WHA INSURANCE

City of Roseburg – Police
Benefits Resource Guide

PLAN YEAR | **2020/2021**

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.

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CONTACT

LOCAL OFFICE	TOLL FREE	FAX	ADDRESS
(541) 342-4441	(800) 852-6140	(541) 484-5434	2930 CHAD DRIVE EUGENE, OR 97408

Contact Information

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

MEDICAL: page 5
PacificSource Health Plans
(800) 624-6052
www.pacificsource.com

HEALTH SAVINGS ACCOUNT page 11
HSA Bank
(800) 357-6246
www.hsabnak.com

DENTAL: page 17
Moda Health
(877) 277-7280
www.modahealth.com

VISION: page 25
PacificSource Health Plans
(800) 624-6052
www.pacificsource.com

HEALTH REIMBURSEMENT ARRANGEMENT (HRA): page 27
HRA VEBA
(888) 659-8828
www.hraveba.org

FLEXIBLE SPENDING ACCOUNTS (FSA): page 30
TASC
(800) 422-4661
www.tasconline.com

LONG-TERM DISABILITY: page 33
The Hartford
(800) 523-2233
www.thehartford.com/employeebenefits

LIFE & ACCIDENTAL DEATH & DISMEMBERMENT: page 37
The Hartford
(800) 523-2233
www.thehartford.com/employeebenefits

VOLUNTARY LIFE & ACCIDENTAL DEATH & DISMEMBERMENT page 42
The Hartford
(800) 523-2233
www.thehartford.com/employeebenefits

EMPLOYEE ASSISTANCE PROGRAM (EAP): page 46
Reliant Behavioral Health
(866) 750-1327
www.myrbh.com

MASA MEDICAL TRANSPORT: page 48

Eligibilty 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

Employee Contribution - $500 Deductible Plan	
Employee Only	**$116**
Employee +Child(ren)	**$127**
Employee + Spouse	**$131**
Full Family	**$135**

Employee Contribution - HSA Plan	
Employee Only	**$0**
Employee +Child(ren)	**$0**
Employee + Spouse	**$0**
Full Family	**$0**

Medical Insurance – PPO Plan
PacificSource Health Plans

PacificSource HEALTH PLANS

City of Roseburg

Medical Benefit Summary
Voyager 500+20_20 S2

Provider Network: **Voyager**

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

Note: Your actual costs for services provided by an out-of-network provider may exceed this policy's out-of-pocket limit for out-of-network services. In addition, out-of-network providers can bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company, and this amount is not counted toward the out-of-network out-of-pocket limit. Please see allowable fee in the Definitions section of your member 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	No deductible, $20	After deductible, 40%
Naturopath office visits	No deductible, $20	After deductible, 40%
Specialist office and home visits	No deductible, $20	After deductible, 40%
Telemedicine visits	No deductible, $10	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%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
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%
Advanced diagnostic imaging	After deductible, 20%	After deductible, 40%
Diagnostic and therapeutic radiology/lab and dialysis	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%
Mental Health and Substance Use Disorder Services		
Office 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 member handbook for additional information or a further explanation of benefits, limitations, and

^ Co-pay waived if admitted into hospital.

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

+ Out-of-network air ambulance coverage is covered at 200 percent of the Medicare allowance. You may be held responsible for the amount billed in excess. Please see your member handbook for additional information or contact our Customer Service team with questions.

Additional information

What is the deductible?

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

In-network provider expense and out-of-network provider 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 medical expenses during the plan 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 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 member 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 providers when it comes to meeting your out-of-pocket limit. Only in-network provider expense applies to the in-network provider out-of-pocket limit. Only out-of-network provider expense applies to the out-of-network provider out-of-pocket limit.

Payments to providers

Payment to providers is based on the prevailing or contracted PacificSource fee allowance for covered services. In-network providers accept the fee allowance as payment in full. Out-of-network providers are allowed to balance bill any remaining balance that your plan did not cover. Services of out-of-network providers could result in out-of-pocket expense in addition to the percentage indicated.

Preauthorization

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called preauthorization. Preauthorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. Preauthorization does not change your out-of-pocket expense for in-network and out-of-network providers. You'll find the most current preauthorization list on our website, PacificSource.com/member/preauthorization.aspx.

Formulary: Preferred Drug List (PDL)

This PacificSource health 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/drug-list.

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

Each time a covered prescription is dispensed, you are responsible for the amounts below:

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	
Out-of-network Pharmacy			
30 day max 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 max fill, no more than three fills allowed per year:		No deductible, the lesser of $150 or 50%	

^Remember to show your PacificSource member ID card each time you fill a prescription at a retail pharmacy. If your ID card is not used, your benefits cannot be applied and may result in higher out-of-pocket cost.

**Compounded medications are subject to a preauthorization 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 co-payment and/or co-insurance 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 co-payment and/or co-insurance. The cost difference between the brand name and generic drug does not apply toward the medical plan's out-of-pocket limit. Does not apply to preventive bowel prep kit medications covered under USPSTF guidelines.

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

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

Medical Insurance – HSA Plan
PacificSource Health Plans

PacificSource HEALTH PLANS

City of Roseburg

Medical Benefit Summary
Voyager HSA 1500_20+Rx Non-embedded S2

Provider Network: **Voyager**

Deductible Per Calendar Year	In-network	Out-of-network
Individual/Family	$1,500/$3,000	$3,000/$6,000
Out-of-Pocket Limit Per Calendar Year	**In-network**	**Out-of-network**
Individual/Family	$5,000/$6,850	$10,000/$20,000

Note: In-network provider deductible and out-of-pocket limit accumulates separately from the out-of-network provider deductible and out-of-pocket limit. Even though you may have the same benefit for in-network and out-of-network providers, your actual costs for services provided by an out-of-network provider may exceed this policy's out-of-pocket limit for out-of-network services. In addition, out-of-network providers can bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company, and this amount is not counted toward the out-of-network out-of-pocket limit. Please see allowable fee in the Definitions section of your member 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, 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		
Office and home 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%
Telemedicine 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%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
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%
Advanced diagnostic imaging	After deductible, 20%	After deductible, 50%
Diagnostic and therapeutic radiology/lab and dialysis	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**		
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	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 member handbook for additional information or a further explanation of benefits, limitations, and exclusions.

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

+ Out-of-network air ambulance coverage is covered at 200 percent of the Medicare allowance. You may be held responsible for the amount billed in excess. Please see your member handbook for additional information or contact our Customer Service team with questions.

Additional information

What is the deductible?

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

Note that there is a separate category for in-network and out-of-network providers when it comes to meeting your deductible. Only in-network provider expense applies to the in-network provider deductible and only out-of-network provider expense applies to the out-of-network provider deductible.

What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for covered medical expenses during the plan 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 year. The individual out-of-pocket limit applies only if you enroll without dependents. If you and one or more dependents enroll, the out-of-pocket limit applies until the family out-of-pocket limit has been met. Be sure to check your member 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 providers when it comes to meeting your out-of-pocket limit. Only in-network provider expense applies to the in-network provider out-of-pocket limit. Only out-of-network provider expense applies to the out-of-network provider out-of-pocket limit.

Payments to providers

Payment to providers is based on the prevailing or contracted PacificSource fee allowance for covered services. In-network providers accept the fee allowance as payment in full. Out-of-network providers are allowed to balance bill any remaining balance that your plan did not cover. Services of out-of-network providers could result in out-of-pocket expense in addition to the percentage indicated.

Preauthorization

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called preauthorization. Preauthorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. Preauthorization does not change your out-of-pocket expense for in-network and out-of-network providers. You'll find the most current preauthorization list on our website, PacificSource.com/member/preauthorization.aspx.

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

Formulary: Preferred Drug List (PDL)

This PacificSource health 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/drug-list.

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

Medical Plan Deductible

You must meet the medical plan deductibles, which are shown on the Medical Benefit Summary, before your prescription drug benefits begin for Tier one, Tier two, Tier three, compound, and specialty prescription drugs.

Each time a covered prescription is dispensed, you are responsible for the amounts below:

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 max 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 max fill, no more than three fills allowed per year:		After deductible, 20%	

^Remember to show your PacificSource member ID card each time you fill a prescription at a retail pharmacy. If your ID card is not used, your benefits cannot be applied and may result in higher out-of-pocket cost.

**Compounded medications are subject to a preauthorization 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 co-payment and/or co-insurance after the medical deductible is met. Does not apply to preventive bowel prep kit medications covered under USPSTF guidelines.

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

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

Dental Insurance
Moda

2020 Delta Dental Premier Plan Benefit Summary

DELTA DENTAL
Delta Dental of Oregon & Alaska

City of Roseburg
Group ID: 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** Amalgem 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 $150 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.

Delta Dental orthodontia rider

Delta Dental of Oregon & Alaska

City of Roseburg

Group ID: 10001801

Adult & Child Ortho 2000	
Lifetime maximum	$2,000
	What members pay
Members age 19+	50%
Members under age 19	50%

How to use this dental plan

When you visit your dental provider, tell him or her 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.

Dental Insurance
Willamette Dental

Summary of Benefits

Group Number: OR368
Effective Date: July 1, 2020

Willamette Dental Group

City of Roseburg

Annual Maximum	No Annual Maximum*
Deductible	No Deductible
General or Orthodontic Office Visit	You pay $15 per Visit
DIAGNOSTIC AND PREVENTIVE SERVICES	
Routine and Emergency Exams	Covered with the Office Visit Copay
X-rays	Covered with the Office Visit Copay
Teeth Cleaning	Covered with the Office Visit Copay
Fluoride Treatment	Covered with the Office Visit Copay
Sealants (per Tooth)	Covered with the Office Visit Copay
Head and Neck Cancer Screening	Covered with the Office Visit Copay
Oral Hygiene Instruction	Covered with the Office Visit Copay
Periodontal Charting	Covered with the Office Visit Copay
Periodontal Evaluation	Covered with the Office Visit Copay
RESTORATIVE DENTISTRY	
Fillings	You pay a $15 Copay
Porcelain-Metal Crown	You pay a $250 Copay**
PROSTHODONTICS	
Complete Upper or Lower Denture	You pay a $375 Copay**
Bridge (per Tooth)	You pay a $250 Copay**
ENDODONTICS AND PERIODONTICS	
Root Canal Therapy - Anterior	You pay a $150 Copay
Root Canal Therapy - Bicuspid	You pay a $175 Copay
Root Canal Therapy - Molar	You pay a $200 Copay
Osseous Surgery (per Quadrant)	You pay a $175 Copay
Root Planing (per Quadrant)	You pay a $175 Copay
ORAL SURGERY	
Routine Extraction (Single Tooth)	You pay a $15 Copay
Surgical Extraction	You pay a $100 Copay
ORTHODONTIA TREATMENT	
Pre-Orthodontia Treatment	You pay a $150 Copay***
Comprehensive Orthodontia Treatment	You pay a $2,500 Copay
DENTAL IMPLANTS	
Dental Implant Surgery	Implant benefit maximum of $1,500 per calendar year
MISCELLANEOUS	
Local Anesthesia	Covered with the Office Visit Copay
Dental Lab Fees	Covered with the Office Visit Copay
Nitrous Oxide	You pay a $40 Copay
Specialty Office Visit	You pay $30 per Visit
Out of Area Emergency Care Reimbursement	You pay charges in excess of $100

**Benefits for implant surgery have a benefit maximum, if covered.*
***Dental implant-supported prosthetics (crowns, bridges, and dentures) are not a covered benefit.*
****Copay credited towards the Comprehensive Orthodontia Treatment copay if patient accepts treatment plan.*

Presented are just some of the most common procedures covered in your plan. Please see the Certificate of Coverage for a complete plan description, limitations, and exclusions.

This is only a summary. The certificate of coverage contains a complete description of the limitations and exclusions.

Exclusions

- *Bone grafting.*
- *Bridges, crowns, dentures, or prosthetic devices requiring multiple treatment dates or fittings if the prosthetic item is installed or delivered more than 60 days after termination of coverage.*
- *The completion or delivery of treatments or services initiated prior to the effective date of coverage.*
- *Cone beam CT X-rays and tomographic surveys.*
- *Dental implant-supported prosthetics or abutment-supported prosthetics (crowns, bridges, and dentures).*
- *A dental implant surgically placed prior to the member's effective date of coverage that has not received final restoration or a dental implant for treatment of a primary or transitional dentition.*
- *Endodontic services, prosthetic services, and implants that were provided prior to the effective date of coverage.*
- *Endodontic therapy completed more than 60 days after termination of coverage.*
- *Eposteal, transosteal, endodontic endosseous, or mini dental implants.*
- *Exams or consultations needed solely in connection with a service not listed as covered.*
- *Experimental or investigational services and related exams or consultations.*
- *Full mouth reconstruction, including the extensive restoration of the mouth with crowns, bridges, or implants; and occlusal rehabilitation, including crowns, bridges, or implants used for the purpose of splinting, altering vertical dimension, restoring occlusions or correcting attrition, abrasion, or erosion.*
- *General anesthesia or moderate sedation.*
- *Hospitalization care outside of a dental office for dental procedures, physician services, or facility fees.*
- *Maintenance, repair, replacement, or completion of an existing implant started or placed by a non-participating provider without a referral from a Willamette Dental Group provider.*
- *Maintenance, repair, replacement, or completion of an existing implant started or placed prior to the member's effective date of coverage.*
- *Nightguards.*
- *Orthognathic surgery.*
- *Personalized restorations.*
- *Plastic, reconstructive, or cosmetic surgery and other services, which are primarily intended to improve, alter, or enhance appearance.*
- *Prescription and over-the-counter drugs and pre-medications.*
- *Provider charges for a missed appointment or appointment cancelled without 24 hours prior notice.*
- *Replacement of lost, missing, or stolen dental appliances; replacement of dental appliances that are damaged due to abuse, misuse, or neglect.*
- *Replacement of sound restorations.*
- *Services and related exams or consultations that are not within the prescribed treatment plan or are not recommended and approved by a Willamette Dental Group dentist.*
- *Services and related exams or consultations to the extent they are not necessary for the diagnosis, care, or treatment of the condition involved.*
- *Services by any person other than a licensed dentist, denturist, hygienist, or dental assistant.*
- *Services for the diagnosis or treatment of temporomandibular joint disorders.*
- *Services for the treatment of an injury or disease that is covered under workers' compensation or that are an employer's responsibility.*
- *Services for treatment of injuries sustained while practicing for or competing in a professional athletic contest.*
- *Services for treatment of intentionally self-inflicted injuries.*
- *Services for which coverage is available under any federal, state, or other governmental program, unless required by law.*
- *Services not listed as covered in the contract.*
- *Services where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.*

Limitations

- *If alternative services can be used to treat a condition, the service recommended by the Willamette Dental Group dentist is covered.*
- *Services listed in the contract, which are provided to correct congenital or developmental malformations of the teeth and supporting structure will be covered if primarily for the purpose of controlling or eliminating infection, controlling or eliminating pain, or restoring function.*
- *Crowns, casts, or other indirect fabricated restorations are covered only if dentally necessary and if recommended by the Willamette Dental Group dentist.*
- *The retreatment of root canal therapy performed by a Willamette Dental Group dentist will be covered as part of the initial treatment for the first 24 months. The retreatment of root canal therapy performed by a non-participating provider will be subject to the applicable copays.*
- *The services provided by a dentist in a hospital setting must meet the requirements in the contract to be covered.*
- *The replacement of an existing denture, crown, inlay, onlay, or other prosthetic appliance is covered if the appliance is more than 5 years old and replacement is dentally necessary.*

Offices & Specialty Locations

Willamette Dental Group

Visit our website at **willamettedental.com**
for up-to-date information about our dental offices and providers,
including addresses, directions, hours and patient ratings & comments.

Oregon Offices

Albany
2225 Pacific Boulevard SE, Ste 201
Albany, OR 97321

General Dentistry

Beaverton
4925 SW Griffith Drive
Beaverton, OR 97005

General Dentistry
Orthodontics
Pediatric Dentistry

Bend
62968 O.B. Riley Road, Ste 12
Bend, OR 97703

General Dentistry
Orthodontics

Corvallis
2420 NW Professional Dr., Ste 150
Corvallis, OR 97330

General Dentistry
Orthodontics

Eugene
2703 Delta Oaks Drive, Ste 300
Eugene, OR 97408

General Dentistry

Grants Pass
702 SW Ramsey Ave, Ste 224
Grants Pass, OR 97527

General Dentistry

Gresham
1107 NE Burnside Road
Gresham, OR 97030

General Dentistry

Hillsboro
5935 SE Alexander Street
Hillsboro, OR 97123

General Dentistry
Dentures

Lincoln City
1105 SE Jetty Avenue, Ste B
Lincoln City, OR 97367

General Dentistry
Dentures

Medford
773 Golf View Drive
Medford, OR 97504

General Dentistry
Dentures
Orthodontics
Periodontics
Implants

Milwaukie
6902 SE Lake Road, Ste 200
Milwaukie, OR 97267

General Dentistry
Dentures

Portland – Jefferson
1933 SW Jefferson Street
Portland, OR 97201

General Dentistry
Orthodontics

Portland – Lents
8931 SE Foster Rd,
Portland, OR 97266

General Dentistry
Endodontics
Orthodontics
Oral Surgery
Pediatric Dentistry
Periodontics
Implants

Portland – Stark 1
13255 SE Stark Street
Portland, OR 97233

General Dentistry

Portland – Stark 2
405 SE 133rd
Portland, OR 97233

General Dentistry

Portland – Weidler
220 NE Weidler
Portland, OR 97232

General Dentistry
Dentures

Roseburg
2365 NW Stewart Parkway
Roseburg, OR 97471

General Dentistry
Dentures
Orthodontics

Salem – Lancaster
3490 Lancaster Drive NE
Salem, OR 97305

General Dentistry
Oral Surgery

Salem – Liberty
142 Pembrook St SE
Salem, OR 97302

General Dentistry
Endodontics

Springfield
2510 Game Farm Road
Springfield, OR 97477

General Dentistry
Dentures

Springfield Specialty
2530 Game Farm Road
Springfield, OR 97477

Endodontics
Oral Surgery
Orthodontics
Implants

Tigard
7095 SW Gonzaga Street
Tigard, OR 97223

General Dentistry
Endodontics
Oral Surgery
Periodontics
Implants

Tualatin
17130 SW Upper Boones Ferry Rd
Durham, OR 97224

General Dentistry

Idaho Offices

Boise
8950 West Emerald Street, Ste 108
Boise, ID 83704

General Dentistry

Coeur d'Alene
943 West Ironwood Dr, Ste 200
Coeur d'Alene, ID 83814

General Dentistry
Orthodontics

Idaho Falls
2860 Valencia Drive, Ste 100
Idaho Falls, ID 83404

General Dentistry
Orthodontics

Meridian
1075 S Wells Street
Meridian, ID 83642

General Dentistry
Endodontics
Oral Surgery
Orthodontics
Implants

Twin Falls
452 Cheney Drive West, Ste 150
Twin Falls, ID 83301

General Dentistry
Orthodontics

For Appointments or Customer Service, please call 1.855.4DENTAL (1.855.433.6825)

Rev 4.17.2020

Offices & Specialty Locations

Willamette Dental Group

Visit our website at **willamettedental.com**
for up-to-date information about our dental offices and providers,
including addresses, directions, hours and patient ratings & comments.

Washington Offices

Bellevue
626 120th Avenue NE, Ste B210
Bellevue, WA 98005

General Dentistry
Orthodontics

Bellingham
4164 Meridian Street, Ste 300
Bellingham, WA 98226

General Dentistry
Orthodontics
Implants

Everett
3216 Norton Ave
Everett, WA 98201

General Dentistry
Endodontics
Orthodontics

Kent
510 Washington Ave N
Kent, WA 98032

General Dentistry
Orthodontics

Longview
1461 Broadway Street, Ste A
Longview, WA 98632

General Dentistry

Lynnwood
6101 200th Street SW, Ste 201
Lynnwood, WA 98036

General Dentistry

Olympia
4550 3rd Ave SE,
Lacey, WA 98503

General Dentistry
Oral Surgery
Periodontics
Implants

Pullman
1646 South Grand Avenue
Pullman, WA 99163

General Dentistry
Orthodontics

Puyallup
702 South Hill Park Drive, Ste 201
Puyallup, WA 98373

General Dentistry
Orthodontics

Richland
1426 Fowler Street
Richland, WA 99352

General Dentistry
Endodontics
Orthodontics
Periodontics
Implants

Seattle
133 Dexter Ave North
Seattle, WA 98109

General Dentistry

Seattle – Northgate
2111 N Northgate Way, Ste 100
Seattle, WA 98133

General Dentistry

Seattle – Northgate Specialty
11011 Meridian Ave N, Ste 104
Seattle, WA 98133

Endodontics
Orthodontics
Periodontics
Implants

Silverdale
3505 NW Anderson Hill Road
Silverdale, WA 98383

General Dentistry
Orthodontics

Spokane – Northpointe
9717 North Nevada
Spokane, WA 99218

General Dentistry
Implants

Spokane Valley
9019 E. Mission Avenue
Spokane, WA 99212

General Dentistry
Endodontics
Orthodontics
Implants

Tacoma
3866 S. 74th Street
Tacoma, WA 98406

General Dentistry
Endodontics
Oral Surgery
Orthodontics
Periodontics
Implants

Tumwater
6120 SE Capitol Boulevard
Tumwater, WA 98501

General Dentistry
Endodontics
Orthodontics

Vancouver – Hazel Dell
910 NE 82nd Street
Vancouver, WA 98665

General Dentistry
Orthodontics

Vancouver – Mill Plain
9609 East Mill Plain Blvd
Vancouver, WA 98664

General Dentistry

Yakima
1200 Chesterly Drive, Ste 230
Yakima, WA 98902

General Dentistry
Orthodontics

For Appointments or Customer Service, please call 1.855.4DENTAL (1.855.433.6825)

Rev 4.17.2020

Vision
PacificSource

PacificSource HEALTH PLANS

Vision Benefit Summary
Vision 10-300

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

If charges for a service or supply are less than the amount allowed, the benefit will be equal to the actual charge. If charges for a service or supply are greater than the amount allowed, the expense above the allowed amount is the member's responsibility and will not apply toward the member's medical plan deductible or out-of-pocket limit.

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Enrolled Members Age 18 and Younger		
Eye exam	No deductible, $10	No deductible up to $40 then 100%
Vision hardware	No deductible, 0% for one pair per year for frames and/or lenses	No deductible, 0% for one pair per year up to $75 then 100% for frames and/or lenses
Enrolled Members Age 19 and Older		
Eye exam	No deductible, $10	No deductible up to $40 then 100%
Vision hardware	No deductible, 0% up to $300	

Benefit Limitations: enrolled members age 18 and younger

One vision exam every calendar year.

Vision hardware includes glasses (lenses and frames) or contacts (lenses and fitting) once per calendar year.

Benefit Limitations: enrolled members age 19 and older

One vision exam every calendar year.

Vision hardware includes glasses (lenses and frames) or contacts (lenses and fitting). Benefit maximum is per calendar year.

Anti-reflective coatings and scratch resistant coatings are covered.

Exclusions

Charges for services or supplies covered in whole or in part under any medical or vision benefits provided by an employer.

Expenses covered under any workers' compensation law.

Eye exams required as a condition of employment, required by a labor agreement or government body.

Medical or surgical treatment of the eye.

Nonprescription lenses.

Plano contact lenses.

Services or supplies not listed as covered expenses.

Services or supplies received before this plan's coverage begins or after it ends.

Special procedures, such as orthoptics or vision training.

Visual analysis that does not include refraction.

Important information about your vision benefits

Your PacificSource health plan includes coverage for vision services. To make the most of those benefits, it's important to keep in mind the following:

In-network Providers: PacificSource is able to add value to your vision benefits by contracting with a network of vision providers. Those providers offer vision services at discounted rates, which are passed on to you in your benefits.

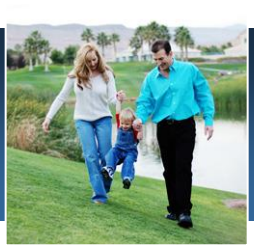
Paying for Services: Please remember to show your current PacificSource member ID card whenever you use your plan's benefits. Our provider contracts require in-network providers to bill us directly whenever you receive covered services and supplies. Providers will verify your vision benefits.

In-network providers should not ask you to pay the full cost in advance. They may only collect your share of the expense up front, such as co-payments and amounts over your plan's allowances. If you are asked to pay the entire amount in advance, tell the provider you understand they have a contract with PacificSource and they should bill PacificSource directly.

Sales and Special Promotions (sales and promotions are not considered insurance): Vision retailers often use coupons and promotions to bring in new business, such as free eye exams, two-for-one glasses, or free lenses with purchase of frames. Because in-network providers already discount their services through their contract with PacificSource, your plan's in-network provider benefits cannot be combined with any other discounts or coupons. You can use your plan's in-network provider benefits, or you can use your plan's out-of-network provider benefits to take advantage of a sale or coupon offer.

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

HRA VEBA
HRA VEBA Trust



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 5% of actual wages

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.hravebaorg.

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

Common Examples

The below list of qualified expenses and premiums is not a complete list, but it does contain many examples of the types of expenses and premiums eligible for reimbursement from your HRA VEBA account. The most common include co-pays, coinsurance, deductibles, retiree insurance premiums (including Medicare Part B and Part D and Medicare supplement plans), and tax-qualified long-term care insurance premiums (subject to annual IRS limits).

Internal Revenue Code § 213(d) defines qualified expenses, in part, as "medical care" amounts paid for insurance or "for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body…" Expenses solely for cosmetic reasons generally are not considered expenses for medical care (e.g. facelifts, hair transplants, hair removal (electrolysis)). Expenses that are merely beneficial to your general health, such as vacations, are not medical care expenses.

Questions?

1-888-659-8828

myHRAVEBA@meritain.com

hraveba.org

General expenses

- Acupuncture
- Alcoholism and drug treatment center costs
- Birth control pills
- Chiropractic
- Christian Science
- Contact lenses, solutions, etc.
- Co-pays
- Coinsurance
- Deductibles
- Dental
- Eye glasses
- Fertility treatments
- Gynecology/Obstetrics
- Hearing aids & batteries
- Immunizations
- Laser eye surgery
- Lifetime care at medical facility
- Medical supplies and equipment
- Naturopathic
- Organ transplants
- Orthodontia
- Osteopathy
- Physical therapy
- Prescription medicines
- Preventive care
- Psychiatric
- Retirement home (costs allocable to medical care)
- Stop smoking programs
- Transportation (subject to IRS limits)
- Vaccines
- Vasectomy
- Vision
- Wheelchair

Over-the-counter (OTC)

PRESCRIPTION REQUIRED (medicines and drugs):

- Acne medications
- Allergy medicines
- Antacids
- Aspirin
- Cold medicines
- Cough suppressants
- Dietary supplements
- Eye products (e.g. Visine®)
- First aid creams/liquids
- Herbal medicines
- Nicotine gum/patches
- Pain relievers
- Sinus medications
- Sleeping aids
- St. John's Wort
- Weight loss drugs

NO PRESCRIPTION REQUIRED (non-medicine items):

- Bandages
- Crutches
- Insulin
- Diagnostic devices (e.g. blood sugar kits)

OTC ITEMS NOT ELIGIBLE:

- Cosmetics; face creams
- Medicated shampoos
- Tooth brushes (including electronic)
- Vitamins (most cases)

Insurance premiums

- Medical
- Dental
- Vision
- Long-term care (tax-qualified; subject to IRS limits)
- Medicare Part B
- Medicare Part D
- Medicare supplement plans

Medicare

- Co-pays
- Coinsurance
- Deductibles
- Home health care
- Hospice care
- Hospital stay
- Outpatient hospital services
- Skilled nursing facility stay

TRICARE (military retirees)

- Co-pays
- Coinsurance
- Deductibles
- Vision
- Miscellaneous
- Premiums:
  - Extra
  - Medicare Part B
  - Medicare Part D
  - Prime supplement plans
  - Retiree dental
  - Standard

Revised (8/13 PRC)

Important Notices

A fully-completed **Claim Form** along with proper documentation is required when requesting reimbursements. Claim Forms are available online at **hraveba.org** or by contacting the third-party administration (TPA) service provider. Please read the **How to File a Claim** handout available online to learn more about your HRA VEBA plan's overall claims process, including IRS documentation requirements and standard claims processing turnaround times. Please note the following:

1. Only qualified expenses and premiums incurred after you become and remain a claims-eligible participant may be submitted for reimbursement.
2. If you are a participant in a Section 125 healthcare flexible spending account (FSA), you must exhaust your FSA benefits before submitting eligible claims.
3. Qualified insurance premiums are reimbursable beginning with the month in which you become a claims-eligible participant.
4. **IRS regulations provide that insurance premiums paid by an employer, or premiums that are or could be deducted from your paycheck pre-tax through your employer's Section 125 cafeteria plan, are not eligible for reimbursement.** When requesting reimbursement of premiums deducted from your paycheck after tax, you should include a letter from your employer that confirms a pre-tax option for the deduction of such premiums is not available to you. Premiums deducted from your spouse's paycheck after tax may be eligible for reimbursement.
5. Systematic reimbursement of recurring qualified insurance premiums may be set up online after logging in to your account or by submitting a **Systematic Premium Reimbursement Form**.

Regarding OTC drugs and medicines: To be eligible for reimbursement, federal healthcare reform requires that OTC medicines and drugs (except insulin) purchased on or after **January 1, 2011** be prescribed by a medical professional or accompanied by a note from a medical practitioner recommending the item or service to treat a specific medical condition. Thus, OTC medicines and drugs such as aspirin, antihistamines, and cough syrup must be prescribed. Eligible OTC medicines and drugs purchased on or before **December 31, 2010** remain reimbursable without a prescription. The prescription requirement applies only to medicines and drugs, not to other types of OTC items such as bandages and crutches.

Definition of Dependent

Generally, dependents must satisfy the definition of **Qualifying Child** or **Qualifying Relative** as of the end of the calendar year in which expenses were incurred to be eligible for benefits. These requirements are defined by Internal Revenue Code § 105(b) and summarized below. Go to **hraveba.org** and click **Covered Dependents** for a detailed definition.

Qualifying child

A **Qualifying Child** is a person who: (1) is the participant's son or daughter, stepchild, or foster child; and (2) at the end of the calendar year in which expenses were incurred will be age 26 or younger or permanently and totally disabled; and (3) is a citizen, national, or resident of the U.S. or a resident of Canada or Mexico. Other individuals are subject to additional requirements.

Qualifying Child of Divorced or Separated Parents. A participant's child is treated as the dependent of both parents for the purposes of health plan coverage if during the calendar year in which expenses were incurred: (1) the participant's child is in the custody of the participant or their other parent for more than half the year; and (2) the participant's child receives over half of his or her support during the year from the participant or their other parent.

Qualifying relative

A **Qualifying Relative** is a person who: (1) is the participant's son or daughter, stepchild, foster child, or other relative as defined by the IRS (e.g. father, mother, brother, sister, niece, nephew, aunt, uncle; go to **hraveba.org** and click **Covered Dependents** for a complete list) or any other person (other than the participant's spouse) who lived with the participant all year as a member of the household if such relationship did not violate local law; and (2) will not be a Qualifying Child of any other person as of the last day of the calendar year in which expenses were incurred; and (3) received over half of his or her support for the calendar year from the participant; and (4) has a gross income for the year of less than $3,650; and (5) is a citizen, national, or resident of the U.S. or a resident of Canada or Mexico.

Flexible Spending Accounts
TASC

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 $2,750. 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)

PARTICIPANT EDUCATION

FlexSystem®

Eligible and Ineligible Expenses for FSA

Expenses that qualify for reimbursement from FlexSystem.

Healthcare FSA | Dependent Care FSA

Below is a partial list of permissible expenses reimbursable through a Flexible Spending Account (FSA) that are incurred by you, your spouse, or qualified dependents. Please note: a Limited Purpose Healthcare FSA only allows dental and vision expenses.

Medical Expenses

- Acupuncture
- Artificial limbs
- Bandages
- Birth control, contraceptive devices
- Birthing classes/Lamaze – only the mother's portion (not the coach/spouse) and the class must be only for birthing instruction, not child rearing
- Blood pressure monitor
- Blood sugar test kits/test strips
- Chiropractic therapy/exams/adjustments
- Contact lens and contact lens solutions
- Co-payments
- Crutches (purchased or rented)
- Deductible and co-insurance
- Diabetic supplies
- Eye exams
- Eyeglasses, contacts, or safety glasses, prescription only (warranties are not reimbursable)
- Flu shots
- Hearing aids and hearing aid batteries (warranties are not reimbursable)
- Heating pad
- Incontinence supplies
- Infertility treatments
- Insulin
- Lactation expenses (breast pumps, etc.)
- Laser eye surgery; LASIK
- Legal sterilization
- Medical supplies to treat an injury or illness
- Mileage to and from doctor appointments
- Nasal strips
- Optometrist's or ophthalmologist's fees
- Orthopedic inserts
- Physicals
- Physical therapy (as medical treatment)
- Physician's fee and hospital services
- Pregnancy test
- Prescription drugs and medications
- Psychotherapy, psychiatric and psychological service
- Reading glasses
- Sales tax on eligible expenses
- Services connected with donating an organ
- Sleep apnea services/products (as prescribed)
- Smoking cessation programs
- Treatment for alcoholism or drug dependency
- Vaccinations
- Wrist supports, elastic wraps
- X-ray fees

OTC Medicines and Drugs

Over-the-counter (OTC) medicines and drugs, except for insulin, require a prescription from your physician to be reimbursable. The prescription will need to be included with each request for reimbursement.

- Bengay, Flexall, pain relieving creams or gels
- Calamine lotion
- Canker/cold sore relievers
- Cold medicines
- Corn removal
- Diaper rash ointment
- GasX, baby gas drops
- Hemorrhoid creams and treatments
- Hydrogen Peroxide or rubbing alcohol
- Indigestion or anti-acid relievers
- Laxatives
- Nicotine patch
- Pain relievers (Tylenol, Advil, Aspirin, etc.)
- Sinus medicines
- Suppositories
- Teething gel
- Wart removal medication

Continued on next page...

TASC® Total Administrative Services Corporation
2302 International Lane | Madison, WI 53704-3140
www.tasconline.com | 800.422.4661

FX-4248-080115

For more information regarding FSA expenses, please review IRS Publication 503 or ask your employer for a copy of your Summary Plan Description (SPD).

You can also find helpful information and rates on our resource page at:

https://www.tasconline.com/biz-resource-center/eligible-expenses/

Dental Expenses

- Braces and orthodontic services
- Cleanings
- Crowns
- Deductibles, co-insurance
- Dental implants
- Dentures, adhesives
- Fillings

Disability Expenses

- Automobile equipment and installation costs for a disabled person in excess of the cost of an ordinary automobile; device for lifting a mobility impaired person into an automobile
- Braille books/magazines in excess of cost of regular editions
- Note-taker for a hearing impaired child in school
- Seeing eye dog (buying, training, and maintaining)
- Special devices, such as a tape recorder or typewriter for a visually impaired person
- Visual alert system in the home or other items such as a special phone required for a hearing impaired person
- Wheelchair or autoette (cost of operating/maintaining)

Requiring Additional Documentation

The following expenses are eligible only when incurred to treat a diagnosed medical condition. Such expenses require a ***Letter of Medical Necessity*** from your physician, containing the medical necessity of the expense, diagnosed condition, onset of condition, and physician's signature.

- Ear plugs
- Massage treatments
- Nursing services for care of a special medical ailment
- Orthopedic shoes (excess cost of ordinary shoes)
- Oxygen equipment and oxygen
- Support hose
- Varicose vein treatment
- Veneers
- Vitamins and supplements
- Wigs (for mental health condition of individual who loses hair because of a disease)

Dependent Care Expenses

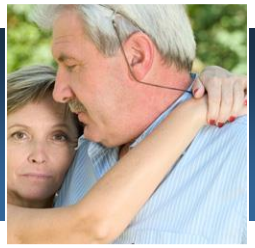
- Fees for licensed day care or adult care facilities
- Before and after school care programs for dependents under age 13
- Amounts paid for services (including babysitters or nursery school) provided in or outside of your home
- Nanny expenses attributed to dependent care
- Nursery school (preschool) fees
- Summer Day Camp – primary purpose must be custodial care and not educational in nature
- Late pick-up fees
- **Does not cover medical costs**; use Healthcare FSA for medical expenses incurred by you or your dependents

Ineligible Medical Expenses

- Athletic mouth guards
- Chapstick/lip balm
- Contributions to state disability funds
- Cosmetic surgery, dentistry, or other cosmetic procedures
- Cosmetic supplies (makeup, cleansers, moisturizers, etc.)
- Deodorant
- Dental floss
- Diet (cost of special foods as substitute for regular diet)
- Dietary and fiber supplements
- Electrolysis/hair removal
- Exercise equipment and fees
- Eye drops for general comfort
- Eyeglass cases
- Hand sanitizer
- Health club or athletic club membership fees
- Herbal supplements
- Insurance premiums, all types
- Lotions or skin moisturizers
- Marriage counseling
- Maternity clothes
- Mattress
- Medicare premiums
- Medicated shampoos, conditioners, and soaps
- Physical treatment unrelated to specific health problems (massage for general well-being, stress, depression, or chiropractic wellness)
- Safety glasses (non-prescription)
- Sunglasses (non prescription) and sun clips
- Teeth whitening products
- Toiletries
- Toothbrush (includes prescribed electronic) and toothpaste
- Vitamins and supplements for well-being
- Warranties
- Weight loss drugs/programs for general well being

TASC®

Long-Term Disability
The Hartford



GROUP LONG-TERM DISABILITY INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

Just over 1 in 4 of today's 20 year-olds will become disabled before they retire (age 67).[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/employeebenefits

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 who works at least 20 hours per week on a regularly scheduled basis, excluding Members, Police, Management, Fire Management, Line Firefighters and HAZMAT employees.

AM I GUARANTEED COVERAGE?

This insurance is guaranteed issue coverage – it is available without having to provide information about your health. If you are a late entrant, evidence of insurability is required for the full coverage amount.[3]

This coverage is subject to a pre-existing condition exclusion, which is detailed on the Limitations & Exclusions sheet.

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.

[1]U.S. Social Security Administration Fact Sheet. Web. 30 June 2017 https://www.ssa.gov/news/press/factsheets/basicfact-alt.pdf
[2]Rates and/or benefits may be changed.
[3]The Long Term Disability policy contains a Pre-Existing Condition Exclusion. Please refer to the certificate for more information on exclusions and limitations, such as Pre-Existing Conditions.

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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. **Benefits are subject to state availability. Policy terms and conditions vary by state.** Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder. 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.

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 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 Limitation.** If you are disabled because of Mental Illness, 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.
- **Substance Abuse Limitation.** If you are disabled because of alcoholism or 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 disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York Department of Financial Services.

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ADDITIONAL SERVICES

City of Roseburg

If you are enrolled in insurance coverage with The Hartford, you may also be eligible to receive additional services at no cost to you. These services help with challenges that come before and after a claim. Be sure to read the information provided below; The Hartford wants to be there when you need us.

SERVICES AVAILABLE

COVERAGE ENROLLED IN	ADDITIONAL SERVICES AVAILABLE
Disability	Ability Assist Counseling Services Health Champion Travel Assistance Services with ID Theft Protection and Assistance

ASKED & ANSWERED

WHAT IS ABILITY ASSIST COUNSELING SERVICES?

Ability Assist®[4] Counseling Services provides access to Master's- and PhD-degreed clinicians for 24/7 assistance if you're enrolled in our long term disability plan. This includes 3 face-to-face visits per occurrence per year for emotional concerns and unlimited phone consultations for financial, legal, and work-life concerns.

For more information on Ability Assist® Counseling Services:
Call 1-800-964-3577
Visit www.guidanceresources.com
Company name: **Abili** Company ID: **HLF902**

WHAT IS HEALTHCHAMPION?

HealthChampion[SM5] offers unlimited access to benefit specialists and nurses for administrative and clinical support to address medical care and health insurance claims concerns if you're enrolled in our long term disability plan. Service includes: guidance on health insurance claims and billing support, explanation of benefits, cost estimates and fee negotiation, information related to conditions and available treatments, and support to help prepare for medical visits.

For more information on HealthChampion[SM] Services
Call 1-800-964-3577
Visit www.guidanceresources.com
Company name: **Abili** Company ID: **HLF902**

WHAT IS TRAVEL ASSISTANCE SERVICES WITH ID THEFT PROTECTION AND ASSISTANCE?

Travel Assistance Services with ID Theft Protection and Assistance[3] includes pre-trip information to help you feel more secure while traveling. It can also help you access medical professionals across the globe for medical assistance when traveling 100+ miles away from home for 90 days or less when unexpected detours arise. The ID theft services are available to you and your family at home or when you travel.

For more information on Travel Assistance Services or ID Theft Services:
Call from United States: 1-800-243-6108
Call collect from other locations: 202-828-5885
Fax: 202-331-1528
Email: idtheft@europassistance-usa.com

Travel Assistance Identification Number: **GLD-09012**

You'll be asked to provide your employer's name, a phone number where you can be reached, nature of the problem, Travel Assistance Identification Number, and your company policy number which can be obtained through your Human Resources/Personnel department.

If you have a serious medical emergency, please obtain emergency medical services first, and then contact Europ Assistance USA for follow-up.

[3] Travel Assistance and ID Theft Protection and Assistance are provided by Europ Assistance USA. Europ Assistance USA is not affiliated with The Hartford and is not a provider of insurance services. Europ Assistance USA may modify or terminate all or any part of the service at any time without prior notice. None of the benefits provided to you by Europ Assistance USA as a part of the Travel Assistance and Identity Theft service are insurance. This brochure, the Travel Assistance and Identity Theft service Terms and Conditions of Use, and the Identity Theft Resolution Kit constitute your benefit materials and contain the terms, conditions, and limitations relating to your benefits. These services may not be used for business or commercial purposes or by any person other than the individual insured under The Hartford's group insurance policy.
[4] Ability Assist® is offered through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services.
[5] HealthChampion[SM] is offered through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services.

Life and AD&D Insurance
The Hartford

BASIC GROUP TERM LIFE INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

Approximately 50 million households recognize they need more life insurance (40 percent of households).[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/employeebenefits

COVERAGE INFORMATION

APPLICANT	LIFE COVERAGE	AD&D COVERAGE
Employee	Benefit[1] : $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.[2]

ASKED & ANSWERED

WHO IS ELIGIBLE?

You are eligible if you are an active full time employee including Police, Management and Fire Management, 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).

AM I GUARANTEED COVERAGE?

This insurance is guaranteed issue coverage - it is available without having to provide information about your family's health. If you are a late entrant, evidence of insurability is required for the full coverage amount.

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

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?

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).

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 are 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.

[1]LIMRA, Facts About Life 2016. Web. 30 June 2017. <https://www.limra.com/uploadedFiles/limra.com/LIMRA_Root/Posts/PR/_Media/PDFs/Facts-of-Life-2016.pdf>
[2]Rates and/or benefits may be changed.

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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

- 65% at 65, 45% at 70, 30% at 75, 20% at 80, 15% at 85, and 10% at 90
- 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.

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GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

GENERAL LIMITATIONS AND EXCLUSIONS

-
- 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
  - Injury sustained on aircraft in certain circumstances
  - Taking prescription or illegal drugs unless prescribed by or administered by a licensed physician
  - Injury sustained while riding, driving, or testing any motor vehicle for racing
  - Injury sustained while committing or attempting to commit a felony
  - Injury sustained while driving while intoxicated
- You must be a citizen or legal resident of the United States, its territories and protectorates.

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 have coverage.

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ADDITIONAL SERVICES

City of Roseburg

If you are enrolled in insurance coverage with The Hartford, you may also be eligible to receive additional services at no cost to you. These services help with challenges that come before and after a claim. Be sure to read the information provided below; The Hartford wants to be there when you need us.

SERVICES AVAILABLE

COVERAGE ENROLLED IN	ADDITIONAL SERVICES AVAILABLE
Life	Beneficiary Assist Counseling Services EstateGuidance Will Services Funeral Planning and Concierge Services Travel Assistance Services with ID Theft Protection and Assistance

ASKED & ANSWERED

WHAT IS BENEFICIARY ASSIST COUNSELING SERVICES?

Beneficiary Assist®[2] Counseling Services offers compassionate expertise to help you or your beneficiaries (those you name in your policy) cope with emotional, financial and legal issues that arise after a loss. Includes unlimited phone contact with a counselor, attorney or financial planner for up to a year, and five face-to-face sessions.
For more information on Beneficiary Assist® Counseling Services, call 1-800-411-7239.

WHAT IS ESTATEGUIDANCE WILL SERVICES?

EstateGuidance®[2] Will Services helps you protect your family's future by creating a will online—backed by online support from licensed attorneys. Your will is customized and legally binding.
For more information on EstateGuidance® Will Services:
www.estateguidance.com/wills Use Code: **WILLHLF**

WHAT IS FUNERAL PLANNING AND CONCIERGE SERVICES?

Funeral Planning and Concierge Services [1] provides a suite of online tools to guide you through key decisions before a loss, including help comparing funeral-related costs. After a loss, this service includes family advocacy and professional negotiation of funeral prices with local providers—often resulting in significant financial savings.
For more information on Funeral Planning and Concierge Services:
Call 1-866-854-5429 or visit www.everestfuneral.com/hartford Use Code: **HFEVLC**

WHAT IS TRAVEL ASSISTANCE SERVICES WITH ID THEFT PROTECTION AND ASSISTANCE?

Travel Assistance Services with ID Theft Protection and Assistance[3] includes pre-trip information to help you feel more secure while traveling. It can also help you access medical professionals across the globe for medical assistance when traveling 100+ miles away from home for 90 days or less when unexpected detours arise. The ID theft services are available to you and your family at home or when you travel.

For more information on Travel Assistance Services or ID Theft Services:
Call from United States: 1-800-243-6108
Call collect from other locations: 202-828-5885
Fax: 202-331-1528
Email: idtheft@europassistance-usa.com

Travel Assistance Identification Number: **GLD-09012**

You'll be asked to provide your employer's name, a phone number where you can be reached, nature of the problem, Travel Assistance Identification Number, and your company policy number which can be obtained through your Human Resources/Personnel department.

If you have a serious medical emergency, please obtain emergency medical services first, and then contact Europ Assistance USA for follow-up.

[1] Funeral Concierge Services are offered through Everest Funeral Package, LLC (Everest). Everest and the Everest logo are service marks of Everest Funeral Package, LLC. Everest is not affiliated with The Hartford and is not a provider of insurance services. Everest and its affiliates have no affiliation with Everest ReGroup, Ltd., Everest Reinsurance Company or any of their affiliates.
[2] EstateGuidance® and Beneficiary Assist® services are provided through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. A simple will does not cover credit shelter trust, printing or certain other features. EstateGuidance and ComPsych are registered trademarks of ComPsych Corporation.
[3] Travel Assistance and ID Theft Protection and Assistance are provided by Europ Assistance USA. Europ Assistance USA is not affiliated with The Hartford and is not a provider of insurance services. Europ Assistance USA may modify or terminate all or any part of the service at any time without prior notice. None of the benefits provided to you by Europ Assistance USA as a part of the Travel Assistance and Identity Theft service are insurance. This brochure, the Travel Assistance and Identity Theft service Terms and Conditions of Use, and the Identity Theft Resolution Kit

Voluntary Life Insurance
The Hartford

VOLUNTARY GROUP TERM LIFE and ACCIDENTAL DEATH & DISMEMBERMENTINSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

Approximately 50 million households recognize they need more life insurance (40 percent of households).[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/employeebenefits**

COVERAGE INFORMATION

APPLICANT	LIFE COVERAGE	AD&D COVERAGE
Employee	Benefit[2]: Increments of $10,000 Maximum: the lesser of 5x earnings or $300,000	AD&D: Optional: Life must be elected to elect AD&D.
Spouse	Benefit[2]: Increments of $10,000. Maximum: the lesser of 100% of your supplemental coverage or $250,000	AD&D: Optional: Life must be elected to elect AD&D.
Child(ren)	Benefit: Increments of $2,000 Maximum: $10,000	AD&D: Optional: Life must be elected to elect AD&D.

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%

[2]65% at 65, 45% at 70, 30% at 75, 20% at 80, 15% at 85, and 10% at 90

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 30 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.

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 current coverage, you 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, or within 31 days of the date you have a change in family status.

WHEN DOES THIS INSURANCE BEGIN?

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).

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.

[1]LIMRA, Facts About Life 2016. Web. 30 June 2017. <https://www.limra.com/uploadedFiles/limra.com/LIMRA_Root/Posts/PR/_Media/PDFs/Facts-of-Life-2016.pdf>
[3]Rates and/or benefits may be changed. 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.

Prepare. Protect. Prevail. With The Hartford. ®

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Home Office is Hartford, CT. 5962a and 5962b NS 08/16 © 2016 The Hartford Financial Services Group, Inc. All rights reserved.
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. **Benefits are subject to state availability. Policy terms and conditions vary by state.** Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder. 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. Life Form Series includes GBD-1000, GBD-1100, or state equivalent.

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

- 65% at 65, 45% at 70, 30% at 75, 20% at 80, 15% at 85, and 10% at 90
- A 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.

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GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

GENERAL LIMITATIONS AND EXCLUSIONS

- 65% at 65, 45% at 70, 30% at 75, 20% at 80, 15% at 85, and 10% at 90
- 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
  - Injury sustained on aircraft in certain circumstances
  - Taking prescription or illegal drugs unless prescribed by or administered by a licensed physician
  - Injury sustained while riding, driving, or testing any motor vehicle for racing
  - 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 08/16 © 2016.The Hartford Financial Services Group, Inc. All rights reserved. Accident Form Series includes GBD-1000, GBD-1300, or state equivalent.

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The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Home Office is Hartford, CT.

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. **Benefits are subject to state availability. Policy terms and conditions vary by state.** Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder.

Premium Worksheet

Rates and/or benefits can change. Rates are based on the employee's age and increase as you enter each new age category.

VOLUNTARY 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 VOLUNTARY TERM LIFE INSURANCE
Monthly Premium Amount (Cost per Pay Period – 12/Year)

Age	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

CREATION DATE: 6/12/2018
CITY OF ROSEBURG/00082804

$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

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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 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		

CHILD(REN) VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE
Monthly Premium Amount (Cost per Pay Period – 12/Year)

Benefit Amount	Cost For All Children	Benefit Amount	Cost For All Children
$2,000	$0.12	$8,000	$0.48
$4,000	$0.24	$10,000	$0.60
$6,000	$0.36		

Employee Assistance Program
RBH

LIVE HEALTHY WITH THE EAP

Free. Fast. Confidential.

The EAP (Employee Assistance Program) helps you **privately solve** problems that may interfere with your work, family, and life in general. EAP services are **FREE** to you, your dependents, and all household members. EAP services are always **confidential** and **provided by experts**.

CONFIDENTIAL COUNSELING

24-hour Crisis Help – toll-free access for you or a family member experiencing a crisis. 866-750-1327

In-person Counseling – up to 4 face-to-face counseling sessions are available for each new issue. Simply call for access to qualified, local counselors who can help you with a variety of problems such as family, parenting, relationship, stress, anxiety, and other challenges. 866-750-1327

Online Consultations – convenient access to online consultations with licensed counselors through RBH *e*Access at MyRBH.com. Online consultations are a great way to get support for brief issues, even when time is limited. www.MyRBH.com

WORKSITE SERVICES

All supervisors have fast access to phone consultations, trainings about the EAP and management topics, critical incident response, and online supervisor resources for using the EAP and making employee referrals during workplace challenges.

MYRBH.COM

Access current health news, tools for parenting, health topic movies, wellness resources, financial calculators, legal forms, and over 50 online trainings.

LIFE-BALANCE RESOURCES

Legal Services – access a free, half-hour consultation, by phone or in person, for any non-work related issue, followed with a 25% discount in legal fees.

Financial Services – access free phone support for up to 30 days for each new financial issue, such as debt counseling, budgeting, and college or retirement planning.

Mediation Services – request free consultations for personal, family, and non-work related issues such as divorce, neighbor disputes, or real estate.

Will Kit – receive a free will template to complete in your own time.

Home Ownership Program – get free support and information about making smarter choices when shopping for a new home; making financing decisions; relocating; or selling a home.

Identity Theft Services – access support in planning the recovery process for restoring your identity and credit after an incident.

MyRBH Access Code: Roseburg

MyRBH.com | 866.750.1327

To find out more about your EAP call or visit us online.

RBH
Reliant Behavioral Health

Emergecy Medical Transport
MASA

EMERGENCY TRANSPORTATION COSTS

MASA MTS is here to protect its members and their families from the shortcomings of health insurance coverage by providing them with comprehensive financial protection for lifesaving emergency transportation services, both at home and away fromhome.

Many American employers and employees believe that their health insurance policies cover most, if notall ambulance expenses. The truth is, they DO NOT!

Even after insurance payments for emergency transportation, you could receive a bill up to $5,000 for ground ambulance and as high as $70,000 for air ambulance. The financial burdens for medical transportation costs are very real.

HOW MASA IS DIFFERENT

Across the US there are thousands of ground ambulance providers and hundreds of air ambulance carriers. ONLY MASA offers comprehensive coverage since MASA is a PAYER and not a PROVIDER!

ONLY MASA provides over 1.6 million members with coverage for **BOTH ground ambulance and air ambulance transport, REGARDLESS of which provider transports them.**

Members are covered ANYWHERE in all 50 states and Canada!

Worldwide coverage is also available with our Platinum Membership.

Additionally, MASA provides a repatriation benefit: if a member is hospitalized more than 100 miles from home, MASA can arrange and pay to have them transported to a hospital closer to their place of residence.

MASA Medical Transport Solutions™

Any Ground. Any Air. Anywhere.™

OUR BENEFITS

Benefit*	Platinum $39/Month	Emergent Plus $14/Month	Emergent Ground $9/Month
Emergent Ground Transportation	U.S./Canada	U.S./Canada	U.S./Canada
Emergent Air Transportation	U.S./Canada	U.S./Canada	
Non-Emergent Air Transportation	Worldwide	U.S./Canada	
Repatriation	Worldwide	U.S./Canada	
Escort Transportation	Worldwide		
Mortal Remains Transportation	Worldwide		
Visitor Transportation	BCA*		
Minor Children/ Grandchildren Return	BCA*		
Vehicle Return	BCA*		
Pet Return	BCA*		
Organ Retrieval	U.S./Canada		
Organ Recipient Transportation	U.S./Canada		

** Please refer to the MSA for a detailed explanation of benefits and eligibility.*

*** Basic Coverage Area (BCA) includes U.S., Canada, Mexico, and Caribbean (excluding Cuba).*

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For more information, please contact

Rich Allm, *WHA Insurance*

541.284.5853 | rallm@whainsurance.com

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RICH ALLM ● WHA INSURANCE
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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.

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