



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.

Your responsibility

The group policy requires that various administrative details of the plan be carried out within a specific time period. For example, it's extremely important that you understand when employees and dependents are first eligible to begin coverage. A late enrollment can result in long waiting periods before coverage becomes effective, creating possible financial hardship for the employee and possible litigation between the employee and your organization.

We want to help you avoid any potential—and costly—misunderstandings. You can help us with this by reviewing this manual in its entirety.

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 a Client Service Representative, Customer Service Representative, and Membership Representative. Please see the next page for a summary of their roles.

If you have questions concerning any area of your coverage, please contact your Client Service Representative.



A version of this manual is available on our website.

Visit PacificSource.com > Employers > Forms and Materials > Manage Your Group Coverage.

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 541-864-5456 or 866-281-1464. When Spanish-speaking members call, they can be transferred to one of several bilingual employees. If those employees are unavailable, callers are encouraged, in Spanish, to leave a voicemail message.

Benefit meetings

PacificSource works with interpreters who can accompany our Client Service Representative, 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 other languages. Our goal is to accommodate all of our members.

Email us securely

Our PacificSource secure email system makes it convenient and safe for you to send us information or documents. Registration is simple:

1. To get started, you'll need to receive a secure message from someone at PacificSource. You can wait until you receive one, simply contact any PacificSource representative, or email PasswordReset@PacificSource.com.
2. When you receive the secure email, click the View Message button in the body of the message. You'll be directed to our secure mail portal where you can follow the on-screen instructions to complete your account registration.

Once you're registered, you can log into <https://smail.PacificSource.com/enduser> to compose messages, attach files, and check your inbox as you would with any email software. (Please note that our secure mail portal can only be used to send secure messages to PacificSource and our subsidiaries, not to other companies.)

Questions? Please email your question or request to PasswordReset@PacificSource.com.



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 16 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](#).

			GROUP: Group Name Two Lines NETWORK: Network Two Lines CARD ISSUED: XX/XX/XX
MEMBER ID: 123456789 GROUP ID: G1234567 SUBSCRIBER: Someone W. Longname			
ID	MEMBER	EFFECTIVE	COVERAGE
00	Someone	XXXXXXXX	M D V
01	Dependent	XXXXXXXX	M V
02	Dependent	XXXXXXXX	M V
03	Dependent	XXXXXXXX	M V
04	Dependent	XXXXXXXX	M V
			DRUG LIST XX RXBIN ##### RXGROUP RX#### RXPCN XXX PAYOR ID #####

MEDICAL BENEFITS & ELIGIBILITY INFORMATION: Members (555) 555-5555 cs@pacificsource.com Providers (555) 555-5555 cs@pacificsource.com DENTAL: (555) 555-5555 Members & Providers dental@pacificsource.com 24-HOUR NURSELINE: (855) 834-6150 PREAUTHORIZATION: (888) 691-8209 PHARMACISTS: (844) 834-6150 Fax (541) 225-3665 Verify benefits on InTouch at PacificSource.com	    
PacificSource Health Plans PO Box 7068, Springfield, OR 97475-0068 This card is not an authorization for services or a guarantee of payment.	

Social security numbers required

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 employee'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 login button.

- Select New Enrollment 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.
 - » You must 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'll be given a reference number, which you can use to track submitted applications.

Enroll employees on paper

- Give employees the Group Medical/Dental Enrollment Application. You'll find this form at PacificSource.com in the Employers section under Forms and Materials.
- Submit the following materials to your PacificSource Membership Representative:
 - » The completed Enrollment Application. Check the last page of the application to be sure the employee's signature and date have been completed.
 - » Additional documentation that 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 Services 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 Services 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. The second month is prorated.

Washington only: Newborns are automatically covered for the first 21 days. 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 Member Services Representative right away. Without a waiver form on file, we are unable to allow the employee to enroll in your coverage if the other coverage is lost involuntarily.



Completing and submitting a waiver of coverage:

- The enrollment application includes a Waiver of Coverage section. You'll find this form at PacificSource.com/employers in the Forms and Materials 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 Enrollment Application and Waiver of Coverage form.
- Submit the completed Enrollment Application and Waiver of Coverage form to your Membership Services 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 > My Employees. 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 his or her previously enrolled dependents may enroll if the employee's employment was terminated by layoff. This provision applies if the employee was rehired within a specific period of time:

- Idaho: six months
- Montana: six months
- Oregon: nine months
- Washington: six 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 a Waiver of Health Plan Coverage form (part of the enrollment application 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. Simply list the employee in the Deletion section of 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 Service Representative Membership@PacificSource.com or fax 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 in the Deletion section of 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 Service 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 75% participation requirement. The option to waive coverage is included on the enrollment 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 that 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—Washington only

Every insurer that issues policies providing group coverage for hospital or medical expense shall offer the policyholder an option to include a policy provision granting a person who becomes ineligible for coverage under the group policy, the right to continue the group benefits for a period of time and at a rate agreed upon. To qualify for continuation of coverage, enrollees must have been covered under the PacificSource group plan for at least three months. Newborn babies and newly acquired family members not covered by another group health plan are the only exception to this rule. If your employer recently switched to this plan from another group health plan without a break in coverage, you will receive credit for time under the previous plan. Submit a completed Continuation Election form to PacificSource within 31 days after the last day of coverage under the group plan. Continuation coverage ends when the first of the following occurs: Three months of coverage has elapsed from the effective date of continuation coverage. Coverage will end on the last day of the third month.

Employer discontinues the group plan. Coverage will end on the last day the plan was in effect. Enrollee fails to pay the premiums for the coverage to employer by the first of each month. Coverage will end on the last day of the last month for which enrollee paid premium. Enrollee becomes eligible for another group health plan or Medicare. Coverage will end on the date you become eligible. If employer provides both medical and dental coverage and you were enrolled in both, you may continue both medical and dental. If employer provides only one type of coverage, or if you were enrolled in only one type of coverage, you may continue only that coverage. Continuation benefits are always the same as your employer's current benefits. Any employee whose compensation includes group disability or blanket disability insurance providing health care services, the premiums for which are paid in full or in part by an employer... may pay the premiums as they become due directly to the policyholder whenever the employee's compensation is suspended or terminated directly or indirectly as the result of a strike, lockout, or other labor dispute, for a period not exceeding six months and at the rate and coverages as the policy provides. During that period of time the policy may not be altered or changed.

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 not 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 employer. 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 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 employer, 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 form 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 Group Coverage Continuation Election Form (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 offers a broad range of services, including:

- **COBRA/retiree administration** – We handle all necessary paperwork, notifications, billing, and personal contact required for COBRA compliance.
- **Flexible spending accounts (FSAs)** – A popular benefit that not only reduces your employees' taxes, it also reduces the FICA taxes your company pays.
- **Health reimbursement arrangements (HRAs)** – You decide what amount to allocate to employees for their healthcare; employees access those funds to pay qualified expenses.
- **Premium-only plans and transportation benefits.**

For more information, contact your agent or Client Service Representative, or visit PacificSource.com/PSA.



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 Services 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).

The member may enroll in individual coverage upon termination of regular group coverage or at the end of continuation coverage.

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 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 Services 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 Services Representative.

EFT payment option makes premium payment easier

EFT (Electronic Funds Transfer) payment option is available for paying your PacificSource health plan group premium. It's easy to sign up with the enrollment form found in the For 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 participating providers that meet your specific needs.

Find a doctor, hospital, or facility

You can access the directory from our website, [PacificSource.com](https://www.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 or primary care dentist (PCP or PCD)

If your health plan requires members to designate a primary care provider or primary care dentist (PCP or PCD), members can use our online provider directory at [PacificSource.com](https://www.pacificsource.com).

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

PCP and PCD 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 our nationwide travel networks

Members have access to providers nationwide. If a member is traveling or lives outside your plan’s network service area, they have access to travel networks First Health® and First Choice Health™, depending on their location. To access these directories:

1. Visit [PacificSource.com](https://www.pacificsource.com) and click Find a Doctor or Drug in the menu at the top of the page.
2. On the Find a Doctor Provider Directory page, under “Outside Our Service Areas,” click the travel network that serves the location where you need to find a provider, and follow the instructions.

Members can check your member handbook or policy before their visit for details on how services provided through these travel networks are covered.



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.



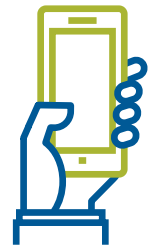
Wellness communication toolkit

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](https://www.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 preauthorizations and referrals, the accumulated expenses towards their plan's deductible, and more.



CaféWell

CaféWell is a secure online health engagement portal with personalized information and tools to help members make the most of their health.

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](https://www.pacificsource.com/mobile).

Provider directory

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

Wellness and care management programs

Virtual healthcare

We've partnered with Teladoc® to offer members virtual healthcare visits. 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.

24-Hour NurseLine

Most medical situations don't happen during business hours. Our 24-Hour NurseLine is staffed around the clock, 7 days a week, so members will never be without a registered nurse to talk to if they have health-related questions. The member toll-free number is 855-834-6150.

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).

Tobacco cessation

Our Quit For Life® program, brought to you by Optum, can help tobacco users kick the habit. Members receive phone and online support to help keep them on track. Member toll-free number: 866-784-8454.

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 know as 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 and YMCAs. The program also includes access to the Active&Fit Direct website, which features a fitness center locator and online fitness tracking. A \$25 enrollment fee, \$25 for the current month, and \$25 for the next month are due at time of enrollment (\$75 total, plus applicable taxes). 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 newsletters with current 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.

AccordantCare® rare disease management program

Our members with certain chronic, rare conditions receive ongoing one-on-one support and care coordination to ensure optimal care, decrease complications, and improve health outcomes.

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.

Travel program

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.



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.



Customer service

cs@pacificsource.com
888-977-9299

Website

PacificSource.com

Idaho

Boise

408 E. Parkcenter Boulevard
Suite 100
Boise, ID 83706
208-342-3709 or 888-492-2875 or TTY 711

Idaho Falls

1498 Milligan Road
Idaho Falls, ID 83402
208-522-1360 or TTY 711

Montana

Billings

2718 Montana Ave
Suite 103
Billings, MT 59101
406-896-7850 or 855-422-1008 or TTY 711

Helena

828 Great Northern Blvd
Suite 101
Helena, MT 59601
406-422-1008 or 855-422-1008 or TTY 711

Washington

Spokane

Bank of America Building
601 W. Riverside Ave, Suite 120
Spokane, WA 99201
866-556-1224 or TTY 711

Tacoma

Columbia Bank Building
South A Street, Suite 200
Tacoma, WA 98402
866-556-1224 or TTY 711

Oregon

Bend

2965 NE Connors Ave
Bend, OR 97701
541-330-8896 or 888-877-7996 or TTY 711

Hood River

33 Nichols Pkwy
Suite 120
Hood River, OR 97031
800-431-4135 or TTY 711

Medford

1301 Poplar Dr.
Suite 100
Medford, OR 97504
541-858-0381 or 800-899-5866 or TTY 711

Portland

Crown Plaza Building
1500 SW First Ave, Suite 200
Portland, OR 97201
503-699-6561 or 866-540-1191 or TTY 711

Salem

4263 Commercial St SE
Suite 400
Salem, OR 97302
971-374-0100 or TTY 711

Springfield (headquarters)

555 International Way
Springfield, OR 97477
541-686-1242 or 888-977-9299 or TTY 711