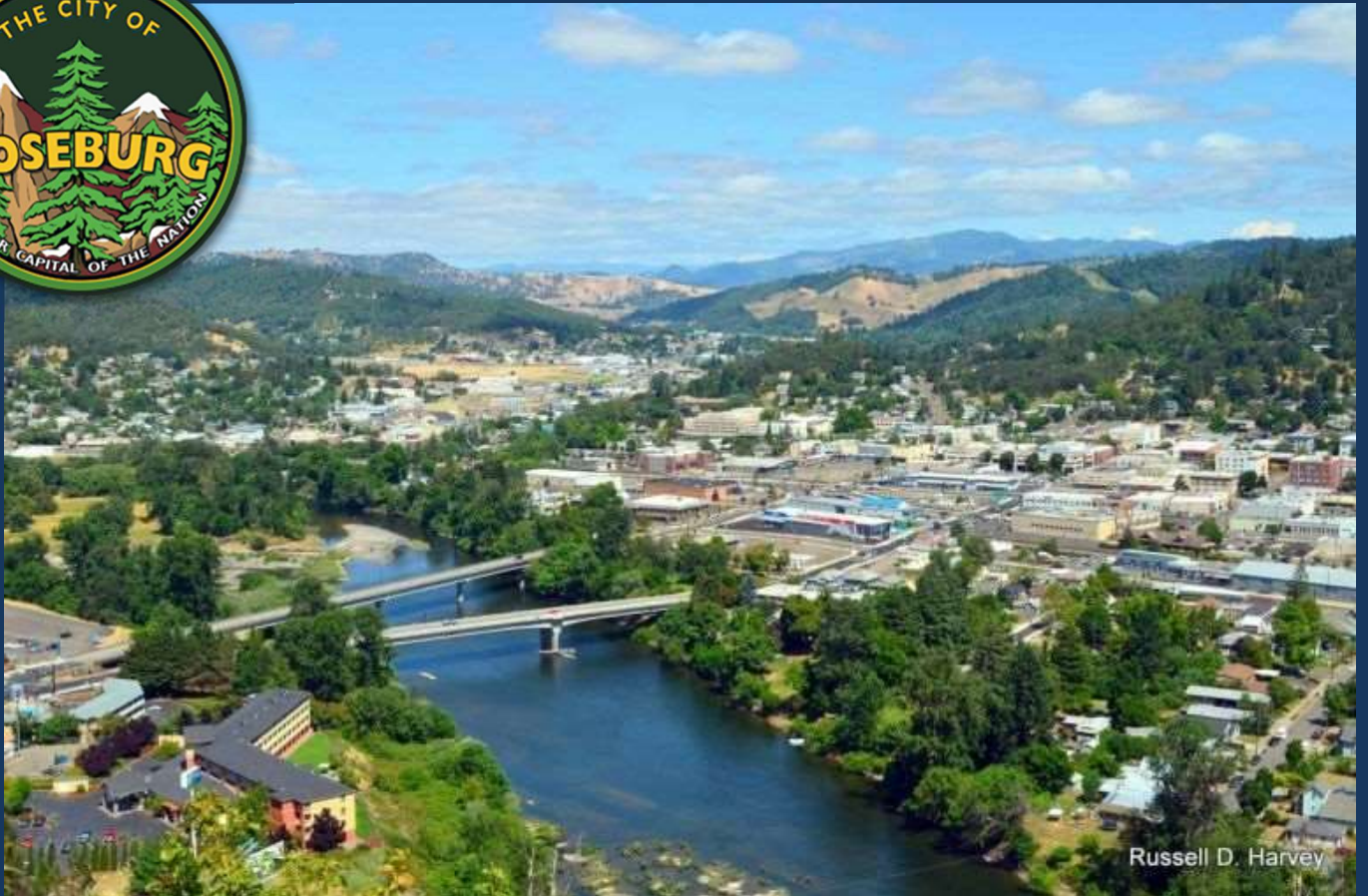
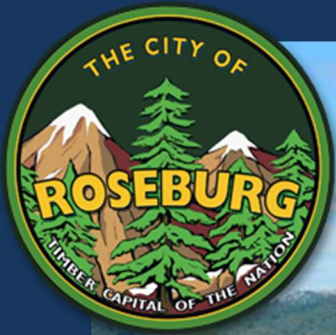


City of Roseburg – IBEW and Non-Represented Benefits Resource Guide





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



RICHARD ALLM
CONSULTANT
rallm@whainsurance.com
DIRECT: (541) 284-5853
Cell: (503) 580-3185



CHRISTINE WALLACE
ACCOUNT MANAGER
cwallace@whainsurance.com
DIRECT: (541) 284-5837

FULL TEAM



KIM NICHOLSEN
ACCOUNT EXECUTIVE
knicholSEN@whainsurance.com
DIRECT: (541) 284-5842



SAMANTHA BIANCO
DEPARTMENT MANAGER
sbianco@whainsurance.com
DIRECT: (541) 284-5849



MARVIN REVOAL
ACCOUNT EXECUTIVE
mrevoal@whainsurance.com
DIRECT: (541) 284-5833



HOLLY BELL
ACCOUNT MANAGER
hbelle@whainsurance.com
DIRECT: (541) 632-8032



FAWN TRACY
ACCOUNT MANAGER
ftarcy@whainsurance.com
DIRECT: (541) 284-5834

CONTACT

LOCAL OFFICE

(541) 342-4441

TOLL FREE

(800) 852-6140

FAX

(541) 484-5434

Eugene Office – 2930 Chad Drive, Eugene, OR 97408

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

Contact Information

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

HEALTH SAVINGS ACCOUNT	page 7
HSA Bank (800) 357-6246 www.hsabnak.com	
MEDICAL VOYAGER HSA \$1650:	page 11
MEDICAL VOYAGER \$500:	page 19
PacificSource Health Plans (800) 624-6052 www.pacificsource.com	
PACIFICSOURCE EXTRAS:	page 27
DENTAL:	page 35
Moda Health (877) 277-7280 www.modahealth.com	
HEALTH REIMBURSEMENT ARRANGEMENT (HRA):	page 45
HRA VEBA (888) 659-8828 www.hraveba.org	
FLEXIBLE SPENDING ACCOUNTS (FSA):	page 53
PacificSource Administrators (800) 422-7038 www.psa.pacificsource.com	
HEALTH SAVINGS ACCOUNT (HSA):	page 59
HAS Bank (800) 357-6246 www.hsabank.com/HSABank/Members	
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT:	page 65
The Hartford (800) 523-2233 www.thehartford.com/employeebenefits	
VOLUNTARY LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	page 69
The Hartford (800) 523-2233 www.thehartford.com/employeebenefits	
LONG-TERM DISABILITY:	page 77
The Hartford (800) 523-2233 www.thehartford.com/employeebenefits	
EMPLOYEE ASSISTANCE PROGRAM (EAP):	page 85
Uprisehealth (800) 395-1616 www.uprisehealth.com/members	
MASA MEDICAL TRANSPORT:	page 89
AFLAC:	page 95

Eligibility Information

Who is Eligible and When:

All full-time employees working over 20 hours per week are eligible for medical benefits the first of the month following their date of employment

Employee Pays:

The City of Roseburg pays a majority of the premium for your medical insurance, please see the chart below for your portion. Also, the City pays 100% of the cost of coverage for your dental, vision and base life coverage.

IBEW and Non-Represented	
Employee Contribution - \$500 Deductible plan	
Employee Only	\$64.02
Employee + Child(ren)	\$106.26
Employee + Spouse	\$123.42
Full Family	\$140.34
Employee Contribution - HSA Plan	
Employee Only	\$0
Employee + Child(ren)	\$0
Employee + Spouse	\$0
Full Family	\$0

If you elect the HSA plan with Pacific Source, the City of Roseburg will deposit into your HSA account on your behalf.

Employee Only - \$750 annually

Employee + 1 or more dependents - \$1500 annually

For questions regarding your HSA account or to check your balance, please contact HSA Bank:

Customer Service: (800) 357-6246

Address: PO Box 939

Sheboygan, WI 53082-0939

www.hsabank.com

City of Roseburg

Plan Options

July 1, 2025



PacificSource

	Voyager HSA 1650		Voyager 500	
Medical Benefits	In-Network		In-Network	
Individual Deductible	\$1,650		\$500	
Family Deductible	\$3,300		\$1,500	
Coinsurance	20%		20%	
Individual OOP Max	\$5,000		\$1,500	
Family OOP Max	\$6,850		\$3,500	
Preventative Office Visit	Covered in full		Covered in full	
Virtual Office Visits (vendor)	1st 3 visits \$0, then	20%	1st 3 visits \$5, then	\$0
Primary Care Office/Virtual Visit		20%		\$20 Bundled copay
Specialist Office Visit	20%		\$20 Bundled copay	
Urgent Care Office Visit	20%		\$20 Bundled copay	
Diagnostic Lab and X-Ray	20%		20%	
Advanced Imaging	20%		20%	
Emergency Room	20%		\$100 then 20%	
Pediatric Vision	Included		Included	
Pediatric Dental	Not Included		Not Included	
Prescription Drug Benefits				
Prescription Supply	30 Day	90 Day	30 Day	90 Day
Deductible	Medical Deductible		None	
Tier 1	20%	20%	\$10	\$30
Tier 2	20%	20%	\$20	\$60
Tier 3	20%	20%	\$40	\$120
Tier 4	20%	20%	Lesser of \$150 or 50%	na
Vision				
Exam	\$10		\$10	
Hardware Allowance	\$300		\$300	
Frequency	Per calendar year		Per calendar year	
Alternative Care				
Office Visit	No Benefit		No Benefit	
Benefit Maximum				

Medical Voyager HSA 1650

City of Roseburg

Benefit Year: Calendar Year

Provider Network: Voyager

Deductible Per Benefit Year	In-network	Out-of-network
Individual/Family	\$1,650/\$3,300	\$3,300/\$6,600
Out-of-Pocket Limit Per Benefit Year	In-network	Out-of-network
Individual/Family	\$5,000/\$6,850	\$10,000/\$20,000
<p>Note: In-network deductible and out-of-pocket limit accumulate separately from the out-of-network deductible and out-of-pocket limit. Even though you may have the same benefit for in-network and out-of-network, your actual costs for services provided out-of-network may exceed this plan's out-of-pocket limit for out-of-network services. In addition, out-of-network providers may in certain situations bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company (called balance billing). Balance billing amounts are not counted toward the out-of-network out-of-pocket limit. For additional information about balance billing or allowable fees, see your handbook.</p>		

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

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Preventive Care		
Well baby/Well child care	No deductible, 0%	After deductible, 50%
Preventive physicals	No deductible, 0%	After deductible, 50%
Well woman visits	No deductible, 0%	After deductible, 50%
Preventive mammograms	No deductible, 0%	After deductible, 50%
Immunizations	No deductible, 0%	After deductible, 50%
Preventive colonoscopy	No deductible, 0%	After deductible, 50%
Prostate cancer screening	No deductible, 0%	After deductible, 50%
Professional Services		

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Office and home visits	First three visits after deductible, 0%. Subsequent visits, after deductible, 20%*	After deductible, 50%
Naturopath office visits	After deductible, 20%	After deductible, 50%
Specialist office and home visits	After deductible, 20%	After deductible, 50%
Telehealth visits	First three visits after deductible, 0%. Subsequent visits, after deductible, 20%*	After deductible, 50%
Office procedures and supplies	After deductible, 20%	After deductible, 50%
Surgery	After deductible, 20%	After deductible, 50%
Outpatient rehabilitation and habilitation services	After deductible, 20%	After deductible, 50%
Hospital Services		
Inpatient room and board	After deductible, 20%	After deductible, 50%
Inpatient rehabilitation and habilitation services	After deductible, 20%	After deductible, 50%
Skilled nursing facility care	After deductible, 20%	After deductible, 50%
Outpatient Services		
Outpatient surgery/services	After deductible, 20%	After deductible, 50%
Diagnostic imaging – advanced	After deductible, 20%	After deductible, 50%
Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced	After deductible, 20%	After deductible, 50%
Urgent and Emergency Services		
Urgent care center visits	After deductible, 20%	After deductible, 50%
Emergency room visits – medical emergency	After deductible, 20%	After deductible, 20%
Emergency room visits – non-emergency	After deductible, 20%	After deductible, 50%
Ambulance, ground	After deductible, 20%	After deductible, 20%
Ambulance, air	After deductible, 20%	After deductible, 20%
Maternity Services**		

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Physician/Provider services (global charge)	After deductible, 20%	After deductible, 50%
Hospital/Facility services	After deductible, 20%	After deductible, 50%
Mental Health and Substance Use Disorder Services		
Office visits	First three visits after deductible, 0%. Subsequent visits, after deductible, 20%*	After deductible, 50%
Inpatient care	After deductible, 20%	After deductible, 50%
Residential programs	After deductible, 20%	After deductible, 50%
Other Covered Services		
Allergy injections	After deductible, 20%	After deductible, 50%
Durable medical equipment	After deductible, 20%	After deductible, 50%
Home health services	After deductible, 20%	After deductible, 50%
Transplants	After deductible, 0%	After deductible, 50%

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

*First three visits per benefit year combined for Professional Services – Office and home visits, Telehealth visits, and Mental Health and Substance Use Disorder Services – Office visits.

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

Additional information

What is the deductible?

Your plan's deductible is the amount of money that you pay first, before your plan starts to pay. You'll see that many services, especially preventive care, are covered by the plan without you needing to meet the deductible. The individual deductible applies if you enroll without dependents. If you and one or more dependents enroll, you and your dependents must satisfy the family deductible before benefits are paid.

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

What is the out-of-pocket limit?

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

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

Payments to providers

Payment to providers is based on the prevailing or allowable fee for covered services. In-network providers accept the allowable fee as payment in full. Services of out-of-network providers could result in out-of-pocket expense in addition to the percentage indicated.

Prior authorization

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called prior authorization. Prior authorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. Prior authorization does not change your out-of-pocket expense for in-network and out-of-network providers. You can search for procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business).

Discrimination is against the law

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

Benefit Year: Calendar Year

Formulary: Preferred Drug List (PDL)

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

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

Medical Deductible

You must meet the medical deductible, which is shown on the Medical Benefit Summary, before your prescription drug benefits begin.

Affordable Care Act Standard Preventive No-cost Drug List

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

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

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

Tier 1, Tier 2, and Tier 3 Member Pays

Specialty Drugs - In-network Specialty Pharmacy

Up to a 30 day supply:

After deductible, 20%

Specialty Drugs - Out-of-network Specialty Pharmacy

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

After deductible, 20%

*Prescription insulin is not subject to a deductible and is limited to \$35 copay per 30 day supply when filled at an in-network pharmacy.

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

MAC C - Regardless of the reason or medical necessity, if you receive a brand name drug or if your provider prescribes a brand name drug when a generic is available, you will be responsible for the brand name drug's copayment and/or coinsurance after the medical deductible is met. Does not apply to preventive bowel prep kits covered under USPSTF guidelines.

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

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

Medical Voyager 500

Benefit Year: Calendar Year

Provider Network: Voyager

Deductible Per Benefit Year	In-network and Out-of-network	
Individual/Family	\$500/\$1,500	
Out-of-Pocket Limit Per Benefit Year	In-network	Out-of-network
Individual/Family	\$1,500/\$3,500	\$6,500/Not applicable

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

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

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Preventive Care		
Well baby/Well child care	No deductible, 0%	After deductible, 40%
Preventive physicals	No deductible, 0%	After deductible, 40%
Well woman visits	No deductible, 0%	After deductible, 40%
Preventive mammograms	No deductible, 0%	After deductible, 40%
Immunizations	No deductible, 0%	After deductible, 40%
Preventive colonoscopy	No deductible, 0%	After deductible, 40%
Prostate cancer screening	No deductible, 0%	After deductible, 40%
Professional Services		
Office and home visits	First three visits no deductible, \$5. Subsequent visits, no deductible, \$20*	After deductible, 40%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Naturopath office visits	No deductible, \$20	After deductible, 40%
Specialist office and home visits	No deductible, \$20	After deductible, 40%
Telehealth visits	First three visits no deductible, \$5. Subsequent visits, no deductible, \$20*	After deductible, 40%
Office procedures and supplies	No deductible, 0%	After deductible, 40%
Surgery	After deductible, 20%	After deductible, 40%
Outpatient rehabilitation and habilitation services	No deductible, \$20	After deductible, 40%
Hospital Services		
Inpatient room and board	After deductible, 20%	After deductible, 40%
Inpatient rehabilitation and habilitation services	After deductible, 20%	After deductible, 40%
Skilled nursing facility care	After deductible, 20%	After deductible, 40%
Outpatient Services		
Outpatient surgery/services	After deductible, 20%	After deductible, 40%
Diagnostic imaging – advanced	After deductible, 20%	After deductible, 40%
Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced	No deductible, 20%	After deductible, 40%
Urgent and Emergency Services		
Urgent care center visits	No deductible, \$20	After deductible, 40%
Emergency room visits – medical emergency	No deductible, \$100 plus 20%^	No deductible, \$100 plus 20%^
Emergency room visits – non-emergency	No deductible, \$100 plus 20%^	After deductible, \$100 plus 40%^
Ambulance, ground	After deductible, 20%	After deductible, 20%
Ambulance, air	After deductible, 20%	After deductible, 20%
Maternity Services**		
Physician/Provider services (global charge)	After deductible, 20%	After deductible, 40%
Hospital/Facility services	After deductible, 20%	After deductible, 40%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Mental Health and Substance Use Disorder Services		
Office visits	First three visits no deductible, \$5. Subsequent visits, no deductible, \$20*	After deductible, 40%
Inpatient care	After deductible, 20%	After deductible, 40%
Residential programs	After deductible, 20%	After deductible, 40%
Other Covered Services		
Allergy injections	No deductible, \$5	After deductible, 40%
Durable medical equipment	After deductible, 20%	After deductible, 40%
Home health services	After deductible, 20%	After deductible, 40%
Transplants	After deductible, 0%	After deductible, 40%

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

^ Copay waived if admitted into hospital.

*First three visits per benefit year combined for Professional Services – Office and home visits, Telehealth visits, and Mental Health and Substance Use Disorder Services – Office visits.

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

Additional information

What is the deductible?

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

In-network expense and out-of-network expense apply together toward your deductible.

What is the out-of-pocket limit?

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

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

Payments to providers

Payment to providers is based on the prevailing or allowable fee for covered services. In-network providers accept the allowable fee as payment in full. Services of out-of-network providers could result in out-of-pocket expense in addition to the percentage indicated.

Prior authorization

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called prior authorization. Prior authorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. Prior authorization does not change your out-of-pocket expense for in-network and out-of-network providers. You can search for procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business).

Discrimination is against the law

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

City of Roseburg

Benefit Year: Calendar Year

Formulary: Preferred Drug List (PDL)

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

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

Affordable Care Act Standard Preventive No-cost Drug List

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

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

Service/ Supply	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays
In-network Retail Pharmacy			
Up to a 34 day supply:	No deductible, \$10*	No deductible, \$20*	No deductible, \$40*
35 - 60 day supply:	No deductible, \$20	No deductible, \$40	No deductible, \$80
61 - 90 day supply:	No deductible, \$30	No deductible, \$60	No deductible, \$120
In-network Mail Order Pharmacy			
Up to a 34 day supply:	No deductible, \$10*	No deductible, \$20*	No deductible, \$40*
35 - 90 day supply:	No deductible, \$20	No deductible, \$40	No deductible, \$80
Compound Drugs**			
Up to a 34 day supply:		No deductible, \$40	
35 - 60 day supply:		No deductible, \$80	
61 - 90 day supply:		No deductible, \$120	

Service/ Supply	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays
Out-of-network Pharmacy			
30 day maximum fill, no more than three fills allowed per year:	Same as retail		
Tier 1, Tier 2, and Tier 3 Member Pays			
Specialty Drugs - In-network Specialty Pharmacy			
Up to a 30 day supply:	No deductible, the lesser of \$150 or 50%		
Specialty Drugs - Out-of-network Specialty Pharmacy			
30 day maximum fill, no more than three fills allowed per year:	No deductible, the lesser of \$150 or 50%		

*Prescription insulin is not subject to a deductible and is limited to \$35 copay per 30 day supply when filled at an in-network pharmacy.

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

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

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

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

PACIFICSOURCE EXTRAS





Value-added extras for you

These extras help you make the most of your plan and live a healthier life. You can find more information about these programs and services at PacSrc.co/extras.

Wellness programs

Health and wellness education

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

Prenatal program

Our prenatal program helps expectant parents learn more about pregnancy and their child's development throughout pregnancy. Participants receive educational materials, and high-risk members receive an enhanced specialized program designed to support their needs throughout pregnancy.

Prenatal vitamins

Women between the ages of 15 and 50 with prescription drug coverage can receive physician-prescribed prenatal vitamins at no cost—all copays and deductibles are waived—when filled through an in-network pharmacy. For more information, visit PacSrc.co/prenatal.

Weight management program

As a part of your PacificSource medical coverage, participate in a WW® (Weight Watchers) program and receive an annual reimbursement of \$100 (\$40 if an online WW participant) for your WW membership. Complete a minimum of ten weeks during a consecutive four-month period to maintain eligibility.

Discounted gym membership

Active&Fit Direct™ gives you access to more than 12,500 fitness facilities nationwide. The program offers a gym locator, 12,000+ online workout videos, online fitness tracking, and wellness product discounts.

Continued >

Email
CS@PacificSource.com

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

PacificSource.com



Travel emergency assistance program

Assist America® global emergency services

If you experience a medical emergency while traveling 100 or more miles from home or outside the US, you can access services provided by Assist America at no cost. Services include filling a prescription that was left at home, finding medical care in another country, locating lost luggage, and pre-trip safety and security checks for your destination country.

Pharmacy

Rx delivery by mail

We partner with CVS Caremark® for home delivery by mail. If your plan includes prescription drug coverage, the mail delivery service is a convenient and cost-saving option. Visit PacSrc.co/rxmail.

CVS Caremark

Web: Caremark.com

Phone: 866-329-3051

Care management

Condition support

Personal support is available to members with the following chronic conditions: diabetes, coronary artery disease, heart failure, chronic obstructive pulmonary disease (COPD), or asthma. It's optional and includes one-on-one coaching with our nurses and dietitian to help you reach your health and wellness goals. PacSrc.co/condsupport.

Rare disease support

Our AccordantCare™ Rare Disease Program provides ongoing one-on-one support and care coordination to people with certain chronic, rare conditions. The program helps ensure optimal care, decrease complications, and improve health outcomes. For more information, visit Accordant.com.

Specialty medication support

Members with conditions that require injectable medications and biotech drugs can access our specialty pharmacy program through Caremark Specialty Pharmacy Services. A pharmacist-led care team provides individual follow-up care and support.

Care management services

If you have an ongoing medical need, our Care Managers can help. The PacificSource clinical and member support staff has extensive experience for working with you and your healthcare providers to ensure continuity of care and to coordinate your health needs.

Phone and video doctor visits

Teladoc® is a national network of U.S. board-certified physicians and pediatricians that you can see on-demand 24/7, via phone or online video consultations, from wherever you happen to be. With most plans, you won't pay anything for a virtual visit with Teladoc. If you have an HSA plan, a virtual visit with Teladoc is subject to deductible. Check your plan summary's telemedicine benefit to confirm your cost share.

Online resources

PacificSource.com offers you a wealth of tools, information, and resources to help you make the most of your benefits.

InTouch: access coverage and benefit information

By logging into InTouch, you can easily and conveniently manage your insurance coverage and health 24/7. Look up coverage information, check the status of a claim, view explanation of benefits (EOB) statements for paid claims, and more.

myPacificSource mobile app

The easiest way to view and manage your benefits while on the go. Available for both iPhone® and Android™. Visit PacSrc.co/mobile-app.

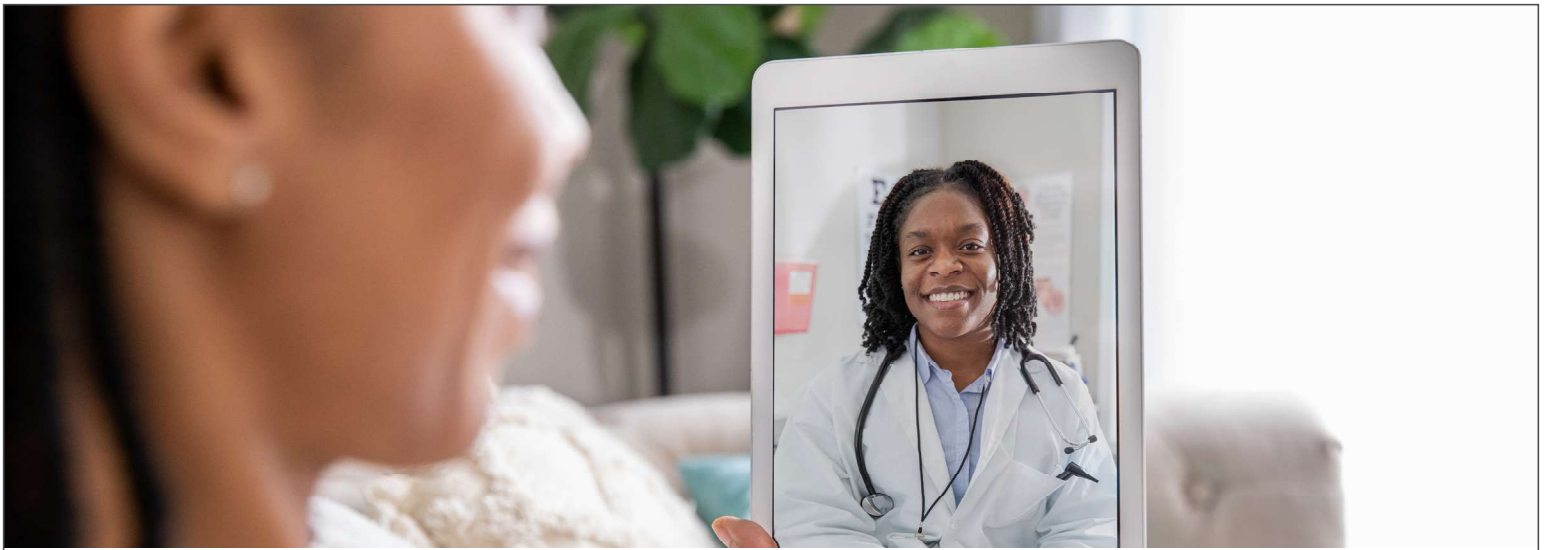
Provider directory

Our online provider directory makes it easy to find in-network healthcare providers for your plan. You can search by specialty, name, location, or other details to access a listing of providers that fit your criteria. Or, you can create your own personalized provider directory to download and print.

To access the directory, go to PacSrc.co/findadoc.

Find more information at PacSrc.co/extras.

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



Doctor's appointments via phone, video, or mobile app with Teladoc®

As a PacificSource member*, you have on-demand access to board-certified doctors 24 hours a day, 7 days a week. Here's how to get started and what you need to know.



1. Set up your Teladoc account

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

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

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

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



2. Provide your medical history

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



3. Request an appointment

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

*Employer group members: To see if Teladoc is available on your plan, contact PacificSource Customer Service at **888-977-9299**, TTY: 711 (we accept all relay calls), or CS@PacificSource.com. You can also check with your employer.

See reverse for FAQ >

Talk to a doctor anytime!

Web

Teladoc.com

Phone

855-201-7488

Mobile App

Teladoc.com/mobile



Frequently Asked Questions

What is Teladoc?

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

Who are the Teladoc doctors?

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

Does Teladoc replace my doctor?

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

What kind of medical care does Teladoc provide?

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

What consult methods are available?

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

How do I set up my Teladoc account?

You can set up your account through InTouch at PacificSource.com, or through the Teladoc website or mobile app. You can also call Teladoc to get started. Note: If setting up your account online, enter "**PacificSource**" for the name of your employer or insurance carrier.

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

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

How do I request a behavioral health visit?

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

How quickly can I talk to the doctor?

The median call back time for a general medical request is just 20 minutes. If you miss the doctor's call, whether you are away from the phone or you have an anonymous call blocker on, you will be returned to the bottom of the waiting list. The consult request is canceled if you miss three calls.

Is there a time limit when talking with a doctor?

There is no time limit for consults.

Can Teladoc doctors write a prescription?

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

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

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

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

The exact amount you will be responsible for is based on your specific plan benefits.

How do I pay for the consult?

You can pay with your HSA (health savings account) card, credit card, prepaid debit card, or by PayPal. Your account will be charged at the time of the visit. Your payment method will be set up when you register for Teladoc, and can be changed anytime.

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

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

Can I provide consult information to my doctor?

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



Manage your benefits with InTouch whenever, wherever

Easily find in-network doctors, hospitals, specialists, alternative care providers, and more with **InTouch**—our secure web portal for members.

You can also:

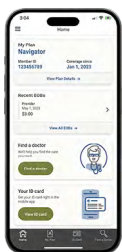
- View your digital member ID card
- See if you've met your deductible and out-of-pocket max
- Find out which services are covered
- View your Explanation of Benefits statements



[PacSrc.co/
account](https://PacSrc.co/account)

Create your InTouch account

1. Scan QR code
2. Click "Create account"
3. Follow the steps provided



Our app puts InTouch in your pocket

The myPacificSource app is a convenient way to access InTouch from your smartphone or tablet. You'll find links to download the iOS or Android app at the page linked above.

After you create your InTouch account, use your username and password to log in to the app.





The Active&Fit Direct™ Fitness Center Program

Members get discounted access to a broad network of participating fitness centers.

Choose standard or premium

- Select the standard or premium fitness center option that best fits you.
- Stop or switch options any time.
- **Discounts range from 20% to 70%** on average.

Freedom and flexibility

- 12,500+ participating centers/YMCAs nationwide. (See PacSrc.co/ActiveAndFitSearch.)
- Switch fitness centers to ensure you find the right fit.
- Find fitness centers with the web-based locator.
- Track your progress with the online fitness tracker.
- 12,000+ online workout videos—for home, work, or on-the-go.
- Receive unlimited 1:1 well-being coaching in areas such as fitness, nutrition, stress management, and sleep.

Get started

1. Visit PacificSource.com/ActiveAndFit for details. Or sign in at InTouch.PacificSource.com/members to register.
2. View and print your Active&Fit membership card.
3. Once the fitness center verifies your enrollment in the program, you will sign a standard membership agreement and receive a card or key tag from the fitness center to check in for future visits.

Note: Your participation is month-to-month after an initial two-month commitment.

Free fitness center trial

- Many fitness centers/YMCAs offer guest passes.
- Request a guest-pass letter for a gym at PacSrc.co/ActiveAndFitSearch. You will need to register and sign in to request the letter.

The Active&Fit Direct program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Active&Fit Direct is a trademark of ASH and used with permission here.

Questions? We're happy to help

Email

CS@PacificSource.com

Phone

888-977-9299

TTY: 711

We accept all relay calls.

En Español 866-281-1464

PacificSource.com



Dental

Moda - Delta Dental

2025 Delta Dental Premier Plan Benefit Summary



Delta Dental of Oregon & Alaska

City of Roseburg - Union

Group: 10001801

Calendar year costs	
Calendar year maximum, per member	\$1,500
Calendar year deductible, per member	\$0
Calendar year maximum deductible, per family	\$0
Preventive	
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	80%
Crowns and other cast restorations	80%
Dentures and bridges (construction or repair of fixed bridges, partial, and complete dentures)	80%

* Deductible waived for preventive services.

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

How to use this dental plan

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

When the member visits:

Delta Dental Premier Dentist:

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

Non Participating Dentists:

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

Limitations

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

Preventive (Class 1 services)

- **Diagnostic** Routine or comprehensive examinations or consultations covered 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 except for evidence of clinical failure.

Basic (Class 2 services)

- **Oral Surgery** Limited to extractions and other minor surgical procedures.
- **Restorative** Amalgam and composite fillings are covered. A separate charge for general anesthesia and/or IV sedation is not covered when used for non-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 mouth guard** covered at 80%, once in any 12-month period for members age 15 and under and once in any 24-month period age 16 and over. Over-the-counter athletic mouth guards are excluded.

Exclusions

- Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
- Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis and disturbance of the temporomandibular joint.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth 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.
- Orthodontic services (except when an orthodontia rider is included).
- 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.

2025 Delta Dental Plan Benefit Summary



Delta Dental of Oregon & Alaska

City of Roseburg - Union

Group ID: 10001801

Delta Dental Adult & Child Ortho AC2500.OR.25

Lifetime maximum benefit	\$2,500
	What members pay
Members age 19+	50%
Members under age 19	50%

Eligible Employees and their covered dependents

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.

This is a summary of the dental plan benefits and is not a contract. If there is any discrepancy between the information in this summary and the contract, it is the contract that will control. Dental plans in Oregon provided by Oregon Dental Service dba Delta Dental Plan of Oregon. Delta Dental is a trademark of Delta Dental Plans Association.

AC2500.OR.25



Delta Dental of Oregon & Alaska

Use Find Care to locate a dental provider near you

Our provider directory tool can help you save money when seeking care.

Find Care, our online provider directory tool, makes it easy for you to locate an in-network provider by name, provider type, specialty, network, location, gender identity, DentaQual provider ratings and more. Plus, finding an in-network dental provider that's right for you can also save you out-of-pocket costs.

How to find a provider

1. Visit deltadentalOR.com.
2. Under the “Online Tools” drop-down menu, select “Find a dentist”.
3. Choose the “In Oregon or Alaska” link or “Outside of Oregon and Alaska” link depending on the state you live in.
4. Under network, choose the Delta Dental PPO or Delta Dental Premier network, which can be found on your member ID card.
5. Under location, enter in a city, state or zip code, and then search.
6. A list of providers will be shown for the area you searched. This list will also include DentaQual dental provider ratings, if available, so you can review providers based on care and performance metrics.

Save costs when you choose in-network care

Getting quality care is easier and more affordable when you see “in-network” dental providers. These providers agree to accept your insurance at lower rates and meet quality standards. Choosing an in-network dental provider keeps your out-of-pocket costs low.

In-and out-of-network costs

It's important to know you may pay more for services from out-of-network dental providers than from in-network providers. If you choose an out-of-network provider, your benefits only cover a percentage of the maximum plan allowance for these services. Out-of-network providers may also bill you for the difference between the maximum plan allowance and their billed charges. This is known as balance billing. In-network dental providers can't do this. Please see your plan summary or your Member Handbook to learn more about in-network and out-of-network benefits and costs.

Questions?

We're here to help. For questions or help finding a provider, please contact the Delta Dental Customer Service team at 888-217-2365.

Moda, Inc. complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. ATENCION: Si habla español, hay disponibles servicios de ayuda con el idioma sin costo alguno para usted. Llame al 1-877-605-3229 (TTY: 711). 注意：如果您說中文，可得到免費語言幫助服務。請致電 1-877-605-3229 (聾啞人專用: 711)。



MEMBER DASHBOARD

Get your benefits on the go

As a member, you have a personalized Member Dashboard that puts the information you need at your fingertips.

What's in the Member Dashboard?

The Member Dashboard is a one-stop resource for all you need to get the most out of your plan, including:



ID cards



Provider search - including DentaQual provider ratings



Explanation of Benefits (EOBs)



Benefits overview



Claim status



Customer service contact information



Healthcare cost estimator


If you don't have a Member Dashboard account, creating one is easy. Go to [DeltaDentalOR.com/memberdashboard](https://www.DeltaDentalOR.com/memberdashboard) and click on "Create an Account". Be sure to have your member ID card handy.

OVER →

Access the Member Dashboard on your smartphone

The easiest way to open the Member Dashboard is to add a shortcut on your phone. Anytime you want to access your benefits or resources, just tap the Member Dashboard icon.

On an iPhone

1. Open the browser on your phone and go to DeltaDentalOR.com/memberdashboard
2. From the login screen, tap the Share  icon in the menu at the bottom of the screen
3. From the Share menu (scroll right to see more options), choose “Add to Home Screen”
4. Tap “Add” to confirm

Your phone will now have an icon that says “Login|Member Dashboard.”

On an Android device:

1. On your phone, go to DeltaDentalOR.com/memberdashboard
2. Using the menu (three vertical dots) at the top of the screen, choose “Add to Home screen”
3. Tap “Add” to confirm
4. On the next screen, choose “ADD AUTOMATICALLY” so the icon will be placed on your phone

Your phone will now have an icon that says “Login|Member Dashboard.”

Questions?

We're here to help.
Call us toll-free at
888-217-2365. TTY
users, please call 711.

ORAL HEALTH, TOTAL HEALTH

Dental benefits that protect more than just your smile

If you are diabetic or pregnant in your third trimester, the Oral Health, Total Health program offers more ways to care for your teeth and mouth — and keep the rest of your body healthy, too.

If you have diabetes

Diabetes increases the risk of cavities, periodontal (gum) disease, tooth loss, dry mouth and infection. If you have been diagnosed with this disease you are eligible for four prophylactic (preventive) cleanings or periodontal maintenance visits per year through our Oral Health, Total Health program. Protect your teeth and gums by enrolling today.

For details on the Oral Health, Total Health program, refer to the dental Member Handbook or visit Member Dashboard, your personalized member website.

If you're pregnant

Pregnant members who have periodontal (gum) disease are more likely to have a premature and underweight baby. Bacteria can enter the bloodstream through the mouth, and the body's response to the infection can trigger early labor.

If you are expecting, you can enroll in the Oral Health, Total Health program to help prevent gum disease. If you've already had two cleanings for the year, you'll be eligible for another cleaning or checkup during your third trimester. This added preventive (prophylactic) visit is covered regardless of normal plan frequency limits. That way, you can receive a dental cleaning during the third trimester, no matter what.

Learn more and enroll

To enroll in the Oral Health, Total Health program, fill out the form on the reverse side of this sheet or access the form online by logging in to Member Dashboard. Once you've signed in, simply click on "Oral Health, Total Health" in the myHealth tab.

Questions?

We're here to help.
For questions, call our dental services team toll free.
Oregon: 888-217-2365
Alaska: 888-374-8906

OVER →

HRA VEBA

Benefits You Receive:

The HRA VEBA plan is a tax-free health reimbursement arrangement (HRA.) HRAs are account-based health plans. You can use your HRA funds to cover qualified healthcare expenses and premiums for you and your family. Employer contributions, earnings, and withdrawals (claims) are exempt from taxes. In other words, the money goes in tax-free, is invested tax-free, and comes out tax-free.

The City of Roseburg will make a monthly contribution based on the annual amount below:

Employee Only	\$1,000
Employee & Spouse	\$1,350
Employee & Children	\$1,350
Full Family	\$1,700

Investment Options

You may invest your account using either one of two investment options. With Option A: Do-it-yourself, you can build your own portfolio using any combination of available funds. Option B: Choose a pre-mix allows you to select any one of four professionally designed pre-mixed allocation portfolios designed and monitored by investment professionals. You can change your investment selection(s) up to once per calendar month.

Qualified Healthcare Expenses:

Common qualified out-of-pocket expenses include:

- Copays
- Coinsurance
- Deductibles
- Dental and Orthodontia
- Vision Expenses
- Retiree insurance premiums
-

To File for Reimbursement: Visit www.hraveba.org and download the claim form and complete.

- Provide proof of each expense: Best document to submit Explanation of Benefits (EOB)
- Submit the claim along with the proof of expense (EOB) to:
 - Via email (preferred): claims@hraveba.org
 - Fax: (206)577-3020
 - Mail: HRA VEBA Plan, PO Box 80587, Seattle, WA 98108

Online Services:

Register for myHRA VEBA online at www.hraveba.org

After logging in, you will be able to quickly and easily:

- View your account balance
- Track claims in progress
- View claims history
- Update your investment selection(s)
- Update your covered spouse and dependent information
- And more!



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 | Fertility treatments | Physicals (annual, DOL) |
| Alcoholism and drug treatment center costs | Gynecology/Obstetrics | Prescription medicines |
| Birth control (male and female) | Hearing aids and batteries | Preventive care |
| Blood pressure monitor | Immunizations | Psychiatric |
| Chiropractic | Lactation aids, consultation | Retirement home (medical care costs) |
| Christian Science office visits | Laser eye surgery | Stem cell therapy |
| Contact lenses | Massages* | Stop smoking programs |
| Copays | Medical supplies and equipment | Transportation |
| Coinurance | Naturopathic office visits | Vaccines |
| COVID-19 tests | Organ transplants | Vasectomy |
| Deductibles | Orthodontia | Vision (exams, glasses, prescription sunglasses) |
| Dental | Orthotics | Wheelchair |
| Flu shots | Osteopathy | |
| | Physical therapy | |

*Letter of medical necessity required.

Premiums

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

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

*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.

More Information

HRAveba.org

Ask Questions

1-888-659-8828



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.



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**.

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.

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 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

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.



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.

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.

More Information

HRAveba.org

Ask Questions

1-888-659-8828

Flexible Spending Account

Benefits You Receive:

FSAs provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pretax basis. By anticipating your family's health care and dependent care costs for the next year, you can actually lower your taxable income.

Health Care Reimbursement FSA:

This program allows City of Roseburg employees to set aside pre-tax money to pay for medically necessary healthcare expenses that are not covered by a health plan. The annual maximum amount you may contribute to the Health Care FSA is \$3,300 in 2025. Some examples of reimbursable expenses include:

- Insurance deductibles, coinsurance, and copayments
- Hearing services, including hearing aids and batteries
- Vision services, including contact lenses, contact lens solution, eye examinations and eyeglasses
- Dental services and orthodontia
- Chiropractic services
- Acupuncture
- Prescription copays

Dependent Care FSA:

The Dependent Care FSA lets City of Roseburg employees use pretax dollars toward qualified dependent care such as caring for children under the age 13 or caring for elders. The annual maximum amount you may contribute to the Dependent Care FSA is \$5,000 (or \$2,500 if married and filing separately) per calendar year. Examples include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

A Flexible Spending Account (FSA) is a type of plan that allows you to receive certain benefits on a pretax basis. This means you will not have to pay Social Security/Medicare taxes or federal/state income taxes on the money. Think of it as a tax-free, interest-free loan to yourself.

The Plans The following FSA components are available through your employer. These expenses are for your tax dependents. Examples include you, your spouse, or child(ren), even if they are not covered on your employer’s group insurance plan.

Insurance Premium Component

- If your employer charges you to have yourself and/or any dependents enrolled on the employer-sponsored benefits, your cost will automatically be deducted from your paycheck on a pre-tax basis.

Health FSA Component – includes the following account(s)

Maximum Election \$3,300 annual

- You can use this account for healthcare expenses for you and your taxable dependents, including medical, dental, and vision expenses that are either not covered or only partially covered by your insurance plan.
- Your full election amount is available at the start of the plan year.
- When you have a qualified change in status—such as if you add or remove dependents from your insurance plan—you can increase or decrease your election.

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

- Eligible expenses include medical, dental, and vision expenses not paid for by insurance: copays, coinsurance, deductibles, etc.
- Over the counter medicines and supplies are eligible, examples include pain relief and allergy medications, bandages, thermometers, etc. Some vitamins and supplements may be eligible with a Letter of Medical Necessity or doctor’s prescription.

Limited-Purpose Flexible Spending Account (LFSA)

- This plan is available for employees, who they themselves or their family contribute to a health savings account (HSA).
- You can use this plan for eligible expenses including dental, vision and preventive medical care expenses.

Dependent Care Assistance Plan (DCAP) Component

Maximum Election \$5,000 annual (\$2,500 annual max if married filing separately)

- You can use this account for childcare expenses for your tax dependents under 13 or disabled taxable dependent who is unable to care for themselves, including elder care expenses.
- This account is accrual-based, and reimbursements will be issued as funds are posted and claims received.
- 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.

Claims Reimbursement

Reimbursement Time Frame

- Dates of service must be between **July 1, 2025**, and **July 30, 2026**
- Reimbursements may be requested during the plan year or after it ends.
- The last date to submit claims is **October 31, 2026**

Submitting Claims

Claims can be submitted through manual submission, using your Prepaid Benefit Card, or enrolling in the EasyPay program. If you're reimbursed for a claim and it is later determined that the expense was not eligible for reimbursement, you will be liable for repaying the money to your FSA. Additional information is listed below.

Manual Claims

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

1. Submit your claim online using our PSAConsumer portal: <https://psa.consumer.pacificsource.com>
2. Submit your claim via our Mobile App: myPacificSource Admin (PSA)
3. Mail or fax a Request for Reimbursement Form. You'll find the form at <https://pacificsource.com/media/32811>

Prepaid Benefit Card

A Prepaid Benefits Debit Card gives you an easy, automatic way to pay for qualified healthcare expenses. Simply swipe your benefits card as you would a credit/debit card (and select "credit" rather than "debit"). When you use the card to make a purchase or payment, it deducts funds directly from your FSA.

Date of service is important! It's assumed the date of service is the day the card is swiped. If you are paying for a prior service, only use your card if the service date is within your current plan year. Prior year services need to be submitted as manual claims for reimbursement. Replacements or additional cards can be purchased for \$10 per set of two cards.

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

EasyPay

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

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

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

Funds Remaining After the Plan Ends

If the plan year ends before you've used all your Health FSA funds, you're allowed to have up to \$660 carry over to the next FSA plan year. If you have more than \$660 remaining, you'll lose those additional funds, along with all other account balances. Carryover funds will be automatically rolled after the prior plan year ends.

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 last day of the month following date of termination.

Forms, Fliers and instructions

Available online. Examples include:

- [Request for Reimbursement Form](#)
- [Health FSA Eligible Expenses](#)
- [FSA Prepaid Benefits Card Flier](#)
- [Online Account Access for Participants](#)
- [FSA Participant Guide](#)
- [Direct Deposit Form](#)
- [PSA Mobile App](#)
- [Authorization to Disclose PHI](#)

Questions?

Our Customer Service Team is happy to help.

Phone

Direct: (541) 485-7488
Toll-free: (800) 422-7038

Email

psacustomerservice@
pacificsource.com

Health Savings Account (HSA)

Health Savings Accounts

Annual IRS contribution limits

2025 Limits
\$4,300 Individuals
\$8,550 Families

Contributions made by all parties to a Health Savings Account (HSA) can't exceed the annual HSA limit set by the Internal Revenue Service. Anyone can contribute to your HSA, but only the accountholder and employer can receive tax deductions on those contributions.

Visit hsabank.com/irs-guidelines to view the annual HSA contribution limits.

Combined annual contributions from the accountholder, employer and third parties (i.e., parent, spouse, or anyone else) must not exceed these limits.*

According to IRS guidelines, you have until the tax filing deadline to contribute to your HSA.

Catch-up contributions

Accountholders who meet the qualifications noted below are eligible to make an HSA catch-up contribution of \$1,000.

- HSA accountholder
- Age 55 or older (regardless of when in the year an accountholder turns 55)
- Not enrolled in Medicare (if an accountholder enrolls in Medicare mid-year, catch-up contributions should be prorated)

Spouses who are 55 or older and covered under the accountholder's healthcare insurance can also make a catch-up contribution into a separate HSA in their own name.

*HSA funds contributed in excess of these limits are subject to penalty and tax unless the excess and earnings are distributed prior to the due date, including any extensions for filing Federal Tax returns. Accountholders should consult with a qualified tax advisor in connection with excess contribution removal. The Internal Revenue Service requires HSA Bank to report distributions that are considered refunds of excess contributions. In order for the distribution to be accurately reported, accountholders may not withdraw the excess directly. Instead, an excess contribution refund must be requested from HSA Bank and an Excess Contribution Removal Form completed.



Visit hsabank.com or call the number on the back of your debit card for more information.



HSA, HRA, Healthcare FSA and Dependent Care FSA eligibility list

The following is a summary of common expenses claimed against Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), Healthcare Flexible Spending Accounts (HC-FSAs) and Dependent Care Flexible Spending Accounts (DC-FSAs). Due to frequent updates to the regulations governing these accounts and arrangements, this list does not guarantee reimbursement and is to be used as a guide for the submission of claims. For more information on IRS-qualified healthcare expenses, please review IRS Publication 502.

If you have an HRA, your employer's plan may only reimburse a subset of expenses. Please refer to your plan document for confirmation of reimbursable expenses under your plan.

If you are currently participating in a high-deductible health plan (HDHP) and are contributing to an HSA, you may also participate in a Limited Purpose or Healthcare FSA. These expenses are limited to dental and vision and are identified with an * in the list below.

Common IRS-qualified healthcare expenses

Acupuncture	Guide dogs	Physical therapy
Ambulance	Hearing aids and batteries	Special education services for learning disabilities (recommended by a doctor)
Artificial limbs	Infertility treatment	Speech therapy
Artificial teeth*	Inpatient alcoholism treatment	Stop-smoking programs (including nicotine gum or patches, if prescribed)
Birth control treatment	Insulin	Surgery, excluding cosmetic surgery
Blood sugar test kits for diabetics	Laboratory fees	Vaccines
Breast pumps and lactation supplies	Laser eye surgery*	Vasectomy
Chiropractor	Medical alert bracelet	Vision exam*
Contact lenses and solutions*	Medical records charges	Walker, cane
Crutches	Menstrual care products	Wheelchair
Dental treatments (including X-rays, cleanings, fillings, sealants, braces and tooth removals*)	Midwife	
Doctor's office visits and co-pays	Occlusal guards to prevent teeth grinding	
Drug addiction treatment	Orthodontics*	
Drug prescriptions	Orthotic Inserts (custom or off the shelf)	
Eyeglasses (Rx and reading)*	Over-the-counter medicines and drugs (see examples below)	
Fluoride treatments*		
Flu shots		

Common over-the-counter (OTC) medicines

Acid controllers	Eye drops*	Ointments for cuts, burns or rashes
Acne medicine	Feminine antifungal or anti-itch products	Pain relievers, such as aspirin or ibuprofen
Aids for indigestion	Hemorrhoid treatment	Sleep aids
Allergy and sinus medicine	Laxatives or stool softeners	Stomach remedies
Anti-diarrheal medicine	Lice treatments	
Baby rash ointment	Motion sickness medicines	
Cold and flu medicine	Nasal sprays or drops	

Services and products that may be eligible with a Letter of Medical Necessity completed

Weight-loss program only if it is a treatment for a specific disease diagnosed by a physician (e.g., obesity, hypertension, heart disease)
Compression hosiery/socks, antiembolism socks or hose

Massage treatment for specific ailment or diagnosis
CPR classes for adult or child

Improvements or special equipment added to a home or other capital expenditures for a physically handicapped person

Ineligible expenses

Aromatherapy
Baby bottles and cups
Baby oil
Baby wipes
Breast enhancement
Cosmetics and skin care

Cotton swabs
Dental floss
Deodorants
Hair re-growth supplies and/or services
Health club membership dues
Humidifier

Lotion
Low-calorie foods
Mouthwash
Petroleum jelly
Shampoo and conditioner
Spa salts

Eligible dependent care expenses

Au pair services
Babysitting services
Before-and after-school programs

Custodial or eldercare expenses, in-home or daycare center (not medical care)
Nursery school

Pre-kindergarten
Summer day camp (not educational in nature)

Ineligible dependent care expenses

Clothing
Food/meals
Kindergarten and higher education/tuition expenses
Overnight camp

This list is not comprehensive. It is provided to you with the understanding that HSA Bank is not engaged in rendering tax advice. The information provided is not intended to be used to avoid federal tax penalties. For more detailed information, please refer to IRS Publication 502 titled, "Medical and Dental Expenses," Catalog Number 15002Q. Publications can be ordered directly from the IRS by calling 1-800-TAXFORM. If tax advice is required, you should seek the services of a professional.



Visit hsabank.com or call the number on the back of your debit card for more information.



Life & AD&D

BASIC GROUP TERM LIFE and ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE BENEFIT HIGHLIGHTS



More than half of Americans (53%) expressed a heightened need for life insurance because of COVID-19.¹

CITY OF ROSEBURG

The group term Life and Accidental Death and Dismemberment (AD&D) insurance available through your employer gives extra protection that you and your family may need. Life and AD&D insurance offers financial protection by providing you coverage in case of an untimely death or an accident that destroys your income-earning ability. Life benefits are disbursed to your beneficiaries in a lump sum in the event of your death.



To learn more about Life and AD&D insurance, visit thehartford.com/employee-benefits/employees

COVERAGE INFORMATION

APPLICANT	LIFE COVERAGE	AD&D COVERAGE
Employee	Benefit ² : \$25,000	AD&D: Included
Dependent(s)	Spouse Benefit: \$1,000 Child(ren) Benefit: \$1,000	AD&D: Not Included

AD&D BENEFITS – PERCENT OF COVERAGE AMOUNT PER ACCIDENT

Covered accidents or death can occur up to 365 days after the accident. The total benefit for all losses due to the same accident will not exceed 100% of your coverage amount.

LOSS FROM ACCIDENT	COVERAGE
Life	100%
Both Hands or Both Feet or Sight of Both Eyes	100%
One Hand and One Foot	100%
Speech and Hearing in Both Ears	100%
Either Hand or Foot and Sight of One Eye	100%
Movement of Both Upper and Lower Limbs (Quadriplegia)	100%
Movement of Both Lower Limbs (Paraplegia)	75%
Movement of Three Limbs (Triplegia)	75%
Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia)	50%
Either Hand or Foot	50%
Sight of One Eye	50%
Speech or Hearing in Both Ears	50%
Movement of One Limb (Uniplegia)	25%
Thumb and Index Finger of Either Hand	25%

PREMIUMS

Your employer pays 100% of the premium for your and your dependents' coverage.³

²Your basic benefit will be reduced by 65% at age 65, 45% at age 70, 30% at age 75, 20% at age 80, 15% at age 85, and 10% at age 90. Reductions will be applied to the reduced amount.

ASKED & ANSWERED

WHO IS ELIGIBLE?

You are eligible if you are an active full time employee, police, management or fire management employee, excluding line firefighters and HAZMAT employees, who works at least 20 hours per week on a regularly scheduled basis.

Your spouse and child(ren) are also eligible for coverage. Any child(ren) must be under age 19 (or under age 26 if a full-time student).

CAN I INSURE MY DOMESTIC OR CIVIL UNION PARTNER?

Yes. Any reference to "spouse" in this document includes your domestic partner, civil union partner or equivalent, as recognized and allowed by applicable law.

AM I GUARANTEED COVERAGE?

This insurance is guaranteed issue coverage - it is available without having to provide information about your family's health.

AD&D is available without having to provide information about your health.

WHEN CAN I ENROLL?

Your employer will automatically enroll you and your dependent(s) for this coverage. If you have not already done so, you must designate a beneficiary.

WHEN DOES THIS INSURANCE BEGIN?

This insurance will become effective for you and your dependents on the date you become eligible.

You must be actively at work with your employer on the day your coverage takes effect. Your spouse and child(ren) must be performing normal activities and not be confined (at home or in a hospital/care facility), unless already insured with the prior carrier.

WHEN DOES THIS INSURANCE END?

This insurance will end when you (or your dependent(s)) no longer satisfy the applicable eligibility conditions, premium is unpaid, you are no longer actively working, you leave your employer, or the coverage is no longer offered.

CAN I KEEP THIS INSURANCE IF I LEAVE MY EMPLOYER OR AM NO LONGER A MEMBER OF THIS GROUP?

Yes, you can take this life coverage with you. Coverage may be continued for you and your dependent(s) under a group portability certificate or an individual conversion life certificate. Your spouse may also continue insurance in certain circumstances. The specific terms and qualifying events for conversion and portability are described in the certificate. Conversion and portability are not available for AD&D coverage. Conversion and portability are not available for AD&D coverage.

¹LIMRA, Facts About Life 2020: <https://www.limra.com/globalassets/limra/newsroom/fact-tank/fact-sheets/liam-facts-2020-final.pdf>, as viewed on October 14, 2020.

³Rates and/or benefits may be changed on a class basis.

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Voluntary Life & AD&D

VOLUNTARY GROUP TERM LIFE and ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE BENEFIT HIGHLIGHTS



More than half of Americans (53%) expressed a heightened need for life insurance because of COVID-19.¹

CITY OF ROSEBURG

The group term Life and Accidental Death and Dismemberment (AD&D) insurance available through your employer is a smart, affordable way to purchase the extra protection that you and your family may need. Life and AD&D insurance offers financial protection by providing you coverage in case of an untimely death or an accident that destroys your income-earning ability. Life benefits are disbursed to your beneficiaries in a lump sum in the event of your death.



To learn more about Life and AD&D insurance, visit thehartford.com/employee-benefits/employees

COVERAGE INFORMATION

APPLICANT	LIFE COVERAGE	AD&D COVERAGE
Employee	Benefit ² : Increments of \$10,000 Maximum: \$300,000	AD&D: Included
Spouse	Benefit ² : Increments of \$10,000. Maximum: the lesser of 100% of your supplemental coverage or \$250,000	AD&D: Included
Child(ren)	Benefit: \$10,000	AD&D: Included

AD&D BENEFITS – PERCENT OF COVERAGE AMOUNT PER ACCIDENT

Covered accidents or death can occur up to 365 days after the accident. The total benefit for all losses due to the same accident will not exceed 100% of your coverage amount.

LOSS FROM ACCIDENT	COVERAGE
Life	100%
Both Hands or Both Feet or Sight of Both Eyes	100%
One Hand and One Foot	100%
Speech and Hearing in Both Ears	100%
Either Hand or Foot and Sight of One Eye	100%
Movement of Both Upper and Lower Limbs (Quadriplegia)	100%
Movement of Both Lower Limbs (Paraplegia)	75%
Movement of Three Limbs (Triplegia)	75%
Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia)	50%
Either Hand or Foot	50%
Sight of One Eye	50%
Speech or Hearing in Both Ears	50%
Movement of One Limb (Uniplegia)	25%
Thumb and Index Finger of Either Hand	25%

³Your supplemental benefit will be reduced by 65% at age 65, 45% at age 70, 30% at age 75, 20% at age 80, 15% at age 85, and 10% at age 90. Reductions will be applied to the reduced amount.

PREMIUMS

See the Life Premium Worksheet.³

ASKED & ANSWERED

WHO IS ELIGIBLE?

You are eligible if you are an active full time employee who works at least 20 hours per week on a regularly scheduled basis.

Your spouse and child(ren) are also eligible for coverage. Any child(ren) must be under age 26.

CAN I INSURE MY DOMESTIC OR CIVIL UNION PARTNER?

Yes. Any reference to "spouse" in this document includes your domestic partner, civil union partner or equivalent, as recognized and allowed by applicable law.

AM I GUARANTEED COVERAGE?

If you are newly eligible and elect an amount that exceeds the guaranteed issue amount of \$100,000, you will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective. If you were previously eligible and are electing coverage for the first time or electing to increase your current coverage, you will need to provide evidence of insurability that is satisfactory to The Hartford before coverage can become effective.

If you are newly eligible and elect an amount that exceeds the guaranteed issue amount of \$40,000, your spouse will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective. If you were previously eligible and are electing coverage for the first time or electing to increase your spouse's current coverage, your spouse will need to provide evidence of insurability that is satisfactory to The Hartford before coverage can become effective.

This insurance is guaranteed issue coverage – it is available without having to provide information about your child(ren)'s health.

AD&D is available without having to provide information about your or your family's health.

HOW DO I PAY FOR THIS INSURANCE?

Premiums will be automatically paid through payroll deduction, as authorized by you during the enrollment process. This ensures you don't have to worry about writing a check or missing a payment.

WHEN CAN I ENROLL?

You may enroll during any scheduled enrollment period within 31 days of the date you have a change in family status, or within 31 days of the completion of any eligibility waiting period established by your employer.

WHEN DOES THIS INSURANCE BEGIN?

The initial effective date of this coverage is 7/1/2022. Subject to any eligibility waiting period established by your employer, if you enroll for coverage prior to this date, insurance will become effective on this date. If you enroll for coverage after this date, insurance will become effective in accordance with the terms of the certificate (usually the first day of the month following the date you elect coverage).

You must be actively at work with your employer on the day your coverage takes effect.

Your spouse and child(ren) must be performing normal activities and not be confined (at home or in a hospital/care facility), unless already insured with the prior carrier.

WHEN DOES THIS INSURANCE END?

This insurance will end when you (or your dependent(s)) no longer satisfy the applicable eligibility conditions, premium is unpaid, or the coverage is no longer offered.

CAN I KEEP THIS INSURANCE IF I LEAVE MY EMPLOYER OR AM NO LONGER A MEMBER OF THIS GROUP?

Yes, you can take this life coverage with you. Coverage may be continued for you and your dependent(s) under a group portability certificate or an individual conversion life certificate. Your spouse may also continue insurance in certain circumstances. The specific terms and qualifying events for conversion and portability are described in the certificate. Conversion and portability are not available for AD&D coverage.

¹LIMRA, Facts About Life 2020: <https://www.limra.com/globalassets/limra/newsroom/fact-tank/fact-sheets/liam-facts-2020-final.pdf>, as viewed on October 14, 2020.

³Rates and/or benefits may be changed on a class basis. Rates are based on the age of the insured person and increase on the policy anniversary date on or following your birthday as you enter each new age category.

The Buck's Got Your Back[®]

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5962a and 5962b NS 07/21

LIMITATIONS & EXCLUSIONS



This insurance coverage includes certain limitations and exclusions. The certificate details all provisions, limitations, and exclusions for this insurance coverage. A copy of the certificate can be obtained from your employer.

GROUP LIFE INSURANCE

GENERAL LIMITATIONS AND EXCLUSIONS

- Your basic benefit will be reduced by 65% at age 65, 45% at age 70, 30% at age 75, 20% at age 80, 15% at age 85, and 10% at age 90. Reductions will be applied to the reduced amount.
- Your supplemental benefit will be reduced by 65% at age 65, 45% at age 70, 30% at age 75, 20% at age 80, 15% at age 85, and 10% at age 90. Reductions will be applied to the reduced amount.
- A supplemental or voluntary life benefit will not be paid if death occurs by suicide within two years (or as allowed by state law) of purchasing this coverage.
- You and your dependent(s) must be citizens or legal residents of the United States, its territories and protectorates.

DEPENDENT LIMITATIONS AND EXCLUSIONS

- Coverage may only be elected for dependents when you elect and are approved for coverage for yourself.
- Coverage may not be elected for a dependent who has employee coverage under this certificate.
- Coverage may not be elected for a dependent who is in active full-time military service.
- Child(ren) may only be covered as a dependent of one employee.
- Infants may receive a reduced benefit prior to the age of six months.

5962a NS 05/21 Life Form Series includes GBD-1000, GBD-1100, or state equivalent.

GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

GENERAL LIMITATIONS AND EXCLUSIONS

- Your basic benefit will be reduced by 65% at age 65, 45% at age 70, 30% at age 75, 20% at age 80, 15% at age 85, and 10% at age 90. Reductions will be applied to the reduced amount.
- Your supplemental benefit will be reduced by 65% at age 65, 45% at age 70, 30% at age 75, 20% at age 80, 15% at age 85, and 10% at age 90. Reductions will be applied to the reduced amount.
- This insurance does not cover losses caused by:
 - Sickness; disease; or any treatment for either
 - Any infection, except certain ones caused by an accidental cut or wound
 - Intentionally self-inflicted injury, suicide or suicide attempt
 - War or act of war, whether declared or not
 - Injury sustained while in the armed forces of any country or international authority
 - Taking prescription or illegal drugs unless prescribed by or administered by a licensed physician
 - Injury sustained while committing or attempting to commit a felony
 - Injury sustained while driving while intoxicated
- You and your dependent(s) must be citizens or legal residents of the United States, its territories and protectorates.

DEPENDENT LIMITATIONS AND EXCLUSIONS

- Coverage may only be elected for dependents when you elect and are approved for coverage for yourself.
- Coverage may not be elected for a dependent who has employee coverage under this certificate.
- Child(ren) may only be covered as a dependent of one employee.

DEFINITIONS

- Loss means, with regard to hands and feet, actual severance through or above wrist or ankle joints; with regard to sight, speech or hearing, entire and irrecoverable loss thereof; with regard to thumb and index finger, actual severance through or above the metacarpophalangeal joints; with regard to movement, complete and irreversible paralysis of such limbs.
- Injury means bodily injury resulting directly from an accident, independent of all other causes, which occurs while you or your dependent(s) have coverage.

5962c NS 05/21 Accident Form Series includes GBD-1000, GBD-1300, or state equivalent.

GROUP LONG TERM DISABILITY INSURANCE

LIMITATIONS AND EXCLUSIONS

GENERAL EXCLUSIONS

- You must be under the regular care of a physician to receive benefits.
- You cannot receive disability insurance benefit payments for disabilities that are caused or contributed to by:
 - War or act of war (declared or not)
 - The commission of, or attempt to commit a felony
 - An intentionally self-inflicted injury
 - Your being engaged in an illegal occupation

PRE-EXISTING CONDITIONS

- Your insurance excludes the benefits you can receive for pre-existing conditions. In general, if you were diagnosed or received care for a condition before the effective date of your certificate, you will be covered for a disability due to that condition only if:
 - You have not received treatment for your condition for 3 months before the effective date of your insurance, or
 - You have been insured under this coverage for 12 months prior to your disability commencing, so you can receive benefits even if you're receiving treatment, or
 - You have already satisfied the pre-existing condition requirement of your previous insurer

LIMITATIONS

- **Mental Illness and Substance Abuse Limitation.** If you are disabled because of Mental Illness or because of alcoholism or the use of narcotics, sedatives, stimulants, hallucinogens or other similar substance, benefits will be payable for a maximum of 24 months in your lifetime, unless at the end of that 24 months, you are confined to a hospital or other place licensed to provide medical care for your disability.

OFFSETS

- Your benefit payments will be reduced by other income you receive or are eligible to receive due to your disability, such as:
 - Social Security disability insurance (please see next section for exceptions)
 - Workers' compensation
 - Other employer-based insurance coverage you may have
 - Unemployment benefits
 - Settlements or judgments for income loss
 - Retirement benefits that your employer fully or partially pays for (such as a pension plan)
- Your benefit payments will not be reduced by certain kinds of other income, such as:
 - Retirement benefits if you were already receiving them before you became disabled
 - Retirement benefits that are funded by your after-tax contributions your personal savings, investments, IRAs or Keoghs profit-sharing
 - Most personal disability policies
 - Social Security cost-of-living increases

This example is for purposes of illustrating the effect of the benefit reductions and is not intended to reflect the situation of a particular claimant under the Policy:

Insured's monthly [Pre-Disability Earnings/Basic Monthly Pay] \$3,000
Long term disability benefits percentage x 60%
Unreduced maximum benefit \$1,800
Less Social Security disability benefit per month - \$900
Less state disability income benefit per month - \$300
Total amount of long term disability benefit per month \$600

THIS POLICY PROVIDES LIMITED BENEFITS.

This limited benefit plan (1) does not constitute major medical coverage, and (2) does not satisfy the individual mandate of the Affordable Care Act (ACA) because the coverage does not meet the requirements of minimum essential coverage.

In New York: This Disability policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.

5962d NS 05/21 Disability Form Series includes GBD-1000, GBD-1200, or state equivalent.

The Buck's Got Your Back®

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including underwriting company Hartford Life and Accident Insurance Company. Home Office is Hartford, CT. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the underwriting company listed above detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued. This Benefit Highlights document explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this document and the policy, the terms of the policy apply. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder. Benefits are subject to state availability. © 2020 The Hartford.

Premium Worksheet



Rates and/or benefits may be changed on a class basis. Rates are based on the employee's age and increase as you enter each new age category.

SUPPLEMENTAL TERM LIFE INSURANCE												
Monthly Premium Amount (Cost per Pay Period – 12/Year)												
Benefit	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
\$10,000	\$0.90	\$0.85	\$0.97	\$1.10	\$1.92	\$2.97	\$4.72	\$7.40	\$10.38	\$16.81	\$33.35	\$68.67
\$20,000	\$1.80	\$1.70	\$1.94	\$2.20	\$3.84	\$5.94	\$9.44	\$14.80	\$20.76	\$33.62	\$66.70	\$137.34
\$30,000	\$2.70	\$2.55	\$2.91	\$3.30	\$5.76	\$8.91	\$14.16	\$22.20	\$31.14	\$50.43	\$100.05	\$206.01
\$40,000	\$3.60	\$3.40	\$3.88	\$4.40	\$7.68	\$11.88	\$18.88	\$29.60	\$41.52	\$67.24	\$133.40	\$274.68
\$50,000	\$4.50	\$4.25	\$4.85	\$5.50	\$9.60	\$14.85	\$23.60	\$37.00	\$51.90	\$84.05	\$166.75	\$343.35
\$60,000	\$5.40	\$5.10	\$5.82	\$6.60	\$11.52	\$17.82	\$28.32	\$44.40	\$62.28	\$100.86	\$200.10	\$412.02
\$70,000	\$6.30	\$5.95	\$6.79	\$7.70	\$13.44	\$20.79	\$33.04	\$51.80	\$72.66	\$117.67	\$233.45	\$480.69
\$80,000	\$7.20	\$6.80	\$7.76	\$8.80	\$15.36	\$23.76	\$37.76	\$59.20	\$83.04	\$134.48	\$266.80	\$549.36
\$90,000	\$8.10	\$7.65	\$8.73	\$9.90	\$17.28	\$26.73	\$42.48	\$66.60	\$93.42	\$151.29	\$300.15	\$618.03
\$100,000	\$9.00	\$8.50	\$9.70	\$11.00	\$19.20	\$29.70	\$47.20	\$74.00	\$103.80	\$168.10	\$333.50	\$686.70
\$110,000	\$9.90	\$9.35	\$10.67	\$12.10	\$21.12	\$32.67	\$51.92	\$81.40	\$114.18	\$184.91	\$366.85	\$755.37
\$120,000	\$10.80	\$10.20	\$11.64	\$13.20	\$23.04	\$35.64	\$56.64	\$88.80	\$124.56	\$201.72	\$400.20	\$824.04
\$130,000	\$11.70	\$11.05	\$12.61	\$14.30	\$24.96	\$38.61	\$61.36	\$96.20	\$134.94	\$218.53	\$433.55	\$892.71
\$140,000	\$12.60	\$11.90	\$13.58	\$15.40	\$26.88	\$41.58	\$66.08	\$103.60	\$145.32	\$235.34	\$466.90	\$961.38
\$150,000	\$13.50	\$12.75	\$14.55	\$16.50	\$28.80	\$44.55	\$70.80	\$111.00	\$155.70	\$252.15	\$500.25	\$1,030.05
\$160,000	\$14.40	\$13.60	\$15.52	\$17.60	\$30.72	\$47.52	\$75.52	\$118.40	\$166.08	\$268.96	\$533.60	\$1,098.72
\$170,000	\$15.30	\$14.45	\$16.49	\$18.70	\$32.64	\$50.49	\$80.24	\$125.80	\$176.46	\$285.77	\$566.95	\$1,167.39
\$180,000	\$16.20	\$15.30	\$17.46	\$19.80	\$34.56	\$53.46	\$84.96	\$133.20	\$186.84	\$302.58	\$600.30	\$1,236.06
\$190,000	\$17.10	\$16.15	\$18.43	\$20.90	\$36.48	\$56.43	\$89.68	\$140.60	\$197.22	\$319.39	\$633.65	\$1,304.73
\$200,000	\$18.00	\$17.00	\$19.40	\$22.00	\$38.40	\$59.40	\$94.40	\$148.00	\$207.60	\$336.20	\$667.00	\$1,373.40
\$210,000	\$18.90	\$17.85	\$20.37	\$23.10	\$40.32	\$62.37	\$99.12	\$155.40	\$217.98	\$353.01	\$700.35	\$1,442.07
\$220,000	\$19.80	\$18.70	\$21.34	\$24.20	\$42.24	\$65.34	\$103.84	\$162.80	\$228.36	\$369.82	\$733.70	\$1,510.74
\$230,000	\$20.70	\$19.55	\$22.31	\$25.30	\$44.16	\$68.31	\$108.56	\$170.20	\$238.74	\$386.63	\$767.05	\$1,579.41
\$240,000	\$21.60	\$20.40	\$23.28	\$26.40	\$46.08	\$71.28	\$113.28	\$177.60	\$249.12	\$403.44	\$800.40	\$1,648.08
\$250,000	\$22.50	\$21.25	\$24.25	\$27.50	\$48.00	\$74.25	\$118.00	\$185.00	\$259.50	\$420.25	\$833.75	\$1,716.75
\$260,000	\$23.40	\$22.10	\$25.22	\$28.60	\$49.92	\$77.22	\$122.72	\$192.40	\$269.88	\$437.06	\$867.10	\$1,785.42
\$270,000	\$24.30	\$22.95	\$26.19	\$29.70	\$51.84	\$80.19	\$127.44	\$199.80	\$280.26	\$453.87	\$900.45	\$1,854.09
\$280,000	\$25.20	\$23.80	\$27.16	\$30.80	\$53.76	\$83.16	\$132.16	\$207.20	\$290.64	\$470.68	\$933.80	\$1,922.76
\$290,000	\$26.10	\$24.65	\$28.13	\$31.90	\$55.68	\$86.13	\$136.88	\$214.60	\$301.02	\$487.49	\$967.15	\$1,991.43
\$300,000	\$27.00	\$25.50	\$29.10	\$33.00	\$57.60	\$89.10	\$141.60	\$222.00	\$311.40	\$504.30	\$1,000.50	\$2,060.10

SPOUSE/PARTNER SUPPLEMENTAL TERM LIFE INSURANCE												
Monthly Premium Amount (Cost per Pay Period – 12/Year)												
Benefit	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
\$10,000	\$0.90	\$0.85	\$0.97	\$1.10	\$1.92	\$2.97	\$4.72	\$7.40	\$10.38	\$16.81	\$33.35	\$68.67
\$20,000	\$1.80	\$1.70	\$1.94	\$2.20	\$3.84	\$5.94	\$9.44	\$14.80	\$20.76	\$33.62	\$66.70	\$137.34
\$30,000	\$2.70	\$2.55	\$2.91	\$3.30	\$5.76	\$8.91	\$14.16	\$22.20	\$31.14	\$50.43	\$100.05	\$206.01
\$40,000	\$3.60	\$3.40	\$3.88	\$4.40	\$7.68	\$11.88	\$18.88	\$29.60	\$41.52	\$67.24	\$133.40	\$274.68
\$50,000	\$4.50	\$4.25	\$4.85	\$5.50	\$9.60	\$14.85	\$23.60	\$37.00	\$51.90	\$84.05	\$166.75	\$343.35
\$60,000	\$5.40	\$5.10	\$5.82	\$6.60	\$11.52	\$17.82	\$28.32	\$44.40	\$62.28	\$100.86	\$200.10	\$412.02
\$70,000	\$6.30	\$5.95	\$6.79	\$7.70	\$13.44	\$20.79	\$33.04	\$51.80	\$72.66	\$117.67	\$233.45	\$480.69
\$80,000	\$7.20	\$6.80	\$7.76	\$8.80	\$15.36	\$23.76	\$37.76	\$59.20	\$83.04	\$134.48	\$266.80	\$549.36
\$90,000	\$8.10	\$7.65	\$8.73	\$9.90	\$17.28	\$26.73	\$42.48	\$66.60	\$93.42	\$151.29	\$300.15	\$618.03

\$100,000	\$9.00	\$8.50	\$9.70	\$11.00	\$19.20	\$29.70	\$47.20	\$74.00	\$103.80	\$168.10	\$333.50	\$686.70
\$110,000	\$9.90	\$9.35	\$10.67	\$12.10	\$21.12	\$32.67	\$51.92	\$81.40	\$114.18	\$184.91	\$366.85	\$755.37
\$120,000	\$10.80	\$10.20	\$11.64	\$13.20	\$23.04	\$35.64	\$56.64	\$88.80	\$124.56	\$201.72	\$400.20	\$824.04
\$130,000	\$11.70	\$11.05	\$12.61	\$14.30	\$24.96	\$38.61	\$61.36	\$96.20	\$134.94	\$218.53	\$433.55	\$892.71
\$140,000	\$12.60	\$11.90	\$13.58	\$15.40	\$26.88	\$41.58	\$66.08	\$103.60	\$145.32	\$235.34	\$466.90	\$961.38
\$150,000	\$13.50	\$12.75	\$14.55	\$16.50	\$28.80	\$44.55	\$70.80	\$111.00	\$155.70	\$252.15	\$500.25	\$1,030.05
\$160,000	\$14.40	\$13.60	\$15.52	\$17.60	\$30.72	\$47.52	\$75.52	\$118.40	\$166.08	\$268.96	\$533.60	\$1,098.72
\$170,000	\$15.30	\$14.45	\$16.49	\$18.70	\$32.64	\$50.49	\$80.24	\$125.80	\$176.46	\$285.77	\$566.95	\$1,167.39
\$180,000	\$16.20	\$15.30	\$17.46	\$19.80	\$34.56	\$53.46	\$84.96	\$133.20	\$186.84	\$302.58	\$600.30	\$1,236.06
\$190,000	\$17.10	\$16.15	\$18.43	\$20.90	\$36.48	\$56.43	\$89.68	\$140.60	\$197.22	\$319.39	\$633.65	\$1,304.73
\$200,000	\$18.00	\$17.00	\$19.40	\$22.00	\$38.40	\$59.40	\$94.40	\$148.00	\$207.60	\$336.20	\$667.00	\$1,373.40
\$210,000	\$18.90	\$17.85	\$20.37	\$23.10	\$40.32	\$62.37	\$99.12	\$155.40	\$217.98	\$353.01	\$700.35	\$1,442.07
\$220,000	\$19.80	\$18.70	\$21.34	\$24.20	\$42.24	\$65.34	\$103.84	\$162.80	\$228.36	\$369.82	\$733.70	\$1,510.74
\$230,000	\$20.70	\$19.55	\$22.31	\$25.30	\$44.16	\$68.31	\$108.56	\$170.20	\$238.74	\$386.63	\$767.05	\$1,579.41
\$240,000	\$21.60	\$20.40	\$23.28	\$26.40	\$46.08	\$71.28	\$113.28	\$177.60	\$249.12	\$403.44	\$800.40	\$1,648.08
\$250,000	\$22.50	\$21.25	\$24.25	\$27.50	\$48.00	\$74.25	\$118.00	\$185.00	\$259.50	\$420.25	\$833.75	\$1,716.75

CHILD(REN) SUPPLEMENTAL TERM LIFE INSURANCE	
Monthly Premium Amount (Cost per Pay Period – 12/Year)	
Benefit Amount	Cost For All Children
\$10,000	\$1.60

5962a NS 07/21 Life Form Series includes GBD-1000, GBD-1100, or state equivalent.

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE							
Monthly Premium Amount (Cost per Pay Period – 12/Year)							
Benefit Amount	Premium Amount	Benefit Amount	Premium Amount	Benefit Amount	Premium Amount	Benefit Amount	Premium Amount
\$10,000	\$0.43	\$90,000	\$3.87	\$170,000	\$7.31	\$250,000	\$10.75
\$20,000	\$0.86	\$100,000	\$4.30	\$180,000	\$7.74	\$260,000	\$11.18
\$30,000	\$1.29	\$110,000	\$4.73	\$190,000	\$8.17	\$270,000	\$11.61
\$40,000	\$1.72	\$120,000	\$5.16	\$200,000	\$8.60	\$280,000	\$12.04
\$50,000	\$2.15	\$130,000	\$5.59	\$210,000	\$9.03	\$290,000	\$12.47
\$60,000	\$2.58	\$140,000	\$6.02	\$220,000	\$9.46	\$300,000	\$12.90
\$70,000	\$3.01	\$150,000	\$6.45	\$230,000	\$9.89		
\$80,000	\$3.44	\$160,000	\$6.88	\$240,000	\$10.32		

SPOUSE/PARTNER VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE							
Monthly Premium Amount (Cost per Pay Period – 12/Year)							
Benefit Amount	Premium Amount	Benefit Amount	Premium Amount	Benefit Amount	Premium Amount	Benefit Amount	Premium Amount
\$10,000	\$0.43	\$80,000	\$3.44	\$150,000	\$6.45	\$220,000	\$9.46
\$20,000	\$0.86	\$90,000	\$3.87	\$160,000	\$6.88	\$230,000	\$9.89
\$30,000	\$1.29	\$100,000	\$4.30	\$170,000	\$7.31	\$240,000	\$10.32
\$40,000	\$1.72	\$110,000	\$4.73	\$180,000	\$7.74	\$250,000	\$10.75
\$50,000	\$2.15	\$120,000	\$5.16	\$190,000	\$8.17		
\$60,000	\$2.58	\$130,000	\$5.59	\$200,000	\$8.60		
\$70,000	\$3.01	\$140,000	\$6.02	\$210,000	\$9.03		

CHILD(REN) VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE	
Monthly Premium Amount (Cost per Pay Period – 12/Year)	
Benefit Amount	Cost For All Children
\$10,000	\$0.60

5962a NS 07/21 Life Form Series includes GBD-1000, GBD-1100, or state equivalent.

Long Term Disability

GROUP LONG-TERM DISABILITY INSURANCE BENEFIT HIGHLIGHTS



More than 1 in 4 adults in the U.S. has some type of disability.¹

CITY OF ROSEBURG

A disability can happen to anyone. Long-term disability insurance helps protect your paycheck if you're unable to work for a long period of time after a serious condition, injury or sickness.



To learn more about Long-Term Disability insurance, visit thehartford.com/employee-benefits/employees

COVERAGE INFORMATION

BENEFIT PERCENTAGE (PERCENT OF YOUR EARNINGS)	MAXIMUM	MINIMUM (BASED ON MONTHLY INCOME LOSS BEFORE THE DEDUCTION OF OTHER INCOME BENEFITS)	BENEFIT STARTS (ELIMINATION PERIOD)	BENEFIT DURATION
60%	\$5,000	The greater of \$100 or 10% of the benefit	After 90 days disabled	Disabled before: Age 63 Benefit duration: As long as you are disabled Benefit duration maximum: The greater of your Social Security Normal Retirement Age or 4 years

PREMIUMS

Your employer pays 100% of the premium for your coverage.²

ASKED & ANSWERED

WHO IS ELIGIBLE?

You are eligible if you are an active full time employee, police, management or fire management employee, excluding line firefighters and HAZMAT employees, who works at least 20 hours per week on a regularly scheduled basis.

AM I GUARANTEED COVERAGE?

This insurance is guaranteed issue coverage – it is available without having to provide information about your health.

This coverage is subject to a pre-existing condition exclusion. Please refer to the Limitations & Exclusions sheet provided with this benefit highlights sheet for more information on limitations and exclusions, such as pre-existing conditions.

WHEN CAN I ENROLL?

Your employer will automatically enroll you for this coverage.

WHEN DOES THIS INSURANCE BEGIN?

This insurance will become effective on the date you become eligible. You must be actively at work with your employer on the day your coverage takes effect.

WHEN DOES THIS INSURANCE END?

This insurance will end when you no longer satisfy the applicable eligibility conditions, premium is unpaid, you leave your employer, or the coverage is no longer offered.

WHAT DOES IT MEAN TO BE DISABLED?

Disability is defined in The Hartford's certificate with your employer. Typically, disability means that you cannot perform one or more of the essential duties of your occupation due to injury, sickness, pregnancy or other medical condition covered by the insurance, and as a result, your current monthly earnings are less than 80% of your pre-disability earnings. Once you have been disabled for 2 years following the

elimination period, you must be prevented from performing one or more of the essential duties of any occupation and as a result, your current monthly earnings are less than or equal to 60% of your pre-disability earnings.

Pre-disability earnings are defined in your policy.

¹Center for Disease Control and Prevention "Disability Impacts All of Us," September 2020: <https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html>, as viewed on 10/14/2020.

²Rates and/or benefits may be changed on a class basis.

The Buck's Got Your Back®

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including underwriting company Hartford Life and Accident Insurance Company. Home Office is Hartford, CT. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the underwriting company listed above detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued. This Benefit Highlights document explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this document and the policy, the terms of the policy apply. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder. Benefits are subject to state availability. © 2020 The Hartford.

The Hartford compensates both internal and external producers, as well as others, for the sale and service of our products. For additional information regarding Hartford's compensation practices, please review our website <http://thehartford.com/group-benefits-producer-compensation>. Disability Form Series includes GBD-1000, GBD-1200, or state equivalent.

TRAVEL ASSISTANCE AND IDENTITY THEFT SUPPORT SERVICES

WHAT DO I DO FIRST?

In the event of a life-threatening emergency, call the local emergency authorities first to receive immediate assistance and then contact **International Medical Group (IMG)**.

WHAT TO HAVE READY

- Your employer’s name
- Phone number where you can be reached

EVEN THE BEST PLANNED TRIPS CAN BE FULL OF SURPRISES

The best laid travel plans can go wrong, leaving travelers vulnerable and potentially unable to find the right help. When the unexpected happens far from home, it’s important to know whom to call for assistance. If you’re covered under a group policy with The Hartford, you and your family may have access to travel assistance and identity theft support services provided by International Medical Group (IMG).¹

Since 1990, IMG has provided global travel assistance services to millions of customers worldwide. IMG has extensive experience handling complex and remote medical transport situations, as well as providing support for travel concerns when they arise. Their team of international, multilingual specialists are accustomed to working across time zones and with different languages and currencies. Utilizing IMG’s extensive global network of medical care providers, the on-site 24/7/365 U.S.-based call center is available day or night to arrange high-quality care you can depend on.

Additionally, IMG stands ready to provide identity theft support services that include assistance on the steps to take once a theft has occurred.

TRAVEL EMERGENCY TRANSPORT SERVICES

IMG will provide payment for transportation expenses associated with the following services up to a \$1 million combined single limit per person. For services to be paid for by IMG, they must be contacted to approve and arrange all services in advance.²

- **Medical evacuation and repatriation:** IMG will arrange a medically necessary transportation to a medical facility capable of providing adequate treatment.
- **Repatriation of mortal remains:** IMG will arrange and coordinate the preparation and transportation of mortal remains to the deceased’s place of residence or to the place of burial.
- **Return of dependent children:** IMG can arrange the transport of dependent children home or to the residence of a family member in the event the parent is hospitalized due to an unforeseen medical situation and the children are left unattended.
- **Return of travel companion:** If someone is hospitalized due to an unforeseen medical situation, IMG can arrange for a travel companion to accompany them on their medical evacuation or repatriation back home.
- **Visit by a family member or friend:** If someone is traveling alone and hospitalized due to an unforeseen medical situation and an emergency evacuation or repatriation is not imminent, IMG can arrange to bring a chosen family member or friend to their location.

(Please cut here and keep in your wallet.) ✂

INTERNATIONAL MEDICAL GROUP (IMG) CONTACT INFORMATION

U.S. and Canada: 800-243-6108 (toll-free)
 Outside U.S.: 202-828-5885
 assist@imglobal.com





Travel assistance and identity theft support services through IMG are available to eligible employees who are covered under certain group insurance policies from The Hartford. The services are also available to eligible employees' spouses and dependent children up to age 26. Identity Theft Support and Pre-Trip Services are available 24/7/365. The services listed for Travel Emergency Transport Services and Travel Medical Assistance are only available when traveling more than 100 miles from home (or while in a foreign country) and while traveling for 90 consecutive days or less.

TRAVEL MEDICAL ASSISTANCE

IMG will provide assistance services only for the following items:

- **Medical and dental referrals:** IMG provides referrals within their global medical network that includes physicians, clinics, hospitals and other healthcare providers worldwide.
- **Medical monitoring:** IMG will continually monitor the medical situation until the traveler is either healthy or transferred to their home hospital. IMG medical staff review and analyze each situation to ensure quality of care.
- **Pre-transport patient assessments:** Prior to coordination of a medical transport such as an emergency evacuation, IMG provides an assessment to determine fitness to travel and identify any risks associated with the transfer.
- **Arrange or facilitate filling prescriptions:** If a traveler requires an emergency prescription, IMG can arrange for or facilitate filling prescriptions locally.
- **Replacement of medical devices and corrective lenses:** IMG will arrange for the replacement of corrective lenses or medical devices if they are lost, stolen or broken during travel.
- **Emergency medical payments:** Upon securing payment or a guarantee to reimburse from the travelers' insurance provider, IMG will coordinate payment to the treating facility.

ADDITIONAL TRAVEL ASSISTANCE SERVICES

IMG will provide assistance services only for the following items:

- **Pre-trip and cultural information:** IMG can provide certain country-specific information such as travel advisories, passport and visa information, general info on local customs and more.
- **Lost luggage assistance:** If luggage is lost, IMG can communicate with commercial flight carriers to coordinate the return of lost luggage and file the requisite reports.
- **Lost document assistance:** When a passport, visa, or other crucial document is lost during travel, IMG can provide support on the next steps to obtain emergency replacements.
- **Legal referrals:** IMG can provide the contact information for local attorneys.

If travel assistance is needed, please contact IMG at **800-243-6108** (U.S. only) or 202-828-5885 (Outside U.S.) or assist@imglobal.com.

- **Emergency cash:** If a traveler's money is lost or stolen, this service provides for the coordination of a cash advance through Western Union.
- **Pet and vehicle return:** IMG will assist with returning a pet home or returning a rented vehicle in the event of an emergency while traveling.

IDENTITY THEFT SUPPORT SERVICES


IMG will provide assistance services only for the following items:

- **Education:** Assistance to help prevent theft and support on the steps to take following theft.
- **Credit bureau notification:** Assistance notifying all three major credit reporting agencies to obtain a copy of your credit report and place an alert on your records.
- **Credit information review:** Assistance to review your credit information and history over the phone to determine if fraud or theft has occurred.
- **Identity theft affidavit:** Assistance with completing an identity theft affidavit and direction on who to send it to.
- **Card replacement:** Assistance replacing credit, debit and membership cards.
- **Translation services:** Assistance when you're overseas and need help communicating with the local police to file a report of an identity theft incident.

(Please cut here and keep in your wallet.) ✂

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Travel Assistance and Identity Theft Support Services are provided by International Medical Group (IMG). IMG is not affiliated with The Hartford. None of the services provided by IMG as a part of the Travel Assistance and Identity Theft Support services are insurance.



THE HARTFORD

This card is not proof of insurance.

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² IMG will provide payment for third-party transport expenses related to a qualified medical evacuation or repatriation, return of dependent children, return of travel companion, return of mortal remains, or visit of a family member or friend. Payment will be limited to \$1,000,000 combined single limit per person; however, any non-transport related expenses, such as medical expenses, related to these services is the responsibility of the traveler. IMG will not provide evacuation services if the transport is not medically advisable or necessary or if the injury or illness can be treated locally. All emergency medical transport services must be arranged by IMG-designated personnel to be eligible for services under this program. No payment for reimbursement of services not approved by IMG in advance will be accepted.



GETTING SUPPORT SHOULD BE EASY

EXTRAS THAT SUPPORT AND ASSIST

For access over the phone,
simply call toll-free

800-96-HELPS
(800-964-3577)

Visit guidanceresources.com
to access hundreds of personal
health topics and resources for
child care, elder care, attorneys
or financial planners.

If you're a first-time user, click
on the **Register** tab.

1. In the Organization Web ID
field, enter: **HLF902**
2. In the Company Name field
at the bottom of
personalization page enter:
ABILI
3. After selecting "**Ability
Assist program**", create
your own confidential user
name and password.



Snap a photo with a mobile device
to capture information above.

For employees covered under a fully insured Group policy or Leave Management services with The Hartford.

Life presents complex challenges. If the unexpected happens, you should have simple solutions to help cope with the stress and life changes that may result. That's why The Hartford Ability Assist® Counseling Services, offered by ComPsych®,¹ can play such an important role. Our straightforward approach takes the complexity out of benefits when life throws you a curve.

COMPASSIONATE SOLUTIONS FOR COMMON CHALLENGES

From everyday issues like job pressures, relationships and retirement planning to highly impactful issues like grief, loss, or a disability, Ability Assist is your resource for professional support.

You and your family, including spouse and dependents can access Ability Assist at any time, as long as you are covered under a fully insured Group policy or Leave Management Services with The Hartford.

SERVICE FEATURES

The service includes up to three face-to-face emotional counseling sessions per occurrence per year. This means you and your family members won't have to share visits. You can each get counseling help for your own unique needs. Work-life services and counseling for your legal, financial, medical and benefit-related concerns are also available by phone.

ABILITY ASSIST COUNSELING SERVICES

Emotional or Work-Life Counseling

Helps address stress, relationship or other personal issues you or your dependents may face. It is staffed by GuidanceExpertsSM – highly trained master’s-level clinicians – who listen to concerns and quickly make referrals to in-person counseling or other valuable resources. Situations may include:

- Job pressures
- Relationship/marital conflicts
- Stress, anxiety and depression
- Work/school disagreements
- Substance abuse
- Child and elder care referral services

Financial Information and Resources

Provides unlimited telephonic support for the complicated financial decisions you or your dependents may face. Speak by phone with a Certified Public Accountant and Certified Financial Planners on a wide range of financial issues. Topics may include:

- Managing a budget
- Retirement
- Getting out of debt
- Tax questions
- Saving for college

Legal Support and Resources

Offers unlimited telephonic assistance if legal uncertainties arise. Talk to an attorney by phone about the issues that are important to you or your dependents. If you require representation, you’ll be referred to a qualified attorney in your area with a 25% reduction in customary legal fees thereafter. Topics may include:

- Debt and bankruptcy
- Guardianship
- Buying a home
- Power of attorney
- Divorce

Health and Benefit Services

HealthChampionSM is a service that supports you through all aspects of your health care issues.² HealthChampion is staffed by both administrative and clinical experts who understand the nuances of any given health care concern. Situations may include:

- One-on-one review of your health concerns
- Preparation for upcoming doctor’s visits/lab work/tests/surgeries
- Answers regarding diagnosis and treatment options
- Coordination with appropriate health care plan provider(s)
- An easy-to-understand explanation of your benefits—what’s covered and what’s not
- Cost estimation for covered/non-covered treatment
- Guidance on claims and billing issues
- Fee/payment plan negotiation

Check with your benefits manager for more information on **Ability Assist Counseling Services**



Business Insurance
Employee Benefits
Auto
Home

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¹ Ability Assist® and HealthChampion® are offered through The Hartford by ComPsych® Corporation. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych and reserves the right to discontinue any of these services at any time. Services may vary and may not be available in all states. Visit TheHartford.com/employee-benefits/value-added-services for more information.

² HealthChampion® specialists are only available during business hours. Inquiries outside of this timeframe can either request a call-back the next day or schedule an appointment.

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Employee Assistance Program



Digitally Enabled EAP with Self-Guided Mental Health & Work-Life Services

Life presents us with challenges at work and at home on a daily basis. You do not have to face these challenges alone, even if you're far away.

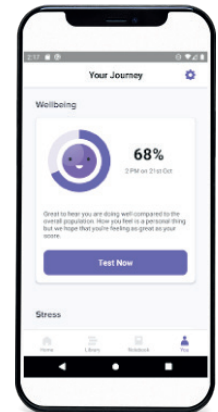
We Are Here to Help

EAP benefits are available to all employees and their families at NO COST to you. The EAP offers confidential advice, support, and practical solutions to real-life issues. You can access these confidential services by calling the toll-free number and speaking with our care team, or accessing online.

Digitally Enabled Employee Assistance Program (EAP)

Our program is designed to help reduce stress and keep you healthy.

- Bite-sized training is available from your desktop or mobile app.
- Access is confidential. Take the assessment and check your wellbeing score.
- Get your own personalized recommendations for self-guided CBT.
- Skills training to develop your resilience, stress management, and mental fitness.
- Visit uprisehealth.com/members to get started.
- Create an account with your email and the access code:



Services for Employees & Families

Confidential Counseling

Up to face-to-face, video or telephonic counseling sessions for relationship and family issues, stress, anxiety, and other common challenges.

24-hour Crisis Help

Toll-free access for you or a family member experiencing a crisis.

Online Peer Support Groups

Online support groups for addiction recovery, anxiety, depression, frontline workers, grief and loss, parenting, and more.

Tess, AI Chat-bot

24/7 chatbot for emotional support and check-ins to boost wellness.

Your EAP provides a wide range of work-life services to help you manage a variety of challenges

Financial Help

30-days of access with a personal money coach who will work with the member toward financial wellness by identifying financial goals, assessing current financial situation, and providing a suggested detailed action plan.

Legal Services

One 30-minute legal consultation per each separate legal matter at no cost, 25% reduction from the normal hourly rate if member retains attorney or mediator.

Online Legal Forms

Create, save, print, and revise online legal forms including wills, contracts, leases, and many more.

Child & Parenting Services

Get information and support on parenting, school issues, adoption, daycare, and other important issues for parents.

Adult & Eldercare Services

Get assistance in finding quality information and services including transportation, meals, activities, daytime care, housing, and more.

Webinars & Trainings

Industry experts will present monthly work-life webinars on a variety of topics.

EAP Services & Support for Supervisors

Managing people can be challenging. All supervisors have fast access to phone consultations and trainings about the EAP and management topics:

- Critical incidents
- Drug-free workplace
- Making employee referrals
- Organizational development
- Education and training
- Conflicts in the workplace

We Are Here to Help

Phone:

Website: uprisehealth.com/members

Access Code:

MASA



Compare plans

Get emergency medical transportation coverage to protect what matters most.

With a MASA plan, you'll have an additional layer of financial protection from the out-of-pocket costs of medical transportation. Explore the options below to compare the benefits offered in each plan.

Gain peace of mind and shield your finances knowing there's a MASA plan best suited for your needs.

	\$14	\$19	\$39
	Emergent Plus plan	Emergent Premier plan	Platinum plan
Emergency Ground Ambulance Coverage	● ²	● ²	● ²
Emergency Air Ambulance Coverage	● ²	● ²	● ²
Hospital to Hospital Ambulance Coverage	● ²	● ²	● ²
Repatriation to Hospital Near Home Coverage	● ²	● ³	● ⁴
Post Admission Continued Care Transportation Coverage		● ¹	
Sick While Away From Home Expense Protection		● ⁴	
Minor Return Transportation Coverage		● ³	● ³
Pet Return Transportation Coverage		● ³	● ³
Patient Return Transportation Coverage			● ⁴
Companion Transportation Coverage			● ³
Hospital Visitor Transportation Coverage			● ³
Mortal Remains Transportation Coverage			● ⁴
Vehicle & RV Return Coverage			● ³
Organ Retrieval & Organ Recipient Transportation Coverage			● ¹

How to use your MASA benefits

Transportation coordination services

Access transport services for the following benefits:

- Repatriation Near Home Coverage
- Child, Pet, and Vehicle Return Coverages
- Companion Transportation Coverage
- Hospital Visitor Transportation Coverage
- Patient Return Transportation Coverage
- Sick While Away from Home Expense Protection
- Organ Retrieval & Organ Recipient Transport Coverage
- Mortal Remains Transportation Coverage



When to access:

During or immediately following your emergency care treatment.



How to access:

Call 800-643-9023.

The MASA Transport Team is available 24/7/365 to assist you and will begin making the necessary arrangements, including working with your medical team.

Note: If you are traveling out of the U.S., please submit your dates of travel through the member portal or to travel@masaglobal.com.

View your benefits online at: masaaccess.com/member or through the MASA app.

Claims

Benefits that you submit claims for include:

- Emergency Ground Ambulance Coverage
- Emergency Air Ambulance Coverage
- Hospital to Hospital Ambulance Coverage
- Post-Admission Continued Care Transportation Coverage



When to file your claim:

When you receive the ambulance bill.

Note: Be sure to file within 180 days of the transport.



How to file your claim:

Online: masaaccess.com/member

Email: ambulanceclaims@masaglobal.com

Note: To process your claim, in addition to the invoice we may require your health insurance claim form (HICFA) and explanation of benefits (EOB), the ambulance run notes, and the ambulance provider's W9. MASA claim specialists will advise you on how to obtain these.

Check the status of your claim at: masaaccess.com/member, through the MASA app, or call (800) 643-9023.

MASA connections



Member services: (800) 643-9023



Member site: masaaccess.com/member



MASA app





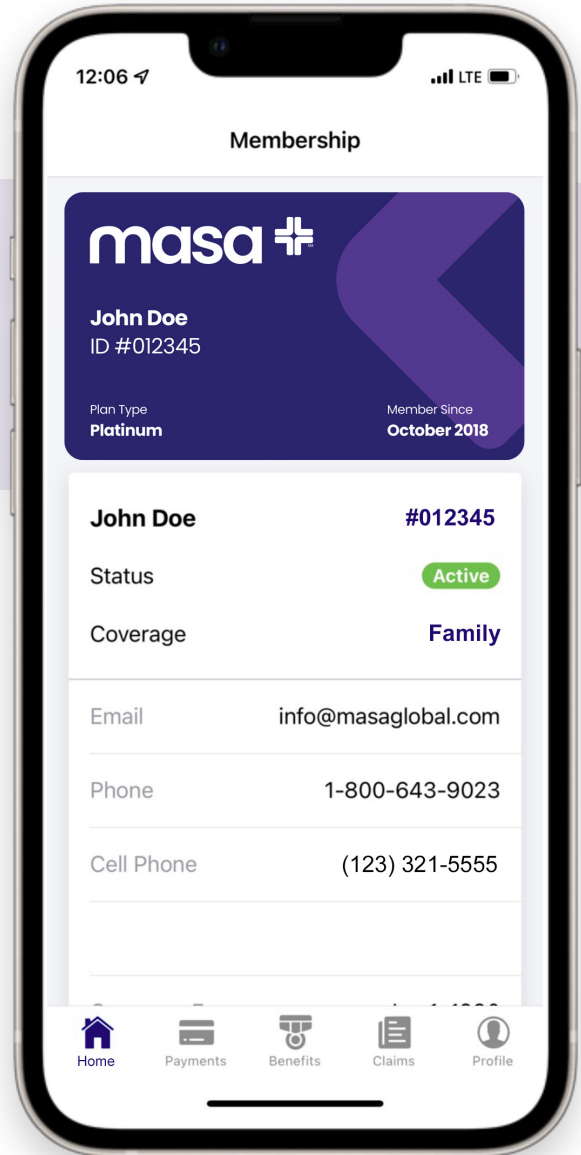
Download the MASA mobile app today!

Registration is easy with your member ID.

- ✔ Access your digital ID cards.
- ✔ View plan documents and benefits.
- ✔ View your claims history.

You now have access to emergency transportation solutions in the palm of your hand. The MASA App allows you to check and update your membership information, view payment history, immediately access benefits and to view up-to-the minute claims processing information, along with many more exciting features to come.

This one stop shop is a must have app for all MASA Global members, while at home or traveling.



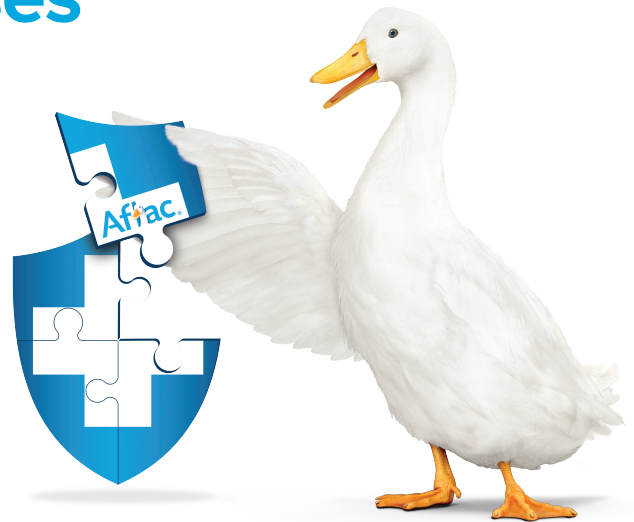
AFLAC



Get help with expenses health insurance doesn't cover

Aflac for City of Roseburg

Who hasn't been blindsided by an unexpected medical bill? That's why there's Aflac. We can help take care of the expenses health insurance doesn't cover, so you can take care of everything else.



Aflac supplemental insurance

Our product portfolio is as broad as your needs, with individual insurance policies that help cover the expected – and unexpected – that's sure to come life's way.



Accident: Accidents happen. When a covered accident happens to you, our accident insurance policy pays you cash benefits, unless assigned otherwise, to help with the unexpected medical and everyday expenses that begin to add up almost immediately.



Short-Term Disability: How would you pay your bills if you're disabled and can't work? An Aflac short-term disability insurance policy can help provide you with a source of income while you concentrate on getting better.



Cancer/Specified-Disease: Aflac's cancer/specified-disease insurance policy can help you and your family better cope financially if a positive diagnosis of cancer occurs.



Hospital Confinement Indemnity: Hospital stays are expensive. An Aflac hospital confinement indemnity insurance policy can help ease the financial burden of hospital stays by providing cash benefits.



Critical Illness (Specified Health Event): An Aflac specified health event insurance policy is designed to help with the costs of treatment if you experience a covered health event.

To learn more, contact your Aflac agents:

Carol Kenyon
carol_kenyon@us.aflac.com
541-580-5002

Marci Otis
marci_otis@us.aflac.com
541-817-9448



This is a brief product overview only. Coverage may not be available in all states, including but not limited to ID, NJ, NM, NY or VA. Benefits/premium rates may vary based on plan selected. Optional riders may be available at an additional cost. Policies/riders have limitations and exclusions that may affect benefits payable. Refer to the specified policy/riders form(s) for complete details, benefits, limitations and exclusions. For availability and costs, please contact your local Aflac agent.

Coverage is underwritten by Aflac. In New York, coverage is underwritten by Aflac New York.
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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.