connected

Visit regence.com to find drug coverage, pricing, network pharmacies and more.

Questions? Call the Customer Service number on your member ID card.

Regence

Pharmacy and pharmacy services are provided by JourniRx, Inc. (a licensed pharmacy). JourniRx is a separate company that provides pharmacy and pharmacist services.

Eye care made easy

Your eyes bring you the world. Keep them healthy with your Regence Exam-Plus-Allowance Vision plan. We make it simple with open access to eye doctors and preventive care that helps catch problems before they start.

Designed to meet your needs

Eye care is a cinch when convenience and flexibility are built right into your plan.

See the doctor who's right for you. Whether it's your neighborhood optometrist or someone at your favorite retail store, we've got you covered. Pick from nearly 96,000 providers across the country in the VSP Choice network for even greater savings.

Be priority no. 1. VSP doctors' personalized care focuses on keeping you and your eyes healthy year after year. Plus, when you see a VSP provider, you'll get the most out of your benefits and have lower out-of-pocket costs.

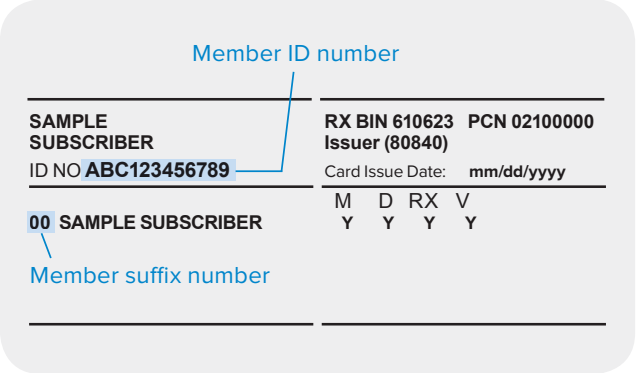
Have an annual exam. Get your VSP WellVision Exam®, included in your plan, and you could prevent health problems down the road. This screening helps your optometrist spot a range of vision troubles, like glaucoma and complications from diabetes, and signs of serious health conditions, like high blood pressure and cholesterol. Wear glasses or contacts? Your exam will ensure your prescription is up-to-date, too.

Pick the eyewear you like best. VSP doctors offer hundreds of frames to choose from, so if you need glasses, you can find the ones that most suit you.

Know before you go

Check your or your covered family members' benefits before your appointment for more details on your plan and what you can expect to pay. Sign in to regence.com and follow the link to vsp.com found in the vision benefits section. Family members covered by your health plan can see their benefits this way, too.

If you choose to go directly to vsp.com, have your Regence member ID card handy. You'll need your member ID number and member suffix number to create an account. Any dependents you have will also appear on your card with a unique suffix number. Use the member ID number and the dependent member suffix to set up a dependent account to view dependent coverage.



You can view your Summary of Benefits Coverage or Regence Exam-Plus-Allowance Vision booklet on regence.com for full details on your vision benefits.

Find an eye doctor

Here are three easy ways to find a VSP doctor and save:

1. Use the **Find a doctor** tool on regence.com.
2. Use the **Find a VSP doctor** tool on vsp.com.
3. Call VSP at 1 (844) 299-3041.

At your appointment, tell them you have VSP and show them your Regence member ID card.

Regence

Regence BlueCross BlueShield of Oregon
is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueCross BlueShield of Oregon
100 SW Market Street | Portland, OR 97201

REG-147902-19/04-OR

VSP is a separate and independent company that provides vision benefit services for Regence BlueCross BlueShield of Oregon members.

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711).

Regence

OREGON

REGENCE PREGNANCY PROGRAM

Get ready for baby with the Regence Pregnancy Program

We're here to help you get the information and support you need to prepare for delivery and care for your new baby. Download the Regence Pregnancy Program app (find it in the App Store or on Google Play) to track milestones and find answers to all your pregnancy and new-parent questions.

With the Regence Pregnancy Program, you'll receive:

Seasonal pregnancy newsletters

A maternity nurse care manager who'll be there to support you every step of the way

Help understanding and following your doctor's or midwife's advice

24/7 access to our toll-free maternity nurse advice line

Download the Regence Pregnancy Program app to get the information and support you need for your pregnancy and your new baby.

Get the Regence Pregnancy Program app and you can:

Read helpful articles and watch videos about pregnancy, caring for your baby and child development

See your weekly to-dos for each trimester

Write down questions to ask your doctor or midwife (and share those notes with loved ones)

Use helpful tools for pregnancy and after delivery, including feeding and growth trackers

Track your baby's development milestones from ages 0-2

Want more information? Email us at CaseManagement@regence.com or call 1 (888) JOY-BABY (1-888-569-2229).

Regence BlueCross BlueShield of Oregon
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Regence BlueCross BlueShield of Oregon
100 SW Market Street | Portland, OR 97201

REG-OR-924180-22/11-Member-Flyer

Know your behavioral health options

If you or your loved one is facing a behavioral health challenge, we want to make it as easy as possible to get care. You can find in-network providers at regence.com.

Help is available. No need to go it alone.

Go to regence.com to find a doctor and look for these in-network options:

- Private practitioners with a variety of expertise, such as psychiatrists, psychologists, social workers, licensed counselors and more
- 24/7 telehealth for counseling and medications
- Inpatient care
- Outpatient programs

Also available are:

- NOCD for app-based care specializing in treatment of obsessive compulsive disorders: treatmyocd.com
- TalkSpace for app-based care specializing in counseling for general behavioral health needs: talkspace.com
- Charlie Health telehealth for treating teens and young adults with behavioral health needs: charliehealth.com
- If your company offers an EAP program for urgent help, this may be a good place for you to start to get care. Talk to your Human Resources representative for further information.

You can also turn to these in-network providers for substance use disorder support:

- Boulder Care for inpatient and outpatient treatment: boulder.care
- Eleanor Health for outpatient treatment: eleanorhealth.com (only available in Washington)
- Hazelden Betty Ford for inpatient and outpatient treatment: hazeldenbettyford.org

Commonly treated behavioral health issues:

Behavioral health issues often involve more than one concern that affect overall health and happiness. Experts can help sort through what can be the most effective treatment path for the following:

- Substance use and abuse
- Trauma and post-traumatic stress disorder (PTSD)
- Anxiety
- Depression
- Obsessive compulsive disorder
- Bipolar disorder

Customer Service

You can call our award-winning team at the phone number listed on the back of your ID card

We're here to help you:

- Understand your benefits
- Check claim status or get an explanation of benefits
- Find an in-network provider

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Regence BlueCross BlueShield of Oregon
100 SW Market Street | Portland, OR 97201

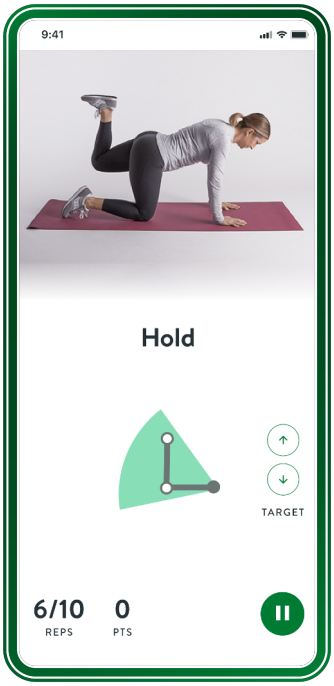
REG-OR-928789-22/10

Boulder Care is a separate company that provides substance abuse and addiction treatment services. Charlie Health is a separate company that provides mental health services. Eleanor Health is a separate company that provides mental health and substance use services. Talkspace is a separate company that provides mental health telehealth services. NOCD is a separate company that provides obsessive compulsive disorder treatment services.

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711).

SDIS Special Districts Insurance Services | Hinge Health

Conquer back and joint pain without drugs or surgery



We provide all the tools you need to get moving again from the comfort of your home. You'll get exercise therapy tailored to your needs, technology for instant feedback in the app, personal coach and physical therapist. Best of all, **it's free** — 100% covered by Special Districts Insurance Services through Regence for you and eligible family members.

Sign up today for help with any of the following:

- **Conquer pain or limited movement**
- **Recover from a past injury**
- **Reduce stiffness in achy joints**

Join for your **back, knee, hip, neck, or shoulder**. On average, participants cut their pain as much as 68%*!

Scan the QR code to learn more or apply at
hinge.health/specialdistrictsinsurance
or call (855) 902-2777

Participants must be 18+ and enrolled in a Special Districts Insurance Services medical plan administered by Regence BlueCross BlueShield of Oregon. Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association. Hinge Health® is a separate and independent company that provides digital MSK services for Regence members.
*Participants with chronic knee and back pain after 12 weeks. Bailey, et al. Digital Care for Chronic Musculoskeletal Pain: 10,000 Participant Longitudinal Cohort Study. JMIR. (2020).

Download the Hinge Health app today!

Does the Hinge Health app work with my device?

The Hinge Health app is available on both smartphones and tablets and can be downloaded via the App Store and Google Play Store.

How do I sign up for Hinge Health?

Visit **hinge.health/specialdistrictsinsurance** and select "Join Program". You will be prompted to create an account with Hinge Health and to confirm your eligibility.

You will be evaluated through a series of questions to help determine which program you will be enrolled in. The questionnaire will only take a few minutes!

How do I access the Hinge Health app?

Once the questionnaire is complete, you will be prompted to download the Hinge Health app via the App Store or Google Play Store.

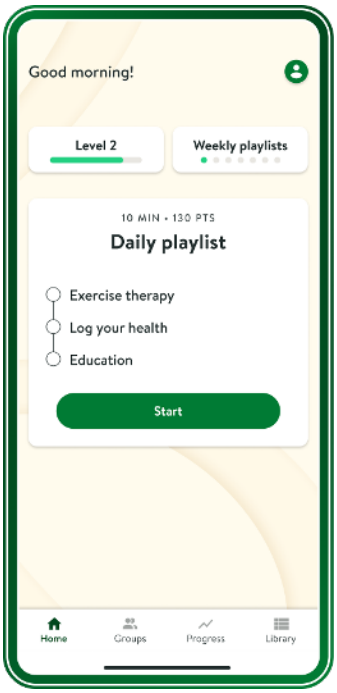
If you do not have a smartphone or tablet, you can request a device with the app pre-installed. There will be an option to request the device once you complete the questionnaire.

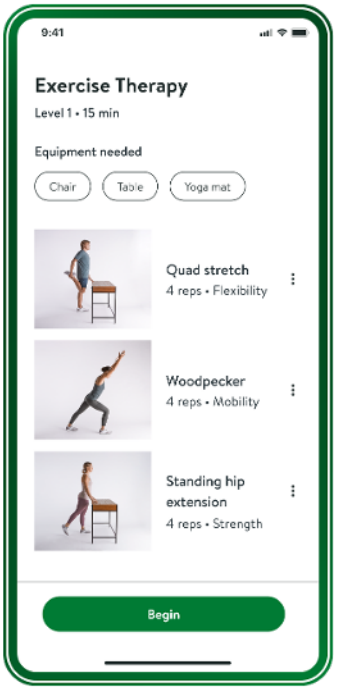
Where can I go for additional help?

If you'd like additional assistance getting started, please reach out to the Hinge Health Support Team at 855-902-2777 or help@hingehealth.com.

Who is eligible for the Hinge Health program?

Participants must be 18+ and enrolled in a Special Districts Insurance Services medical plan administered by Regence BlueCross BlueShield of Oregon. Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association. Hinge Health® is a separate and independent company that provides digital MSK services for Regence members.





Scan the QR code to learn more or apply at
hinge.health/specialdistrictsinsurance
or call (855) 902-2777

Regence | SDIS SPECIAL DISTRICTS INSURANCE SERVICES | omada

Access a health program built just for you

Omada® is a personalized program that helps members manage diabetes through one-on-one personal coaching, support from a specialist, and the tools needed to make long-lasting health changes.

*Included for eligible participants.

If you or your adult family members are living with diabetes and are enrolled in the Regence BlueCross BlueShield of Oregon health plan, SDIS will cover the Omada program. This may include a connected glucose meter with as many test strips as you need, and a digital scale—all yours to keep! Other eligibility requirements may apply.

Get started today:
omadahealth.com/sdis

Your personal Omada health coach will help you:

✓ **Lose weight and boost energy**
Learn how food, activity, sleep, and stress relate to diabetes.

✓ **Prevent blood sugar highs and lows**
Your certified specialist will help you keep blood sugar in check.

✓ **Track your health anytime, anywhere**
Chat with your health coach and track your progress with the Omada app.

✓ **Stay motivated and accountable**
Gain a team of supporters and online community to help you reach your health goals.

What do you get as a member?

- ✓ A personal health coach and a certified diabetes specialist
- ✓ A personalized care plan
- ✓ Weekly lessons
- ✓ Tools for managing stress
- ✓ Online peer group and communities

Plus, easier blood glucose monitoring with smart devices.† Yours to keep.

- ✓ 2 continuous glucose monitor sensors*
- ✓ Blood glucose meter and ongoing supply of test trips and lancets
- ✓ Smart scale (if clinically eligible)

“ Members love Omada

”This Omada program really works! I’m mindful of what I eat, buy, and prepare. I look for opportunities to keep moving, not excuses. I feel good about myself which has more positive effects. Life is good and I want to live it!”
- Vinny, Omada member

Testimonials are based on the member’s real experiences and individual results. Results may vary based on individual and demographic factors. We do not claim that these are typical results that members will generally achieve.

*CGMs are only available with the Omada for Diabetes program and only available to members within this program who receive a prescription and have a compatible smartphone. Eligible members will receive two (2) CGM sensors - one CGM is to wear upon enrollment, the other CGM is for a six-month follow-up.

†Included for eligible participants.

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association.

Omada is a separate company that provides care and disease management services.

Active&Fit DIRECT™

One Membership. Thousands of Ways to Stay Active and Save Money.

- 12,200+ Gyms
- 9,300+ On-Demand Videos
- 1:1 Well-Being Coaching
- Enroll Your Spouse[1]

No annual fees or long-term contracts. Switch gyms anytime.

LA Fitness · Golds Gym · Crunch · the Y · Anytime Fitness · snap fitness 24/7 · CHUZE FITNESS · blink FITNESS · Curves · EōS FITNESS

STANDARD FITNESS MEMBERSHIP
$28/mo[2]
12,200+ FITNESS CENTERS
9,300+ WORKOUT VIDEOS
Active&Fit DIRECT™ TM

Plus: 5,700+ Premium Gym Options at exercise studios, outdoor experiences, and others with 20% – 70% discounts at most locations[3]

Get Started: Regence.com/Advantages

[1] Add a spouse/domestic partner to a primary membership for additional monthly fees. Spouses/domestic partners must be 18 years or older. Fees may vary based on fitness center selection.

[2] Plus an enrollment fee and applicable taxes.

[3] Costs for premium exercise studios exceed $28/mo. and an enrollment fee will apply for each premium location selected, plus applicable taxes. Fees vary based on premium fitness studios selected.

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RESOURCES

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HEALTH INSURANCE TERMS YOU NEED TO KNOW

ACA – Affordable Care Act

Ambulatory Care – Health care services that do not require a hospital stay, such as those delivered in a doctor's office, clinic or day surgery center.

Assignment of Benefits – This means signing a document that allows your hospital or doctor to collect your health insurance benefits directly from your health carrier. Otherwise, you pay for treatment and the insurance company reimburses you.

Benefits – The amount of money payable by an insurance company to a claimant under the insurance policy.

Case Management – A technique that insurance companies use to ensure that individuals receive appropriate, timely and reasonable health care services.

Claim – A request by an individual (or his or her provider) for the insurance company to pay for services obtained.

Coinsurance – The money that an individual is required to pay for services, after a deductible has been paid. It is often a specified percentage of the charges. For example, the employee pays 20 percent of the charges while the health plan pays 80 percent.

Copayment – An arrangement where an individual pays a specified amount for various health care services and the health plan or insurance company pays the remainder. The individual must usually pay his or her share when services are rendered. The concept is similar to coinsurance, except that copayments are usually a set dollar amount (such as $20 per office visit), rather than a percentage of the charges.

Deductible – A set dollar amount that a person must pay before insurance coverage for medical expenses can begin. They are usually charged on an annual basis.

Denial of claim – Refusal by an insurance company to pay a submitted request for health care services obtained.

Employee Assistance Program (EAP) – Mental health counseling services that are sometimes offered by insurance companies or employers. Typically, individuals or employers do not have to pay directly for EAP services provided.

EOB (Explanation of Benefits) – is a statement sent by a health insurance company to covered individuals explaining what medical treatments and/or services were paid for on their behalf. The EOB should provide the date of service, total charges of the claim, non-covered charges, deductible, provider discounts, remaining covered charges, your copay, patient responsibility, total benefit paid by the carrier, and any comments.

Exclusions and Limitations – Specific conditions or circumstances for which an insurance policy or plan will not provide coverage (exclusions), or for which coverage is specifically limited (limitations).

HRA (Health Reimbursement Arrangement – is an employer-funded spending account that can be used to pay for qualified medical expenses. The HRA is 100% funded by your employer. The terms of these arrangements can provide first dollar medical coverage until the funds are exhausted or insurance coverage kicks in.

In-Network –Typically refers to physicians, hospitals or other health care providers who contract with the insurance plan (usually an HMO or PPO) to provide services to its members. Coverage for services received from in-network providers will typically be greater than for services received from out-of-network providers, depending on the plan.

Long-Term Care Insurance – Insurance policies that cover the costs of providing nursing care, home health care services, and custodial care for the aged and infirm.

Maximum Benefit – The maximum dollar amount that an insurance company will pay for claims, either for a specific service or procedure, or during a specified period of time.

Medically Necessary – A term used to describe the supplies and services needed to diagnose and treat a medical condition in accordance with the standards of good medical practice. Many health plans will only pay for treatment deemed medically necessary. For example, most plans will not cover elective cosmetic surgery.

MERP – MERP stands for Medical Expense Reimbursement Plan and is any plan or arrangement under which an employer reimburses an employee for out-of-pocket medical expenses incurred by employees and/or their dependents. Redmond Fire & Rescue currently reimburses their employees a portion of their deductible and out-of-pocket maximum that they incur during the plan year.

Out-of-Network – Typically refers to physicians, hospitals or other health care providers who do not contract with the insurance plan (usually an HMO or PPO) to provide services to its members. Depending upon the insurance plan, expenses incurred for services provided by out-of-network providers might not be covered, or coverage may be less than for in-network providers.

Out-of-Pocket Maximum – The total amount paid each year by the member for the deductible and coinsurance. After reaching the out-of-pocket maximum, the plan pays 100 percent of the allowable charges for covered services the rest of that calendar year.

Pre-Admission Certification – Also called "precertification" or "pre-admission review." Approval granted by a case manager or insurance company representative (usually a nurse) for a person to be admitted to a hospital or inpatient facility before admittance. The goal is to ensure that individuals are not exposed to inappropriate health care services, or services that are not medically necessary.

Pre-Existing Condition –Any medical condition that was diagnosed or treated within a specified period immediately before a health insurance policy became effective. These conditions may not be covered for a specified period of time under the new policy.

Preferred Provider Organization (PPO) – A type of managed care plan in which doctors and hospitals agree to provide discounted rates to plan members. Patients are typically reimbursed 80 to 100 percent for treatment received within the network, versus 50 to 70 percent outside the network.

Primary Care Physician (PCP) – A health care professional who is responsible for monitoring an individual's overall health care needs. Typically, a PCP serves as a gatekeeper for an individual's medical care, referring him or her to specialists and admitting him or her to hospitals when needed.

Reasonable and Customary Charges – The commonly charged or prevailing fees for health services within a geographic area. If charges are higher than what an insurance carrier considers reasonable and customary, the carrier will not pay the full amount and instead will pay what is deemed appropriate for the particular service. The remaining charges then are the responsibility of the patient.

Self-Insured – A health benefits plan in which the employer is responsible for the cost of its employees' health care. Typically, a third party provides administrative services for the plan to the employer group.

VEBA – "VEBA" stands for voluntary employees' beneficiary association. VEBAs are a type of trust instrument used to hold plan assets for the purpose of providing employee benefits. VEBAs are authorized by Internal Revenue Code § 501(c)(9). VEBA Trust offers a health reimbursement arrangement commonly known as the VEBA Plan

Waiting Period – A period of time in which your health plan does not provide coverage for a particular pre-existing condition.

Waiver – A rider or amendment to a policy that restricts benefits by excluding certain medical conditions from coverage.

Notes

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The information in this Benefits Resource Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Resource Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.