



Employer Administration Manual



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About this manual

Thank you for choosing PacificSource for your employees' health insurance. It's our pleasure to serve you and your employees.

While your insurance contract and handbook include your policy's details, this manual serves as a quick reference for policy administration procedures and provisions. We'll provide you with an updated contract when your coverage renews each year.

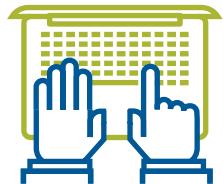
Tools and support

You can handle many of your administrative duties online through our secure web portal, InTouch for Employers. InTouch allows you to enroll members online and gives you access to your plan's policy documents, member benefit materials, and more. For more information, visit PacificSource.com.

A service team is assigned to your account, including an Account Executive, Membership Representative, and Customer Service Representatives. Please see the next page for a summary of their roles.

We look forward to working with you

Working together with your service team will provide a seamless experience for you and your employees. If you have questions concerning any area of your coverage, please contact your Account Executive.



A version of this manual is available on our website

Visit PacificSource.com > Employers > Documents and Forms

Your account management team

A service team is assigned to your account. Here's a summary of the scope of their roles.



Spanish and other language services

Plan materials

Spanish plan materials are available upon request, including:

- Benefit summaries
- Administrative forms
- Informational fliers
- Summary of benefits and coverage (SBC)

Customer service

We have a special Spanish telephone queue at **866-281-1464**. When Spanish-speaking members call, they can be transferred to one of several bilingual employees. Calls are returned within 2 business hours and we have a dedicated priority queue for Spanish voicemails.

Benefit meetings

PacificSource works with interpreters who can accompany our Account Executive, who will make the necessary arrangements. Advance notice will allow us to provide all the appropriate translated benefit summaries and other materials.

Spanish-speaking providers

Our provider directories list any languages practitioners speak in addition to English. Spanish-speaking members can call **541-684-5456** or **866-281-1464** to request a directory.

Other language needs

We realize that Spanish-speaking employees are not the only group that might need language services. With this in mind, we also work with a translation service for more than 200 other languages. Our goal is to accommodate all of our members.

Email us securely

In early 2025, PacificSource upgraded our secure email system.

If you were a user of the previous system, you'll be asked to set up a new account. The process is simple and straightforward. You'll click a link to receive a one-time passcode, then you'll be established as a known user.

We made this change to help keep sensitive data safe and secure.



Enrollment

Please refer to your organization's policy for all group-specific guidelines.

Enroll employees in coverage

The following information explains how to enroll members who are eligible for coverage under the terms of your policy. You'll find information about your plan's eligibility provisions and deadlines in your member benefit handbook.

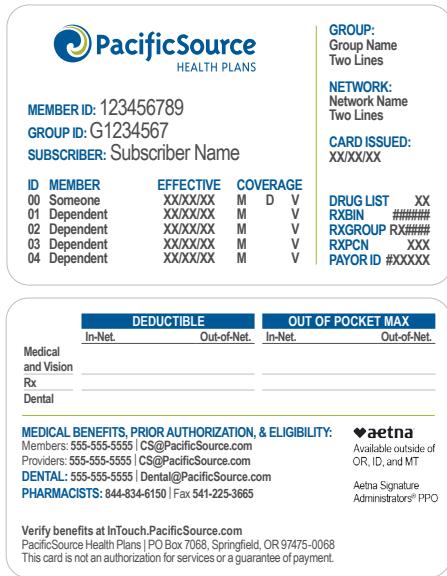
Application deadlines

When you add employees or dependents to your health plan, it's extremely important that we receive all enrollment materials on time. Please refer to your member benefit handbook for deadline information.

Member ID cards

When employees or family members are added to your group health plan, member ID cards are generated and mailed directly to the members. Cards are issued to all members 15 years of age or older. Members may be required to show their ID card in order to receive healthcare services under this plan. Members may order replacements for lost or stolen ID cards through InTouch For Members, our secure web portal for members, or by calling our Customer Service Department. As an administrator, you may also request an ID card for any of your active employees through InTouch for Employers.

To print temporary ID cards, visit InTouch.PacificSource.com.



Social Security numbers may be requested

To meet the reporting requirements of the federal Mandatory Insurer Reporting Law, we require plan member Social Security numbers. This includes **employees and dependents**. If a Social Security number is not provided at the time of enrollment, PacificSource will send a letter to the member each year, requesting the member's Social Security number.

Enroll new employees and dependents

You may enroll your new employees and eligible family members online via InTouch for Employers, or on paper via mail, fax, or secure email. Regardless of the method you choose, please remember to do the following:

- Give your employee access to a member benefit handbook and summary of benefits and coverage.
- Dental enrollees who have had prior coverage will need to submit proof of prior coverage to credit the waiting periods, if applicable.

Change from part-time, temp, or contracted to full-time

Part-time to full-time: If the employee is moving from part-time to full-time status, enter the date the employee began working full-time in the form's space for date of full-time hire. The appropriate enrollment waiting period (per your organization's policy) should then be applied from the date of full-time employment.

Temp to full-time: If a temporary employee was employed directly by you (and not another employer, such as a temp agency), we'll credit the time to their full-time probationary period upon your request.

Contracted to full-time: We're unable to credit a contracted employee's time to their full-time probationary period.

Online enrollment

Sign in to InTouch for Employers. To get there, go to PacificSource.com, click on Employers, and then the Employer InTouch button.

- Select Members, then Enroll or Waive Subscriber from the InTouch menu.
- Follow the on-screen instructions to complete your application. If errors are detected or information is missing, you'll be prompted to make corrections along the way. Mandatory fields are noted by asterisks.
 - » You'll need to fill out the subscriber information and benefit plan selection for your employee.
 - » You'll have the option to enroll dependents at this same time, if applicable.
 - » To ensure complete enrollment, please answer all of the questions in the Coverages section.
- Review the summary page to make sure the information you entered is correct. Print the summary page along with the disclosure, and give them to the employee.
- Click the Complete Enrollment button to submit the application to PacificSource. You can track submitted applications in the Recent Activity section of the homepage.

Enroll employees on paper

- Give employees the Employee Enrollment and Waiver Form. You'll find this form at PacificSource.com in the Employers section under Documents and Forms.
- Submit the following materials to your PacificSource Membership Representative:
 - » The completed Enrollment Application:
 - Verify that the employee's signature has been completed.
 - Verify that the For Employer to Complete section is populated.
 - » Additional documentation may be required for enrollment (such as adoptions, guardianship, court orders, or proof of prior coverage for medical or dental, if applicable).

You may send these forms via mail, fax, or secure email to your Membership Representative any time prior to the employee's effective date of coverage. If you choose to mail the forms, send them to PO Box 7068, Springfield OR 97475-0068. Charges for the new enrollee will be reflected in your next bill.

Adding dependents to coverage outside open enrollment

The following information explains how to enroll family members who are eligible for coverage under the terms of your policy. You'll find information about your plan's eligibility provisions and deadlines in your member benefit handbook.

You may enroll family members online via InTouch for Employers, by secure email, or on paper via mail or fax. Regardless of the method you choose, please remember to do the following:

- If the enrolling family members have creditable coverage under a prior plan, you'll need to submit proof of prior coverage to your Membership Representative by mail, fax, or secure email.

New spouse or domestic partner

Eligibility criteria: For new spouse or domestic partner, first of the month following the marriage or domestic partnership. Enrollment must be completed within 60 days.

Premium: Charged from first day of coverage.

Newborn children

Eligibility criteria: Day of birth. Enrollment must be completed within 60 days.

Premium: Charged from first day of coverage; prorated for first month.

Montana only: Newborns are automatically covered for the first 31 days. No premium will be billed for days one through 31. Coverage will end thereafter unless an application is received.

Adopted children/legal custody

Eligibility criteria: First day of placement with the employee. Enrollment must be completed within 60 days.

Premium: Charged from first day of coverage; prorated for first month.

Court order

Eligibility criteria: First of the month following receipt of the court order. Enrollment must be completed within 60 days.

Premium: Charged from first day of coverage.

Waivers of coverage

Your policy has very specific minimum participation requirements that must be continuously met in order for your policy to remain active. Please refer to the participation requirements in your member benefit handbook for specific information.

When eligible employees choose not to participate in your group health plan, they must complete a waiver form and send it to your Membership Representative right away.



Completing and submitting a waiver of coverage:

- The Employee Enrollment and Waiver Form includes a Waiver of Coverage section. You'll find this form at PacificSource.com/Employers in the Documents and Forms section.
- Enter employer and the employee information, such as name, address, Social Security number, date of birth, and date of hire.
- If the employee/dependent is waiving both medical and dental coverage, please ensure that the correct boxes are marked. Next, skip to the Declination of Coverage section.
- Mark the appropriate box for the reason coverage is being declined.
- If the employee/dependent is waiving due to other group coverage, provide the other group coverage information, including who it is through (such as spouse's employer or Medicare) and insurance carrier. If you don't provide this information, it could cause your group to be out of compliance with your group insurance policy.
- Make sure that the employee signs and dates the Employee Enrollment and Waiver Form.
- Submit the completed Employee Enrollment and Waiver Form to your Membership Representative at Membership@PacificSource.com within 60 days of the effective date of the waiver.

Report changes for enrolled members

There are several ways to update enrolled members' personal information.

- Employees may change their personal information online by logging into InTouch for Members and selecting Profile.
- You may change a member's personal information on their behalf through InTouch for Employers > Members. Or, email your Membership Representative at Membership@PacificSource.com.

Open enrollment

Employees can add or remove dependents during open enrollment. Late enrollees may enroll by completing and submitting an enrollment application during your annual open enrollment period. Coverage becomes effective the first day of the plan year.

Note: Some large groups have custom enrollment rules. See your group contract and handbook.

Enrollment after a layoff, leave of absence, or a reduction of hours

An eligible employee and their previously enrolled dependents may enroll if the employee's employment was terminated for one of these reasons. This provision applies if the employee was rehired within a specific period of time:

- Idaho: six months
- Montana: six months
- Oregon: nine months

Coverage for the employee and previously enrolled dependents becomes effective the date the employee returns to work. Previously enrolled dependents may enroll by completing and submitting an enrollment form according to the enrollment procedures stated in the enrollment section. The enrollment form must be submitted within 31 days of the employee's return to work.

Special enrollment period

- If someone originally waived coverage under this plan due to coverage under another health plan, and that other coverage is *involuntarily* lost, they will be allowed to enroll in this plan. A completed Enrollment Application and proof of loss of prior coverage are required, and coverage will be effective on the first of the month following termination of the other coverage. The enrollee must apply for coverage within 60 days of loss of the other coverage.
- This special enrollment period applies only to cases where the other coverage is lost involuntarily due to one of the following:
 - » Loss of eligibility (including legal separation, divorce, death, termination of employment, reduction in hours, termination of the other plan).
 - » Termination of employer's premium contributions.
- Employees who acquire new dependents because of marriage, birth, eligible foster child, adoption, or placement for adoption may be able to enroll themselves and/or their dependents at that time. For the employee to be eligible to enroll under this provision, the employee must have submitted an Employee Enrollment and Waiver Form to PacificSource at the time they were initially eligible to enroll, or at the time of disenrollment. To enroll, the employee must submit an enrollment application within 60 days after the marriage, birth, adoption, or placement for adoption. In the case of marriage, coverage begins on the first day of the month after the marriage. In the case of birth, eligible foster child, adoption, or placement for adoption, coverage begins on the date of birth, adoption, or placement.

Ending coverage

Please note: Under state and federal laws, you are required to notify all terminating members of their continuation rights. Please refer to the continuation coverage sections of this manual for more information.

Members have the opportunity to seek an individual plan direct with PacificSource when their group coverage ends.

Ending employee coverage

If an employee is terminated for any reason or no longer meets your group's eligibility requirements (for example: due to reduced work hours or a leave of absence), coverage for the employee and dependents will end as specified in your member handbook.

You may discontinue coverage for a terminating employee up to 60 days retroactively or according to your contract. You may complete member terminations via InTouch for Employers, or simply list the employee on the Enrollment Change Form included with your billing statement. Include name, PacificSource member ID number, termination date, and a brief explanation (for example: laid off, quit, hours reduced).

You can email your termination notices to your Membership Representative Membership@PacificSource.com or fax to 541-225-3642.

Please note that when coverage is retroactively terminated, claims for services after the termination date will be reprocessed and become the employee's financial responsibility.

Ending dependent coverage

List the dependents discontinuing coverage on the Enrollment Change Form included with your billing statement. Include names, the employee's PacificSource member ID number, termination date, and a brief explanation.

You can email the request to your Membership Representative at Membership@PacificSource.com. Or, you can cancel dependent coverage via InTouch for Employers.

Rescission restrictions of group policies

Under healthcare reform, health plans are not permitted to rescind (or retro-terminate) coverage except in cases of fraud or intentional misrepresentation of a material fact.

Group health coverage must comply with the rescission of coverage provisions. Following are a few guidelines:

- The prohibition is not intended to apply for failure to pay the correct premium on time.
- The prohibition is not intended to apply when retroactive termination is attributed only to delays of normal terminations because of administrative processes (e.g., a delay in notifying an insurer that an employee terminated employment and is no longer eligible for coverage).
- The prohibition would likely apply if an employer continued to pay the premium for an employee whose hours were reduced below the eligibility requirement and attempted to retroactively terminate the employee's coverage to the date when hours were reduced. In this scenario, the employee may unknowingly rely on the coverage for which premium was paid.
- The prohibition would likely apply if an employee inadvertently indicated an incorrect birth date of a dependent child and doing so caused coverage to continue beyond the dependent's normal termination date. Since the incorrect information was not an intentional misrepresentation, coverage could not be terminated retroactively.

If an employer terminates an employee's or dependent's coverage because of an intentional misrepresentation of material fact, the employer must give at least 30 days advance notice to the employee or dependent before taking the action to retroactively terminate the coverage. This 30-day requirement is intended to allow the individual to appeal the employer's action.

Dental plan administration

Some aspects of your PacificSource group dental plan are administered differently than your group health plan. This section outlines the procedures and regulations that differ from those of your health plan.



Plan requirement and restrictions

- For a nonvoluntary plan, all eligible employees must enroll in the group dental plan, except as indicated under Waiving Dental Coverage.
- The employee's family members are not required to enroll in dental coverage. However, anyone who does not enroll when first eligible will be allowed to enroll during open enrollment.
- Employees may enroll family members in dental coverage even if the family members are not enrolling in the medical coverage.
- Anyone who discontinues dental coverage for any reason, other than termination of employment or layoff, may not re-enroll in the dental plan until the policy renewal date.

Waiving dental coverage

Employees may waive the group dental coverage as long as the group meets the participation requirement. The option to waive coverage is included on the Employee Enrollment and Waiver Form.

Administer continuation coverage—Idaho only

No State Continuation option. Members can enroll on an individual policy.

Administer continuation coverage—Montana only

No State Continuation option. However, a person who experiences a reduction of hours below the minimum hour requirement may remain eligible on the plan for up to one year with the consent of the group. Members can enroll on an individual policy.

Administer continuation coverage—Oregon only

For Oregon employers with 19 or fewer employees, continuation coverage is available for medical, vision, and dental coverage. Domestic partners are eligible for continuation coverage. The continuation coverage benefits are always the same as your group's current benefits. If your group changes plans, the continuation plan will change as well.

If your insurance is through an association or other organization, please contact the plan administrator for additional information on continuation coverage.

Requirements

If an eligible person's coverage is terminated under the group health policy, and the policy is not replaced by similar coverage under another group policy, the insurer must provide written notice to the covered person and any qualified beneficiary no later than 10 days after the insurer is notified of the qualifying event. The notice must include all of the following:

- Contact information for the insurer
- Forms necessary to request continuation of coverage (including instruction for completing the forms)
- Information sufficient to determine premium rates for continuation of coverage and instructions for paying premium
- A clear statement of who is eligible to continue coverage
- Enrollment information for any other coverage provided by the employer for which the covered person or qualified beneficiary may be eligible
- An explanation of the process to appeal a denial of a claim
- Information about how to contact the consumer advocacy unit of the Oregon Insurance Division
- Other information as may be required by subsequent regulations

Continuation procedures

Anyone who qualifies for continuation coverage needs to complete the Group Coverage Continuation Election Form and return the form to you, the plan administrator. If the member chooses continuation coverage:

- Review the form to ensure that it is complete, including the employee's signature and date.
- Submit the completed Group Coverage Continuation Election Form within 31 days of loss of coverage.

Premium

The employee or enrolled dependent is responsible for the full cost of continuation. All continuation participants must make premium payments to you, the plan administrator, for inclusion in your monthly premium payment to us. We do not accept payment directly from members.

When participants choose continuation coverage, they must also make the first premium payment. After the initial payment, they should submit the continuation premium to you within 30 days of your group premium due date each month. We will pend claims for continuation participants until their premium is received from you with your monthly payment. If continuation premium is not received within the 30-day grace period, the continuation coverage will be terminated. **Please notify us immediately if you do not receive the premium payment.**

Premium for continuation coverage is the same as the group plan's premium.

Administer COBRA continuation coverage

Groups with an average of 20 or more employees during the last calendar year are affected by federal continuation laws (COBRA). COBRA allows the choice of continuing health benefits only, or continuing health as well as all the other benefits (i.e., dental) the employee had while under the group plan. Continuation of only dental coverage is not an option unless your group has dental coverage only, and not medical coverage, through PacificSource.

The continuation coverage benefits are always the same as your group's current benefits; if your group changes plans, the continuation plan will change as well. COBRA participants also have the same enrollment options as active employees covered by your group policy, including the option of enrolling dependents during open enrollment.

Notification requirements

According to COBRA guidelines, it is the responsibility of the employer, and not the insurance carrier, to notify employees and enrolled family members of their continuation rights. PacificSource makes continuation materials available to you as a service, but it is your legal responsibility to communicate the information to your plan's participants. We have no obligation to provide continuation coverage if the member, plan administrator, or employer does not fulfill the following notification requirements.

Initial notice

COBRA regulations require that the group notify all employees and spouses of their continuation rights when they first become covered under your group health plan. This is known as the "initial notice." Penalties for failing to provide initial notice can be severe, so to ensure compliance with this regulation, we recommend you notify all employees of their COBRA rights once a year. Whatever method you choose for providing initial notice, be sure your procedures are consistent and well documented for every enrollment.

We make a sample COBRA Initial Notice Template available to you as a convenience. The form is available online at PacificSource.com. Each covered employee and covered spouse must receive an initial notice when enrolling in the plan. If an employee marries after enrollment in the plan, the new spouse should receive an initial notice when enrolling. By mailing a copy of this document to each enrolling employee and spouse at their last known address, you will be in compliance with the regulations.

Qualifying event notice

Employees are required to notify you of any divorce, legal separation, or child no longer qualifying as a dependent within 60 days of the occurrence. You, the plan administrator, are responsible for notifying PacificSource of any employee's death, termination of employment, reduction in hours, or Medicare eligibility within 30 days of the occurrence. These events are all known as "qualifying events" and trigger a series of deadlines and notifications required by COBRA regulations.

When an employee or enrolled family member becomes eligible for continuation due to a qualifying event, you are required to again provide notification of continuation rights, as well as any continuation deadlines, premium information, and a continuation election form. PacificSource makes all this information available on a single form, the COBRA Election Form Federal Template (available on our website, PacificSource.com). The qualifying event notice must be distributed within 14 days of the qualifying event. You may distribute the notice either in person or through the mail, but again, be sure to provide these materials consistently in all cases and document your procedures.

Premium

The employee or enrolled dependent is responsible for the full cost of the continuation. All continuation participants must make premium payments to you, the employer, for inclusion in your monthly premium payment to us. We do not accept payment directly from participants.

When participants elect continuation coverage, they are allowed 45 days in which to make the first premium payment. After the initial payment, they must submit the continuation premium to you within 30 days of your group premium due date each month. We will pend claims for continuation participants until their premium is received from you with your monthly payment. If continuation premium is not received within the 30-day grace period, the continuation coverage will be terminated. Please notify us immediately if you do not receive the premium payment.

Premium for continuation coverage is the same as the group plan's premium, but you may charge an additional administration fee of up to 2% at your discretion. The rate classifications for COBRA members are as follows:

Members enrolling	Rate classification
Employee	Employee-only rate
Widowed or divorced spouse or domestic partner	Employee-only rate
Widowed or divorced spouse or domestic partner with dependent children	Employee-and-children rate
Employee and family	Employee-and-family rate
Employee and dependent children	Employee-and-children rate
Employee and spouse or domestic partner	Employee-and-spouse rate
Dependent child (one)	Employee-only rate
Dependent children (more than one)	Employee-and-children rate



Let us do more for you

PacificSource Administrators, Inc. offers administration services for employers with PacificSource Medical Plans.

- **COBRA/retiree administration –** We handle all necessary paperwork, notifications, billing, and personal contact required for COBRA compliance.
- **Premium-only plans and transportation benefits.**

For more information, contact your agent or Account Executive.



COBRA continuation procedures

Anyone who qualifies for continuation coverage should complete the Group Coverage Continuation Election Form (available at PacificSource.com). If you have questions about filling out the election form, contact your Membership Representative.

The effective date is the first day of the month after the member's regular group coverage ends. The election period expires 60 days from either the date regular group coverage ends or the date of the qualifying event, whichever is later. Your group's current premium rates can be found in your contract or most recent renewal endorsement.

Submit the continuation election form as soon as you have verified that all information is complete.

If the employee has paid continuation premium to you, include the premium with your next premium payment. PacificSource will accept continuation premium only if it is included in your group's regular monthly premium payment. Please do not send personal checks from an employee.

If the member declines continuation coverage, keep the completed form for your records and list the eligible member on the Deletions section of your next group billing statement.

The following qualifying events allow otherwise eligible individuals to continue under the employer's group plan for the lengths of time listed below. Each qualified beneficiary (employee, spouse, or dependent child) may elect continuation together or separately.

Qualifying event	Continuation period
Employee's termination of employment* or reduction in hours	Employee, spouse, domestic partner, and children may continue for up to 18 months ¹
Employee's divorce	Spouse, domestic partner, and children may continue for up to 36 months ²
Employee's eligibility for Medicare benefits if it causes a loss of coverage	Spouse, domestic partner, and children may continue for up to 36 months
Employee's death	Spouse, domestic partner, and children may continue for up to 36 months ²
Child no longer qualifies as a dependent	Child may continue for up to 36 months ²

¹ An 11-month extension of coverage may be available if any of the qualified beneficiaries are determined under the Social Security Act (SSA) to be disabled. The disability has to have started at some time on or before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must make sure that the Plan Administrator is notified in writing of the SSA's determination within 60 days after the date of the determination and before the end of the 18-month period of COBRA continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined to no longer be disabled under the SSA, you must notify the Plan of that fact within 30 days after that determination.

² The total maximum continuation period is 36 months, even if there is a second qualifying event. A second qualifying event might be a divorce, death, or child no longer qualifying as a dependent after the employee's termination or reduction in hours.

* Employees terminated for gross misconduct are not eligible for continuation coverage.

Individual and Medicare plans

Employees and covered family members are eligible to purchase a PacificSource **individual policy**:

- When coverage under a PacificSource group health policy ends,
- When the continuation coverage has been exhausted, or
- During the open enrollment period for state or federal marketplaces (exchanges).



For more information on individual policies, contact the PacificSource Individual Sales Department by phone at toll-free at **855-330-2792**, or by secure email at CoverageAdvisors@PacificSource.com.

We also offer Medicare Advantage plans for your employees who are eligible for the program. For more information, call **800-587-6435** or visit Medicare.PacificSource.com.

Read and understand your billing statement

PacificSource generates and mails billing statements for the following month between the 14th and 28th of the current month. Besides showing the total premium amount due for the month, your billing statement shows which employees and how many dependents are enrolled, as well as which have been terminated or added since the last billing.

You can request an alternate billing date between the 14th and the 28th by contacting your Membership Representative at Membership@PacificSource.com. Any adjustments made after the billing date will be reflected on the following billing statement. The due date will remain the first of the following month, regardless of the billing generation date requested.

Cover page

The statement's cover page shows general administrative changes or plan news.

Covered members table

This table shows each enrolled employee's name, PacificSource member ID number, effective date of coverage, the number of family members covered, and premium amounts for medical and other coverage.

Family composition totals

This table shows the family composition for the various types of coverage available under your plan.

Premium payment

Return the completed payment coupon to us with your premium payment; you may wish to make a copy for your files.

Please mail your premium payment to the address provided on the payment coupon. We ask that you pay your group premium as it is billed rather than making adjustments to the billing statement. If you have any questions or concerns related to your billing statement, you're welcome to contact your Membership Representative.

EFT payment option makes premium payment easier

EFT (Electronic Funds Transfer) payment option is available for paying your PacificSource group plan's premium. It's easy to sign up with the enrollment form found in the Employers section on our website at PacificSource.com.

Save time with online payments

Online payments are easy and convenient with our InTouch for Employers website. With just a few clicks, you can make a payment, manage payment accounts, view and download billing statements, and access your online payment history. Need more reasons to use online payment?

- It's cost-effective – there's no charge for the service, and you'll save on postage.
- It's flexible – you can make one-time payments or set up automatic recurring payments to pull on the 1st of each month.
- It's fast – payments received Monday through Friday by 2:00 p.m. Pacific Time will be posted to your account the same day. (After 2:00 p.m., it will be posted the next business day.)

How to get started: If you're already using other helpful tools and reports in InTouch for Employers, simply click the Payments tab at the top of the page to access all the payment options.

Reinstatement after grace period expires

If this policy is terminated for nonpayment of premium, the policyholder may have the policy reinstated by remitting all past due premium within 15 days after the grace period ends. Reinstatement of this policy may not be made more than twice in one contract year. At its discretion, PacificSource may require that funds remitted by the policyholder to be in the form of a cashier's check.

Using our online provider directory

Our online provider directory makes it easy to find in-network providers that meet specific needs.

Find a doctor, hospital, or facility

You can access the directory from our website, PacificSource.com. Click Find a Doctor or Drug in the navigation bar at the top of the page, or select an option from the pull-down menu.



Selecting a primary care provider (PCP)

NOTE: Oregon members are required to choose a PCP (except those on self-funded plans).

If your health plan requires members to designate a PCP, members can use our online provider directory at PacificSource.com.

Under Find a Doctor or Drug in our top menu bar, select “Find a Doctor.” Follow the online search instructions.

PCP selection information is also included on the initial enrollment form and our “Selecting a Primary Care Provider” member flier.

Members are always welcome to simply call our Customer Service team toll-free at **888-977-9299**. We’ll be happy to help them with the process of designating a new PCP.

Accessing care nationwide

Members have nationwide access to Aetna’s PPO through Aetna Signature Administrators® (outside Idaho, Montana, Oregon, and Cowlitz and Clark Counties in Washington). When visiting Aetna PPO providers and facilities, members will receive their plan’s in-network level of benefits.

Aetna’s PPO network includes more than 1.5 million participating physicians and ancillary providers, including more than 6,000 hospitals.

To find an Aetna PPO provider, members can search their directory at Aetna.com/ASA. Links to this directory are also available on our website, PacificSource.com/find-a-doctor, as well as our free mobile app, MyPacificSource.



Employer-required notifications

Employers offering group health coverage are subject to numerous federal notification requirements. Below are examples of the more common notices; *this is not a comprehensive list.*

Because requirements vary, you'll need to consult with the appropriate government agency (see below) or your legal counsel for guidance specific to your organization.



Health plan identifier (HPID)

The HPID provides a standard way for insurers and plan sponsors to identify themselves in electronic transactions. More information can be found on the Centers for Medicare & Medicaid website, [CMS.gov](https://www.cms.gov).

Summary of benefits and coverage (SBC)

This standardized summary, required by the ACA, includes covered benefits, cost-sharing examples, and coverage limitations. More information can be found on the Centers for Medicare & Medicaid website, [CMS.gov](https://www.cms.gov).

Medicare Part D creditable coverage – CMS reporting

Employers (plan sponsors) who offer prescription drug coverage are required to complete the Disclosure to CMS Form to report the creditable coverage status of their prescription drug plan. More information can be found on the Centers for Medicare & Medicaid website, [CMS.gov](https://www.cms.gov).

Creditable determinations for most of our prescription drug plans are available in the Employers > Documents and Forms area of [PacificSource.com](https://www.pacificsource.com).

IRS reporting requirements

This is a requirement to report the cost of coverage (both the employer and employee contribution) on each employee's W-2. It is based on the number of W-2s filed in the prior year. More information can be found on the Internal Revenue Service website, [IRS.gov](https://www.irs.gov).

We are pleased to offer the following value-added programs and services at no cost to all eligible PacificSource members with medical coverage.

Online tools and resources for employers at PacificSource.com

InTouch for Employers

By logging in with a user name and password, you can enroll new members or dependents, order ID cards, update addresses, and terminate member coverage. You can also access your plan's contract documents, member benefit materials, and much more, 24 hours a day. If you prefer doing business online, you'll appreciate the convenience of InTouch. Requests that do not require backup documentation are entered immediately.



Wellness communication toolkit

Actively promote health and wellness in your organization with these articles, posters, and payroll stuffers on a variety of topics. Visit PacificSource.com/Employers/Wellness-Toolkits.

Online tools and resources for members at PacificSource.com

InTouch for Members

Members can access their benefit information by logging on to the secure InTouch for Members area of our website. They can view their claims, the status of prior authorizations and referrals, the accumulated expenses towards their plan's deductible, and more.



myPacificSource mobile app

Members can stay "InTouch" with their PacificSource coverage, no matter where they are, with our free mobile app. The myPacificSource app is available for both iPhone® and Android™. Visit PacificSource.com/mobile.

Provider directory

Members can find up-to-date in-network provider information based on their location or the provider's name. Members can also make a personalized directory.

Wellness and care management programs

Telehealth

We've partnered with Teladoc® to offer members care from the comfort of home. Teladoc is a national network of U.S. board-certified physicians and pediatricians that members can see on-demand, 24/7, via phone or online video consultations, from wherever they happen to be. Some limitations apply. Visit PacificSource.com/members/getting-care/telehealth for details.

Prenatal Program

Our Prenatal Program helps expectant mothers learn more about their pregnancy and the development of their child. Participants receive educational materials and toll-free telephone access to a nurse consultant. High-risk members receive additional, proactive nurse support.

Prenatal vitamins

Pregnant members with pharmacy coverage are eligible to receive up to nine months of physician-prescribed prenatal vitamin supplements at no cost. (All copays and deductibles are waived.)

Health education classes

Members can receive a reimbursement of up to \$150 per plan year on health and wellness education classes, including CPR, financial planning, and more.

Weight management programs

Members with medical coverage can participate in a WW (formerly Weight Watchers) program and receive an annual reimbursement.

For full details and eligibility requirements, visit the Members > Healthy Resources area of PacificSource.com.

Discounted gym membership

The Active&Fit Direct™ program gives PacificSource members access to a broad network of participating fitness centers. The program also includes access to the Active&Fit Direct website, which features a fitness center locator and online fitness tracking. Visit PacificSource.com/activeandfit to learn more.

Wellness for kids

Six- and nine-year-olds currently covered by a PacificSource medical plan may be invited by mail to join HealthKicks!, a children's program that promotes healthy behaviors. Parents will receive an invitation to enroll their child in HealthKicks! If enrolled, children will receive age-appropriate, fun activity books on health and wellness topics to encourage healthy habits. Contact us for more information.

Condition Support Program

Our Condition Support Program offers support and information to members with asthma and diabetes (including members age 18 and younger), heart failure (HF), chronic obstructive pulmonary disease (COPD), and coronary artery disease (CAD). The program includes personal support to help participants reach their health and wellness goals, ongoing support to help them maintain healthy lifestyle changes, and helpful information about their health condition. Participants may also contact our nurses and registered dietitian via email or toll-free phone number to ask health questions.

Rare Disease Management

We offer rare disease management and specialty pharmacy programs that give individualized support for members with certain uncommon conditions, or those requiring injectable medications or biotech drugs.

Chronic Disease Self-Management Program

The Chronic Disease Self-Management Program provides six weekly sessions to help participants establish immediate goals. Members will learn to manage their symptoms and take control of their health. If there is a charge for the program, \$25 is reimbursable.

Caremark® Specialty Pharmacy

Caremark® Specialty Pharmacy Services is our provider for injectable medications and biotech drugs. A pharmacist-led CareTeam provides individual follow-up care and support to our members with certain conditions.

Nurse case management

Our Health Services Department provides individual case management for members who require specific help in managing their healthcare needs. Nurse Case Managers work collaboratively with providers and members to improve members' health, financial outcomes, and quality of life.

LifeTrac™ Transplant Network

We partner with LifeTrac Transplant Network to ensure that our members requiring transplant services have access to nationally recognized centers of excellence. Our Case Managers assist members by coordinating all phases of transplant services. Serving clients since 1988, LifeTrac is a national network of more than 50 carefully selected facilities that perform organ and bone marrow transplants—one of the most comprehensive networks in the United States.

Global emergency services

Assist America® global emergency services

Members with medical coverage who experience a medical emergency when traveling 100 or more miles from home or abroad can call Assist America for help. Services include medical consultation and evaluation, medical referrals, foreign hospital admission guarantee, critical care monitoring, and when medically necessary, evacuation to a facility that can provide treatment. These services are provided at no cost to members when arranged and provided by Assist America. Member toll-free number within the United States: **800-872-1414**; from outside the United States: **+1 609-986-1234**.





Contact us

Customer service

CS@PacificSource.com

888-977-9299

Idaho

Boise

408 E. Parkcenter Blvd
Suite 100
Boise, ID 83706
208-342-3709 or 888-492-2875

Montana

Helena

828 Great Northern Blvd
Suite 101
Helena, MT 59601
406-422-1008 or 855-422-1008

Washington

Spokane

Bank of America Building
601 W. Riverside Ave, Suite 120
Spokane, WA 99201
866-556-1224

Website

PacificSource.com

Oregon

Bend

2965 NE Conners Ave
Bend, OR 97701
541-330-8896 or 888-877-7996

Hood River

33 Nichols Pkwy
Suite 120
Hood River, OR 97031
800-431-4135

Portland

Crown Plaza Building
1500 SW First Ave, Suite 200
Portland, OR 97201
503-699-6561 or 866-540-1191

Salem

4263 Commercial St SE
Suite 400
Salem, OR 97302
971-374-0100

Springfield (headquarters)

555 International Way
Springfield, OR 97477
541-686-1242 or 888-977-9299

TTY: **711**. We accept all relay calls.