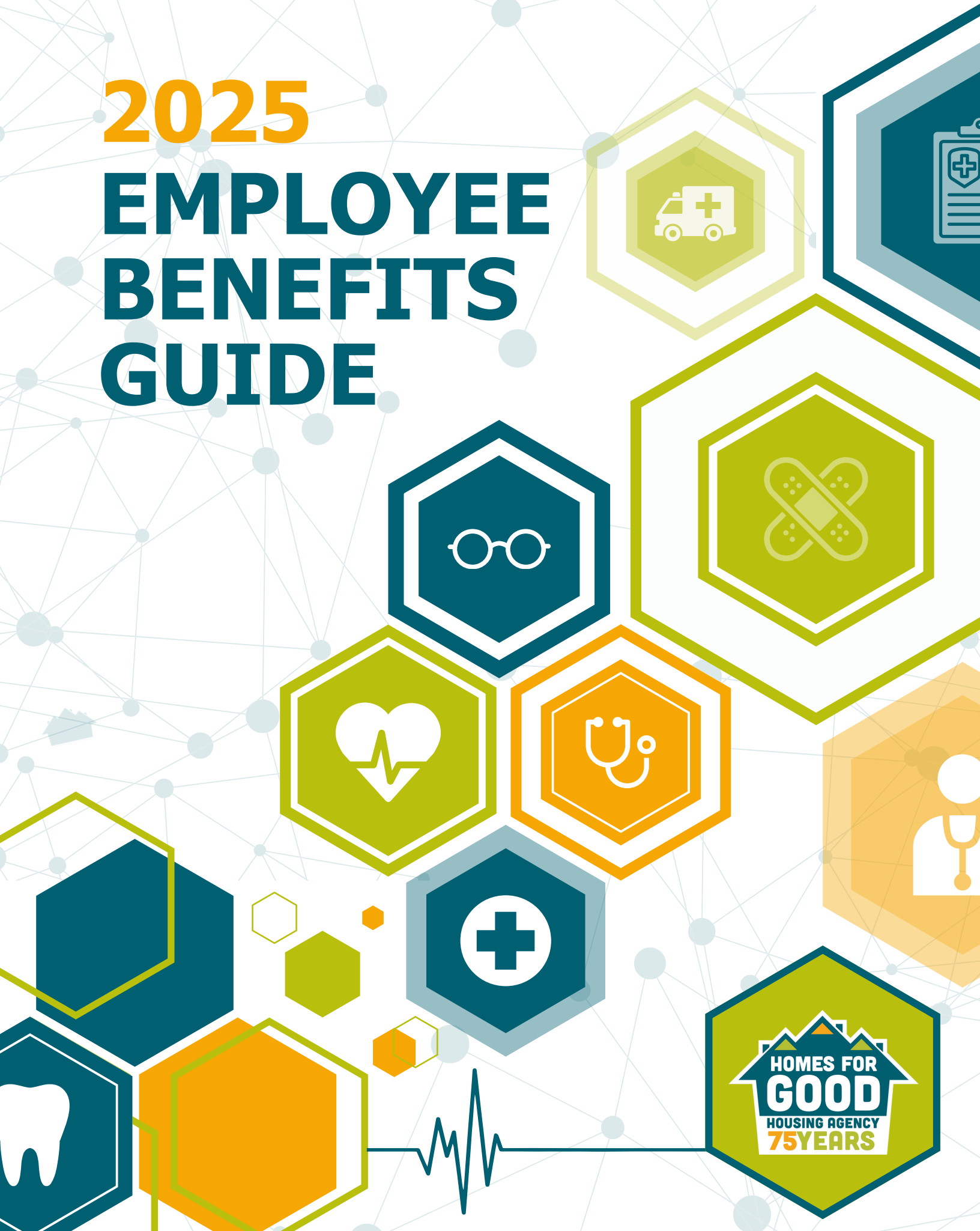
2025 EMPLOYEE BENEFITS GUIDE



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A Message to Our Employees

At Homes for Good we know how important it is to have comprehensive, affordable health benefits. That's why we offer competitive plans that can provide protection, peace of mind, and savings. It's time for you to begin thinking about your 2025 benefits choices.

Homes for Good conducts an annual open enrollment period during which benefits-eligible employees can enroll in, or make changes to, their benefits.

Your Enrollment Responsibilities

Your 2025 Benefits Guide will help you navigate through the process and make the best choices for you and your family.

Your benefits will begin on the 1st of the month following 30 days of employment. We prefer you enroll by the 15th of the month prior to your eligibility date. You should have received a registration email from our administrator CIS. You can enroll in your benefits through CIS at www.cisbenefits.org.

Benefit Resource Center

We encourage you to contact the USI Benefit Resource Center (BRC) Team. The Benefit Specialists at USI are experienced professionals, and their primary responsibility is to assist you! They can answer many of the benefits questions you have, or they will help you find an answer.

Monday through Friday 8:00am to 5:00pm Mountain, Pacific and Alaska Standard
Time Phone: 866-468-7272 Email: BRCWest@usi.com

Questions

If you have questions in the meantime, contact Isabelle Le at 541-682-2533, via Teams or via e-mail at ile@homesforgood.org.

Benefits for You & Your Family

Homes for Good is pleased to announce our 2025 benefits program, which is designed to help you stay healthy, feel secure, and maintain a work/life balance. Offering a competitive benefits package is just one way we strive to provide our employees with a rewarding workplace.

Please read the information provided in this guide carefully. For full details about our plans, please refer to the summary plan descriptions. Listed below are the Homes for Good benefits available during open enrollment:

- Medical / Vision
- Dental
- Basic Life and AD&D
- Long Term Disability
- Voluntary Life and AD&D
- Flexible Spending Account (FSA)
- Health Savings Account (HSA)
- Health Reimbursement Arrangement (HRA)
- Accident Insurance

Who is Eligible?

- Full-Time employees working 20 hours per week or more
- Spouses, Children, and Domestic Partners
- Eligibility begins on the first of the month following 1 month of employment

Dependents are defined as:

- Dependent “child” up to age 26. (Child means the employee’s natural child or adopted child and any other child as defined in the certificate of coverage)
- Your spouse and domestic partner

When and How Do I Enroll?

Open enrollment will be conducted from October 2024 through October 2025 at CIS-Connect.

CIS-Connect is CIS's enrollment system. If you have not accessed your CIS account, you must register for CIS-Connect before you can log in. You can register at www.cisbenefits.org, and click on the "CIS-Connect Login" button to get started.

Click here for written instructions.

Click here to view an instructional video.

All eligible employees are required to complete the enrollment process, even if you do not wish to make any changes to your benefits.

When is My Coverage Effective?

The effective date for your benefits is the 1st of the month following 30 days of employment.

Changing Coverage During the Year

You can change your coverage during the year when you experience a qualified change in status, such as marriage, divorce, birth, adoption, placement for adoption, or loss of coverage. The change must be reported to the Human Resources Department within 30 days of the event. The change must be consistent with the event.

For example, if your dependent child no longer meets eligibility requirements, you can drop coverage only for that dependent.

Regence Plan Summaries

CIS High Deductible Health Plan 4 w/ HSA Alternative Care

Benefits Summary
Effective January 1, 2025

cis benefits
www.cisbenefits.org

These medical plans are insured by CIS, but administered by Regence BlueCross BlueShield (BCBS) of Oregon. This means that CIS, not Regence BCBS, pays for your covered medical services and supplies.

HDHP 4 w/ HSA	
Deductible Per Calendar Year	$1,700 Individual $3,400 Family
Out-of-Pocket Maximum Per Calendar Year **Category 1, 2, & 3** – Preferred, Participating, Non-Preferred Providers (includes deductible, medical copays and prescription copays*)	$3,400 Individual $6,800 Family
*__Important Note:__ The family out-of-pocket maximum for a calendar year is satisfied when two or more family members' deductible and coinsurance for covered services for that calendar year total and meet the family's out-of-pocket maximum amount.	

Medical Services	**Member Pays** **Category 1 - Preferred** **Category 2 - Participating**	**Member Pays** **Category 3 - Non-Preferred**
Preventive Care Services		
Routine well-baby care, physical examinations, health screenings, and immunizations *(for a list of covered services, visit our website regence.com, hover over "Member dashboard" at the top, select Preventive Care from the drop down)*	0% for Category 1 & 2 (*deductible waived*) 40% for Category 3 (*after deductible*)	
Professional Services	**After Deductible – Member Pays**	
Office visits for illness or injury, mental/behavioral health or substance use disorder *(primary care, specialist, naturopath, urgent/immediate care center or virtual care)*	0% for first 3 visits for Primary Care, Behavioral Health and Virtual Care visits 20% for additional office visits	40%
Outpatient laboratory, radiology, and diagnostic procedures	20%	40%
Maternity care	20%	40%
Therapeutic injections including allergy shots	20%	40%
Hospital/Facility Services	**After Deductible – Member Pays**	
Ambulatory Surgical Center	10% *(20% for all other facilities)*	40%
Emergency room care *(including professional charges)*	20%	
Inpatient/outpatient surgery and surgeon fees	20%	40%
Inpatient mental/behavioral health & substance use disorder	20%	40%
Skilled Nursing Facility – *120 inpatient days per year*	20%	40%
Other Services	**After Deductible – Member Pays**	
Ambulance	20%	
Rehabilitation Services*: Inpatient: Unlimited / Outpatient: 77 visits per year (visit limit shared with Neurodevelopmental therapy)*	20%	40%
Hearing Aids- *applies to children 18 years or younger or children 19 to 25 enrolled in an accredited education institution*	20%	40%
Home health care - *180 visits per year*	20%	40%
Hospice – *14 respite days per lifetime*	20%	40%
Durable Medical Equipment	20%	40%
Weight Management/Nutritional Counseling and Bariatric Surgery:		
- Weight management and nutritional counseling visits *Four visits per year*	0%	40%
- Bariatric surgery may be covered to treat morbid obesity (participant must meet participation requirements) *Limited to one surgery per claimant lifetime*	$1,000 copay then 20%	$1,000 copay then 40%

Prescription Medication Benefit *If you need drugs to treat your illness or condition, your prescription drug coverage is administered through Express Scripts (ES). Please visit Express Scripts' web site at www.express-scripts.com or contact their customer service at 1 (800) 496-4182.* *Regence BlueCross BlueShield of Oregon assumes no liability for the accuracy of your prescription drug benefits information.*	**At the Pharmacy (30-day supply)** **Member Pays**	**Mail Order thru the Express Scripts Pharmacy Program (90-day supply)** **Member Pays**
Individual deductible per calendar year	Shared with Medical Services	
Out-of-pocket maximum each calendar year	Shared with Medical Services	
Generic drugs	20% Retail/Mail Order Prescription	
Preferred brand drugs		
Non-Preferred brand drugs		
Specialty Drugs	Refer to generic, preferred brand and non-preferred brand drugs above, for specialty drugs or self-administrable cancer chemotherapy drug coverage.	
Limitations and Exceptions	*Coverage is limited to 30-day supply retail or 90-day supply mail order. Long-term medication fills at participating retail pharmacies may be filled for up to a 90-day supply. Visit Express Scripts' website for details. Specialty drug coverage is limited to a 30-day supply and must be filled through Accredo Specialty Pharmacy.* *Specialty medications filled at a retail pharmacy are subject to 100% copay/coinsurance, and this amount does not accumulate towards the out-of-pocket maximum.* *Certain preventive items and services as defined by the Affordable Care Act are covered at zero-dollar cost share.* ***Deductible*** *waived and $0 patient responsibility for generic and preferred brand drugs designated as preventive for treatment of chronic diseases that are on the Preventive Medications List.* *Product Selection Cost -If you request and obtain a brand name drug when a generic equivalent is available, you are responsible for the applicable coinsurance plus the cost difference between the brand name drug and the generic drug.*	

Additional Medical Services

Alternative Care Services – Member Pays	
Acupuncture and Chiropractic Spinal Manipulations	20% Category 1 & 2, 40% Category 3 - Maximum allowance of 12 visits per calendar year for Acupuncture and 20 visits per calendar year for Chiropractic Spinal Manipulations.

Other services included in your CIS medical plan	Contact Information
Hinge Health - Hinge Health provides all the tools you need to get moving again from the comfort of your home. You'll get exercise therapy tailored to your condition and a personal care team of experts. Best of all, there's no additional cost to you.	To learn more, please call 1 (855) 902-2777 or sign on to the CIS Health Manager at www.regence.com. Scroll down to Resources and click on Hinge Health.
Lantern (formerly SurgeryPlus) – A comprehensive surgical program that provides a personalized concierge experience from dedicated Care Advocates and access to quality-centric health care through a network of credentialed surgeons. By using the SurgeryPlus benefit, you may also save money through reduced financial responsibility.	To learn more, please call (833) 633-0511, go to cisbenefit.surgeryplus.com, or email cisbenefits@surgeryplus.com
MDLIVE (Telehealth) - With MDLIVE's telehealth service, you can see a doctor or therapist from home, work or on the go, 24/7/365. Board-certified doctors visit with you by phone or secure video to treat non-emergency medical conditions. They can diagnose symptoms, prescribe medication, and send prescriptions to your pharmacy.	To learn more, please call 1 (888) 725-3097 or sign on to the CIS Health Manager at www.regence.com and hover on "Programs & Resources", then click on Telehealth. Scroll down to Resources and click on MDLIVE.
Chronic Condition Coaching supports and educates members with chronic conditions including hypertension, diabetes, COPD, CAD, CHF, asthma and obesity.	To learn more, please call 1 (866) 865-6725.
BeyondWell - A comprehensive well-being solution for members that integrates wellness activities, goals, rewards and challenges into a single location for a holistic wellness offering.	To learn more, please call 1 (866) 865-6725 or sign on to the CIS Health Manager at www.regence.com. Scroll down to Resources and click on BeyondWell.
Case Management - Supports and educates members with serious illnesses or injuries.	To learn more, please call 1 (866) 543-5765 or sign on to the CIS Health Manager at www.regence.com. Scroll down to Resources and click on Care Management
Pregnancy Program (*Childbirth to Newborn resources*).	To learn more, please call 1 (888) 569-2229 or sign on to the CIS Health Manager at www.regence.com. Scroll down to Resources and click on Pregnancy Program
BlueCard Program (Out of Area Services) – access hospital and physicians when outside the four-state area Regence services (Oregon, Idaho, Utah and Washington) as well as receive care in 200 countries around the world.	Find a provider near you at www.regence.com or call 1 (800) 810-BLUE (2583).

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to https://regence.com or call 1 (888) 370-6159. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 1 (888) 370-6159 to request a copy. **Please Note:** Your medical plan is provided and insured by CIS, but administered by Regence BlueCross BlueShield of Oregon. This means that CIS, not Regence BlueCross BlueShield of Oregon, pays for your covered medical services and supplies.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,700 individual (single coverage) / $3,400 family per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Certain preventive care and those services listed below as "deductible does not apply." "No charge" means $0 copayment or 0% coinsurance, regardless of deductible applicability.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$3,400 individual (single coverage) / $6,800 family* per calendar year. *An individual on family coverage will not have their out-of-pocket limit exceed $6,800.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://regence.com/go/OR/Preferred or call 1 (888) 370-6159 for a list of network providers.	You pay the least if you use a provider in the preferred network. You pay more if you use a provider in the participating network. You will pay the most if you use a non-participating provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use a non-participating provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge for upfront office visits; 20% coinsurance for additional office visits; 20% coinsurance for other services	20% coinsurance	40% coinsurance	First 3 upfront office visits / year. Limit is for primary care and behavioral health visits combined.
	Specialist visit	20% coinsurance	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge, deductible does not apply	No charge, deductible does not apply	40% coinsurance	Coinsurance and deductible waived for childhood immunizations from non-participating providers. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition	Generic drugs	Not applicable, refer to the participating provider column.	20% coinsurance 30-day / retail prescription; 20% coinsurance 90-day / mail order prescription	Not covered	Out-of-pocket limit is shared with medical services. Deductible waived and $0 patient responsibility for generic and preferred brand drugs specifically designated as preventive for treatment of certain chronic diseases that are on the Preventive Medications List. 30-day supply / retail prescription 90-day supply / mail order prescription Long term medication fills at participating retail pharmacies may be filled for up to a 90-day supply. Visit Express Scripts website for details. 30-day supply / specialty drug retail prescription
	Preferred brand drugs	Not applicable, refer to the participating provider column.	20% coinsurance 30-day / retail prescription; 20% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
Your prescription drug coverage is administered through Express Scripts (ES). Please visit Express Scripts' web site at www.express-scripts.com or contact their customer service at 1 (800) 496-4182. Regence BlueCross BlueShield of Oregon assumes no liability for the accuracy of your prescription drug benefits information.			90-day / mail order prescription		Specialty drug coverage is limited to a 30-day supply and must be filled through Accredo Specialty Pharmacy. Specialty drugs filled at a retail pharmacy are subject to 100% copayment / coinsurance, and this amount does not accumulate towards the out-of-pocket limit. Certain preventive items and services as defined by the Affordable Care Act are covered at zero-dollar cost share. Production Selection Cost – If you request and obtain a brand name drug when a generic equivalent is available, you will be charged a penalty equal to the cost difference between the brand name drug and the generic drug.
	Non-Preferred Brand drugs	Not applicable, refer to the participating provider column.	20% coinsurance 30-day / retail prescription; 20% coinsurance 90-day / mail order prescription	Not covered	
	Specialty drugs	Not applicable, refer to the participating provider column.	20% coinsurance 30-day / specialty generic prescription; 20% coinsurance 30-day / specialty preferred brand prescription; 20% coinsurance 30-day / specialty brand prescription; Specialty drugs must be filled through Accredo Specialty Pharmacy.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance for ambulatory surgery centers; 20% coinsurance for all other facilities	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
	Physician/surgeon fees	10% coinsurance for ambulatory surgery center physicians; 20% coinsurance for all other physicians	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	20% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge for upfront office or psychotherapy visits; 20% coinsurance for additional office or psychotherapy visits; 20% coinsurance for other services	20% coinsurance	40% coinsurance	First 3 upfront visits / year. Limit is for primary care and behavioral health visits combined.
	Inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	40% coinsurance	130 visits / year
	Rehabilitation services	20% coinsurance	20% coinsurance	40% coinsurance	77 visits / year for all habilitation and outpatient rehabilitation services Includes physical therapy, occupational therapy, speech therapy and neurodevelopmental therapy services.
	Habilitation services	20% coinsurance	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	20% coinsurance	40% coinsurance	120 inpatient days / year
	Durable medical equipment	20% coinsurance	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	20% coinsurance	40% coinsurance	14 respite inpatient or outpatient days / lifetime
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery, except congenital anomalies
- Dental care
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care
- Routine foot care, except for diabetic patients
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Acupuncture, 12 visits / year
- Bariatric surgery, 1 surgery / lifetime
- Chiropractic care, 20 visits / year
- Hearing aids (individuals up to age 26), 1 per ear / 36 months
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1 (877) 267-2323 ext. 61565 or cciio.cms.gov or your state insurance department. You may also contact the plan at 1 (888) 370-6159. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 1 (800) 318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the plan at 1 (888) 370-6159 or visit regence.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform. You may also contact the Oregon Division of Financial Regulation by calling 1 (503) 947-7984 or the toll-free message line at 1 (888) 877-4894; by writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx; or by E-mail at: DFRInsuranceHelp@oregon.gov.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1 (888) 370-6159.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,700**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,460**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,700**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$700
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$2,600**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1,700**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

The plan would be responsible for the other costs of these EXAMPLE covered services.

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Regence:
Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator.

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Customer Service
Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

Medicare Customer Service
Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

VSP Customer Service
Phone: 1-844-299-3041
TTY: 1-800-428-4833

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347 (TTY:711）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíilnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم TTY: 711)

Your one-stop shop for managing your health

With the CIS Health Manager on **regence.com**, you can find important health information in one place, customized for you. Use your computer, phone or tablet to easily access health benefits, telehealth and behavioral health resources, explanations of benefits, wellness tools and much more.

BeyondWell℠

Wellness activities, goal setting and rewards are all in one place for a personalized well-being experience.

MDLIVE

With MDLIVE, you can securely chat with a doctor by phone or video, 24/7 wherever you are.

Healthy Benefits

The CIS Healthy Benefits program provides financial assistance for certain weight management and tobacco cessation programs.

VSP: Vision

Your vision plan uses the VSP Choice network of providers. View your benefits, find a provider, get special offers and shop for eyewear.

Telehealth

Chat by phone or video with in-network providers who offer this service. Reach out to your doctor or clinic to find out if they provide virtual care.

Express Scripts

Express Scripts provides prescription drug coverage. Sign in to the CIS Health Manager for more information.

Mental health support

If you're feeling low or in need of support, we can help you find the right care. Many therapists and psychiatrists offer both in-person and virtual appointments, so you can get care just how you need it. Your plan also includes additional options for virtual therapy and virtual substance use disorder treatment.

Pregnancy program

Get support from caring professionals throughout your pregnancy with our maternity management program. A nurse will reinforce your doctor's or midwife's care and answer questions 24/7.

Hinge Health

Take control of your joint and back pain through virtual muscle and joint support. Join the thousands of people who have cut their pain through easy-to-do 15-minute exercise therapy sessions.

If you're considering surgery, Hinge Health also gives you an option to access in-network surgeons and a care advocate to guide you through care and recovery to get you to the finish line.

Start with your CIS Health Manager!

Download the Regence app or go to **regence.com** to create an account.
All you need is your member ID card to get started.

Regence

BeyondWell is a separate company that provides health information services. Hinge Health is a separate company that provides virtual physical therapy services. MDLIVE is a separate company that provides telehealth services. Express Scripts and VSP do not provide Blue Cross Blue Shield services and are separate companies solely responsible for their products/services.

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

Regence BlueCross BlueShield of Oregon
200 SW Market Street, 11th Floor | Portland, OR 97201

REG-OR-860116-24/08

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

A Look at Your VSP Vision Coverage

With VSP and CIS TRUST, your health comes first.

Enroll in VSP® Vision Care to get access to savings and personalized vision care from a VSP network doctor for you and your family.

vsp vision care | CIS cis benefits cisbenefits.org

Value and savings you love.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over $3,000 in savings.

Provider choices you want.

Maximize your benefits at a Premier Program location, including thousands of private practice doctors and over 700 Visionworks retail locations nationwide.

vsp PREMIER PROGRAM

Preferred private practice and retail in-network choices

private practice doctors

Visionworks

Quality vision care you need.

You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

Using your benefit is easy!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

More Ways to Save

Extra

$20

to spend on Featured Brands†

bebe · CALVIN KLEIN · COLE HAAN · DRAGON · FLEXON · LACOSTE · and more

See all brands and offers at **vsp.com/offers**.

+

Up to

40%

Savings on lens enhancements‡

Contact us: **800.877.7195** or **vsp.com**

Your VSP Vision Benefits Summary

CIS TRUST Vision Plan A and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Choice
EFFECTIVE DATE:
01/01/2025

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$10	Every calendar year
ESSENTIAL MEDICAL EYE CARE	• Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 per screening $20 per exam	Available as needed
PRESCRIPTION GLASSES		**$25**	
FRAME†	• $190 featured frame brands allowance • $170 frame allowance • 20% savings on the amount over your allowance • $95 Walmart®/Sam's Club®/Costco® frame allowance	Included in Prescription Glasses	Every other calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses	Included in Prescription Glasses	Every calendar year
LENS ENHANCEMENTS	• Anti-glare coating • Tints/Light-reactive lenses • Impact-resistant lenses • Scratch-resistant coating • UV protection • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $0 $0 $0 $0 $50 $50 $50	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• $166 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation)	$0	Every calendar year
SAFETY GLASSES (EMPLOYEE-ONLY COVERAGE)			
FRAME†	• $65 allowance for a safety frame • 20% savings on the amount over your allowance • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	$0	Every other calendar year
LENSES	• Prescription single vision, lined bifocal, and lined trifocal • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	$0	Every calendar year
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	Routine Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider. Your plan provides the following out-of-network reimbursements:

Exam ..... up to $50	Lined Bifocal Lenses ..... up to $55	Contacts ..... up to $110
Frame ..... up to $70	Lined Trifocal Lenses ..... up to $70	Tints ..... up to $5
Single Vision Lenses ..... up to $35	Progressive Lenses ..... up to $105	

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.
‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington.

Classification: Restricted

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cisbenefits.org

Surgery Plus

¡Visita la página **SurgeryPlus.com** y selecciona español para obtener más información!

New Name in 2025 · lantern · Same Trusted Team

Guided Access to Excellent Surgical Care

What is SurgeryPlus?

With your SurgeryPlus benefit, you can be sure you're getting the best surgical care for your unique needs. And the best part is that it's already included in your benefits at **no additional cost**.

Here's What's Covered

You'll pay less when you use your SurgeryPlus benefit. Your coverage includes:*

- Dedicated support and guidance
- Personalized matching with the best surgeon for your needs from our network of excellent providers
- Consults and appointments with your SurgeryPlus surgeon
- Anesthesia, procedure and facility (hospital) fees

*Testing, scans, imaging, durable medical equipment, and physical therapy expenses may not be included. However, coverage may be available through your medical plan.

Getting back to health is easy.

Just follow these simple steps:

Step 1

Call a Care Advocate to get started. They're here to help you every step of the way.

Step 2

We'll match you with highly qualified surgeons from our network who specialize in the care you need.

Step 3

Be on your way to feeling better without the stress of high medical costs.

When you need to plan a surgery, make SurgeryPlus your first call:

(833) 603-0511

Scan to log in to your personalized portal to understand what's covered.

Frequently Asked Questions

¡Visita la página **SurgeryPlus.com** y selecciona español para obtener más información!

New Name in 2025 lantern Same Trusted Team

Surgery Plus

SurgeryPlus is an additional medical benefit that provides you with access to excellent and affordable care for many planned surgical procedures. In partnership with CIS Benefits, SurgeryPlus covers the most expensive costs associated with your surgery so you don't have to.

What does SurgeryPlus cover?

Your SurgeryPlus coverage includes:

- Dedicated support and guidance
- Access to our network of thousands of highly qualified and carefully selected surgeons
- Consults and appointments with your SurgeryPlus surgeon
- Anesthesia, procedure and facility (hospital) fees

How do I access the benefit?

If you have questions about the benefit, or if you or one of your dependents need surgery, make us your first call. To learn more, contact your SurgeryPlus Care Advocate today at (833) 603-0511.

Does SurgeryPlus cost me anything?

You're automatically enrolled in the benefit as part of the medical benefits offered by CIS Benefits at no additional cost to you.

Who will help me through this process?

Your benefit includes guided access from a SurgeryPlus Care Advocate who will:

- Provide personalized support throughout your surgical journey.
- Educate you on the benefit, with an understanding of your surgical need.
- Provide you with the resources to help you make the best decisions regarding your care, including how to find the best surgeon in our network.

How do I know if a surgery is covered?

Contact us at (833) 603-0511 or visit your portal to confirm whether your procedure is covered.

How do I find the right surgeon?

With an understanding of your healthcare needs, your Care Advocate will provide a list of the best surgeons in our network so you can choose the one that's right for you.

If I already have a surgeon, how do I know if they are in the SurgeryPlus network?

Call your Care Advocate and they will be able to confirm whether your current surgeon is in our network.

What will my surgery cost?

We cover the most expensive costs associated with surgery, so you'll pay less for your procedure when you use your benefit. To maximize your savings, call your Care Advocate as soon as possible to confirm the details of your benefit and what you'll be responsible for covering, if anything.

What happens after my surgery?

Your Care Advocate will follow up and ensure you received the highest quality care and schedule any post-procedure appointments.

What isn't covered by SurgeryPlus?

Testing, scans, imaging, durable medical equipment, and physical therapy expenses may not be included. However, coverage may be available through your medical plan.

When you need to plan a surgery, make SurgeryPlus your first call:

(833) 603-0511

Scan to log in to your personalized portal to understand what's covered.

Welcome to Express Scripts

CIS and Express Scripts want you to know that Express Scripts manages your prescription plan. We care about your health and work to make medications safer and more affordable. We encourage you to take advantage of the services and resources available to help you and your dependents manage your pharmacy benefit. We look forward to serving you soon!

Why pay more? Make the move to a 3-month supply.

Under your prescription plan, you have the option to order 3-month supplies of long-term medications from certain participating retail pharmacies or through home delivery from Express Scripts® Pharmacy. [1]

To start ordering a 3-month supply from Express Scripts® Pharmacy, register or log in at **express-scripts.com**. (Standard shipping is free with home delivery.[2])

To find a retail pharmacy that participates in 3-month supplies, log in at **express-scripts.com** and choose Find a Pharmacy from the menu under Prescriptions. The pharmacy can tell you how to transfer your prescription or start a new one. Search results will indicate whether a pharmacy is eligible to dispense up to a 3-month supply.

According to your plan, you can keep filling one month at a time, but you could miss out on convenience and savings.

[1]Long-term medications are taken for an ongoing condition, such as high blood pressure, high cholesterol and asthma.
[2]Cost of standard shipping is included as part of your prescription plan.

Accredo, your specialty pharmacy

Accredo is the Express Scripts specialty pharmacy. A specialty pharmacy provides medication and therapy for patients with serious, chronic conditions like cancer and hepatitis C. Accredo offers teams of pharmacists, nurses and clinicians who are specialty trained on your condition. This level of individualized, focused care gives you the most comprehensive, compassionate and customized care available.

Accredo offers many patient support services, including:

- Personal care and health advocacy assistance from patient care coordinators
- Coordination of financial assistance (availability varies by plan)
- Guidance for patients and caregivers for taking specialty medications most effectively
- All necessary ancillary supplies, such as syringes and sharps containers

Specialty medications must be filled through Accredo to receive coverage. To learn more about Accredo, please visit **accredo.com.**

CIS has partnered with SaveOnSP to provide a specialty pharmacy copayment assistance program. If you attempt to fill a specialty prescription that falls under this program, an Accredo representative will assist you with enrollment in the program by transferring you to SaveOnSP. More information about this program can be found in your plan booklet.

EXPRESS SCRIPTS®

Network retail pharmacies

Network pharmacies are retail pharmacies that are preferred by your prescription plan. Use them for prescriptions you need on a short-term basis, like an antibiotic to treat an infection. When you go to an in-network pharmacy for up to a 30-day supply of medication, you'll typically pay less than at a retail pharmacy that's out of your network.

To find an in-network pharmacy near you, go to **express-scripts.com/CIS6** and select **Locate a Pharmacy**. Search results will indicate whether a pharmacy is eligible to dispense up to a 3-month supply. You may also log in at **express-scripts.com** and choose **Find a Pharmacy** from the menu under **Prescriptions** or call Express Scripts at 800.496.4182.

If you're new to Regence BCBS coverage, be sure to show your new Express Scripts ID card at the pharmacy. You can also access your ID card by downloading the Express Scripts® mobile app. If you don't show your ID card and instead choose to pay the entire cost of the medication, you must submit a claim form to Express Scripts for reimbursement. You'll be reimbursed based on the covered medication's contracted rate minus the appropriate copayment. This amount will be lower than the amount you paid out of pocket at the retail pharmacy.

If you need to transfer your prescription from an out-of-network pharmacy to an in-network pharmacy, just choose one of the following:

- Bring your prescription vial or container to an in-network pharmacy, and the pharmacist will transfer it.
- Call a pharmacy in your network, and ask the pharmacist to transfer your medication.
- Ask your doctor to send your prescription in to an in-network pharmacy using e-prescribing.

Manage your prescription

One of the great things about being an Express Scripts member is that you can manage your medication easily on your laptop, tablet, desktop or phone. Whether you want to check your order status, look for savings opportunities, look up information about your benefit, get a refill or even find a pharmacy, the Express Scripts website and mobile app can help!

Just register at express-scripts.com, or download the mobile app to your mobile device for free by searching your app store for Express Scripts. (Availability and features may vary.)

Formulary

A preferred medication list, also called a formulary, helps keep healthcare costs down for everybody. It's a list of medications that have been reviewed and approved for safety and effectiveness by a panel of doctors and pharmacists. This list is continually reviewed and updated as new medications become available.

Note that certain medications are excluded from your formulary, which means they're not covered. An equally effective and safe alternative may be available. To check pricing and coverage for a medication, visit express-scripts.com/CIS6. Drug classes with excluded medications include Autonomic and Central Nervous System, Cardiovascular and Dermatological.

EXPRESS SCRIPTS®

Kaiser Plan Summaries

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www.cisbenefits.org

KAISER PERMANENTE®

Copay B: Alternative Care & Vision **January 1, 2025 - December 31, 2025**	
Out-of-Pocket Maximum (Note: All Copayment, and Coinsurance amounts count toward the Out-of-Pocket Maximum, unless otherwise noted.)	
For one Member	$1,500
For an entire Family	$3,000
Office visits	**You pay**
Routine preventative physical exam	$0
Telehealth (phone/video)	$0*
Primary Care	$5 for first 3 visits; then $20 for additional visits in the same Year *
Specialty Care	$30
Urgent Care	$40
Tests (outpatient)	**You pay**
Preventive Tests	$0
Laboratory	$20 per department visit
X-ray, imaging, and special diagnostic procedures	$20 per department visit
CT, MRI, PET scans	$50 per department visit
Medications (outpatient)	**You pay**
Prescription drugs (up to a 30 day supply)	Generic $10, Preferred $20, Non-preferred $40, Specialty $40 (Per prescription)
Mail Order Prescription drugs (up to a 90 day supply)	2 x Copay
Administered medications, including injections (all outpatient settings)	20% Coinsurance
Nurse treatment room visits to receive injections	$10
Maternity Care	**You pay**
Scheduled prenatal care visits and postpartum visits	$0
Laboratory	$20 per department visit
X-ray, imaging, and special diagnostic procedures	$20 per department visit
Inpatient Hospital Services	$200 per day up to $1,000 per admission
Hospital Services	**You pay**
Ambulance Services (per transport)	$75
Emergency services	$200 (Waived if admitted)
Inpatient Hospital Services	$200 per day up to $1,000 per admission
Outpatient Services (other)	**You pay**
Outpatient surgery visit	$50
Chemotherapy/radiation therapy visit	$30
Durable medical equipment	20% Coinsurance
Physical, speech, and occupational therapies (up to 20 visits per therapy per Calendar Year)	$30
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services (up to 100 days per Calendar Year)	$0
Mental Health and Substance Use Disorder Services	**You pay**
Outpatient Services (Group visit ½ copay)	$5 for first 3 visits; then $20 for additional visits in the same Year *
Inpatient hospital & residential Services	$200 per day up to $1,000 per admission
Alternative Care** (self-referred)	**You pay**

Acupuncture Services (up to 12 visits per year)	$20 per visit
Chiropractic Services (up to 20 visits per year)	$20 per visit
Massage Therapy (up to 12 visits per year)	$25 per visit
Naturopathic Medicine	$5 for first 3 visits; then $20 for additional visits in the same Year *
Vision Services	**You pay**
Routine eye exam (Covered until the end of the month in which Member turns 19 years of age)	$0
Vision hardware and optical Services (Covered until the end of the month in which Member turns 19 years of age)**	No charge for eyeglass lenses or frames or contact lenses every 12 months.
Routine eye exam (For members 19 years and older)	$20
Vision hardware and optical Services (For members 19 years and older)*	Balance after $150 allowance, once every calendar year

***** First 3 visits (or days) are any combination of in-person or telemedicine Services for primary care non-specialty medical Services, mental health outpatient Services, naturopathic medicine, or Substance Use Disorder outpatient Services.

** **Any amount you pay for covered Services does not count toward the Out-of-Pocket Maximum.**

kp.org Resources: Here are some ways to make managing your care easier:
Sign on to our convenient online services and stay on top of your treatment from the comfort of your home.

- Find or switch doctors
- View lab test results
- Health risk assessments
- Order prescription refills
- Schedule and cancel appointments
- Exchange secure emails with your doctor and health care team
- Find locations of our medical centers and offices

Appointment Alternatives:
-Advice Nurse Line - If you have a health concern but aren't sure where to go for care, call the Kaiser Permanente advice nurse line at (800) 813-2000. Available 24 hours a day, our advice nurses can give you guidance on getting the care you need, view your medical record, and help schedule an appointment if needed.
-Virtual Care - Virtual care options are available for many health concerns. You can skip a copay and schedule a visit to see a doctor using your computer or mobile device. Call (800) 813-2000 (toll free), (503) 813-2000, or 711 (TTY for the hearing/speech impaired). You can use online scheduling to make an appointment with our Urgent Care providers. We offer both same-day Urgent Care Telephone Appointments and Urgent Care Video Visits.
-Email Your Doctor - You can send a secure email to your doctor and care team for answers to non-urgent health and wellness questions at any time by logging on to kp.org on your computer or mobile device.

Disease Management:
Our integrated health care delivery system provides comprehensive and coordinated care for our members with chronic conditions. All members who are identified by specified criteria are automatically enrolled in one of our disease management programs. Your personal physician, specialists, pharmacists, nurses, nutritionists, class instructors, and others will care for the whole you, body and mind.

Healthy Lifestyle Programs: kp.org/healthylifestyles or **kphealthylifestyles.org**.:
Digital and telephonic health coaching programs are available at no cost to members. These personalized interactive programs can help a member's goals to lose weight, eat better, manage stress, quit smoking, and more.
The online healthy lifestyle programs include:

- **Balance®** - A weight management program
- **Breathe®** - A program to help you quit smoking (**kp.org/quit smoking)**
- **Care® for Your Back –** Delivers personalized strategies for preventing and managing back pain
- **Care® for Diabetes –** Tools for managing Diabetes
- **Care for Pain® -** For members living with chronic pain
- **Care® for Depression –** Help with managing depression
- **Care® for sleep –** Tools for sleeping better
- **Relax® -** Stress management

Member Discounts: kp.org/choosehealthy
Available to you at no cost through your health plan, ChooseHealthy™offers a directory of complementary care providers, an online store, fitness club discounts, savings on health products and services, and more. You'll find reduced rates on:

- Fitness facility memberships
- Massage therapy services
- Chiropractic care
- Acupuncture
- Health & fitness books & videos
- Herbs, vitamins, and supplements

Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). EOCs are available upon request or you may go to **kp.org/plandocuments**.

Questions? Call Member Services (M-F, 8 am-6 pm) or **visit kp.org** Portland area: 503-813-2000
All other areas: 1-800-813-2000 TTY.711. Language Interpretation Services, all areas 1-800-324-8010

This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on benefit coverage, claims review, and adjudication procedures, please see your EOC or call Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see www.kp.org/plandocuments or call 1-800-813-2000 (TTY: 711). For definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at http://www.healthcare.gov/sbc-glossary or call 1-800-813-2000 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not applicable.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$1,500 Individual / $3,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, health care this plan doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.kp.org or call 1-800-813-2000 (TTY: 711) for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist?	Yes, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 / visit	Not covered	$5 / visit for the first 3 outpatient visits combined for primary care, mental/behavioral health, substance abuse services, and other qualified visits.
	Specialist visit	$30 / visit	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: $20 / visit Lab tests: $20 / visit	Not covered	None
	Imaging (CT/PET scans, MRIs)	$50 / visit	Not covered	Some services may require prior authorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/formulary	Generic drugs	$10 (retail); $20 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines.
	Preferred brand drugs	$20 (retail); $40 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines.
	Non-preferred brand drugs	$40 (retail); $80 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines, when approved through exception process.
	Specialty drugs	Applicable Generic, Preferred brand, Non-Preferred brand drug cost shares apply.	Not covered	Up to a 30-day supply (retail). Subject to formulary guidelines, when approved through exception process.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 / visit	Not covered	Prior authorization required.
	Physician/surgeon fees	No charge	Not covered	Physician/surgeon fees are included in the Facility fee.
If you need immediate medical attention	Emergency room care	$200 / visit	$200 / visit	Copayment waived if admitted directly to the hospital as an inpatient.
	Emergency medical transportation	$75 / trip	$75 / trip	None
	Urgent care	$40 / visit	Not covered	Non-Participating Providers covered when temporarily outside the service area: $40 / visit
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 / day up to $1,000 / admission	Not covered	Prior authorization required.
	Physician/surgeon fees	No charge	Not covered	Physician/surgeon fees are included in the Facility fee.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 / visit	Not covered	$5 / visit for the first 3 outpatient visits combined for primary care, mental/behavioral health, substance abuse services, and other qualified visits.
	Inpatient services	$200 / day up to $1,000 / admission	Not covered	Prior authorization required.
If you are pregnant	Office visits	No charge	Not covered	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	Professional services are included in the facility fee.
	Childbirth/delivery facility services	$200 / day up to $1,000 / admission	Not covered	None
	Home health care	No charge	Not covered	130 visit limit / year. Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special needs	Rehabilitation services	Outpatient: $30 / visit Inpatient: $200 / day up to $1,000 / admission	Not covered	Outpatient: 20 visit limit / therapy / year. Prior authorization required. Inpatient: Prior authorization required.
	Habilitation services	$30 / visit	Not covered	20 visit limit / therapy / year. Prior authorization required.
	Skilled nursing care	No charge	Not covered	100 day limit / year. Prior authorization required.
	Durable medical equipment	20% coinsurance	Not covered	Subject to formulary guidelines. Prior authorization required.
	Hospice services	No charge	Not covered	Prior authorization required.
If your child needs dental or eye care	Children's eye exam	No charge for refractive exam	Not covered	None
	Children's glasses	No charge	Not covered	Limited to one pair of select frames and lenses or contact lenses / 12 months.
	Children's dental checkups	Not covered	Not covered	None

Excluded Services & Other Covered Services

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult and Child)
- Long-term care
- Non-emergency care when traveling outside the U.S
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (12 visit limit / year)
- Bariatric surgery
- Chiropractic care (20 visit limit / year)
- Hearing (dependents under age 26: 1 aid / ear, every 36 months)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the agencies in the chart below.

Kaiser Permanente Member Services	1-800-813-2000 (TTY: 711) or www.kp.org/memberservices
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov
Oregon Division of Financial Regulation	1-888-877-4894 or www.dfr.oregon.gov
Washington Department of Insurance	1-800-562-6900 or www.insurance.wa.gov

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-813-2000 (TTY: 711).

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-813-2000 (TTY: 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-813-2000 (TTY: 711).

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-813-2000 (TTY: 711) uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-813-2000 (TTY: 711).

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-813-2000 (TTY: 711).

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-813-2000 (TTY: 711).

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-813-2000 (TTY: 711).

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$30
Hospital (facility) copayment	$200
Other (blood work) copayment	$20

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$360**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$30
Hospital (facility) copayment	$200
Other (blood work) copayment	$20

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$810**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$30
Hospital (facility) copayment	$200
Other (x-ray) copayment	$20

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$550**

[The **plan** would be responsible for the other costs of these EXAMPLE covered services.]

Nondiscrimination Notice

Kaiser Foundation Health Plan of the Northwest (Kaiser Health Plan) complies with applicable federal and state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Member Services at **1-800-813-2000** (TTY: **711**).

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator, by mail, phone, or fax. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You may contact our Civil Rights Coordinator at: Member Relations Department, Attention: Kaiser Civil Rights Coordinator, 500 NE Multnomah St. Ste 100, Portland, OR 97232-2099, Phone: **1-800-813-2000** (TTY: **711**), Fax: **1-855-347-7239.**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 2020, Phone: 1-800-368-1019, TDD: 1-800-537-7697. Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

For Washington Members

You can also file a complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal, available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 1-800-562-6900, or 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-813-2000** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-813-2000** (TTY: **711**).

ملحوظة: (Arabic) العربية إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-813-2000** (TTY: **711**).

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-813-2000**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-813-2000** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-813-2000** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-813-2000** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-813-2000**（TTY: **711**）まで、お電話にてご連絡ください。

ខ្មែរ (Khmer) ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរទូរស័ព្ទ **1-800-813-2000** (TTY: **711**)។

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-813-2000** (TTY: **711**) 번으로 전화해 주십시오.

ລາວ (Laotian) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັ້ງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-800-813-2000** (TTY: **711**).

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-813-2000** (TTY: **711**).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-800-813-2000** (TTY: **711**) 'ਤੇ ਕਾਲ ਕਰੋ।

Română (Romanian) ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la **1-800-813-2000** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-813-2000** (TTY: **711**).

Español (Spanish) ATENCION: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-813-2000** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-813-2000** (TTY: **711**).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-813-2000** (TTY: **711**).

Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером **1-800-813-2000** (TTY: **711**).

Tiêng Việt (Vietnamese) CHU Y: Nêu bạn nói Tiêng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi sô **1-800-813-2000** (TTY: **711**).

Employee Cost Sharing

Employee Monthly Cost Share

Employee Monthly Cost for Medical & Vision Regence HDHP						
FTE/Hours	**Percent Cost Share**	**EE Only**	**EE + Spouse**	**EE + Family**	**EE + Child**	**EE + Children**
20	50%	$364.23	$779.13	$1,071.04	$681.67	$928.59
21	45%	$327.80	$701.22	$963.93	$613.50	$835.73
22	40%	$291.38	$623.30	$856.83	$545.33	$742.87
23	35%	$254.96	$545.39	$749.72	$477.17	$650.01
24	30%	$218.54	$467.48	$642.62	$409.00	$557.15
25	25%	$182.11	$389.57	$535.52	$340.83	$464.29
26	20%	$145.69	$311.65	$428.41	$272.67	$371.43
27	15%	$109.27	$233.74	$321.31	$204.50	$278.58
28	10%	$72.85	$155.83	$214.21	$136.33	$185.72
29	5%	$36.42	$77.91	$107.10	$68.17	$92.86
30-40	**0%**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Employee Monthly Cost for Medical & Vision Kaiser HMO						
FTE/Hours	**Percent Cost Share**	**EE Only**	**EE + Spouse**	**EE + Family**	**EE + Child**	**EE + Children**
20	50%	$445.20	$932.79	$1,269.66	$816.50	$1,101.23
21	45%	$400.68	$839.51	$1,142.69	$734.85	$991.10
22	40%	$356.16	$746.23	$1,015.72	$653.20	$880.98
23	35%	$311.64	$652.95	$888.76	$571.55	$770.86
24	30%	$267.12	$559.67	$761.79	$489.90	$660.74
25	25%	$222.60	$466.39	$634.83	$408.25	$550.61
26	20%	$178.08	$373.11	$507.86	$326.60	$440.49
27	15%	$133.56	$279.84	$380.90	$244.95	$330.37
28	10%	$89.04	$186.56	$253.93	$163.30	$220.25
29	5%	$44.52	$93.28	$126.97	$81.65	$110.12
30-40	**0%**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Employee Monthly Cost for Medical & Vision Delta Dental						
FTE/Hours	**Percent Cost Share**	**EE Only**	**EE + Spouse**	**EE + Family**	**EE + Child**	**EE + Children**
20	50%	$23.15	$40.80	$70.05	$35.97	$70.05
21	45%	$20.84	$36.72	$63.04	$32.37	$63.04
22	40%	$18.52	$32.64	$56.04	$28.77	$56.04
23	35%	$16.21	$28.56	$49.03	$25.18	$49.03
24	30%	$13.89	$24.48	$42.03	$21.58	$42.03
25	25%	$11.58	$20.40	$35.02	$17.98	$35.02
26	20%	$9.26	$16.32	$28.02	$14.39	$28.02
27	15%	$6.95	$12.24	$21.01	$10.79	$21.01
28	10%	$4.63	$8.16	$14.01	$7.19	$14.01
29	5%	$2.32	$4.08	$7.00	$3.60	$7.00
30-40	**0%**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Employee Monthly Cost for Medical & Vision Willamette Dental						
FTE/Hours	**Percent Cost Share**	**EE Only**	**EE + Spouse**	**EE + Family**	**EE + Child**	**EE + Children**
20	50%	$29.68	$52.33	$90.48	$46.05	$78.66
21	45%	$26.71	$47.09	$81.43	$41.45	$70.79
22	40%	$23.74	$41.86	$72.38	$36.84	$62.93
23	35%	$20.78	$36.63	$63.34	$32.24	$55.06
24	30%	$17.81	$31.40	$54.29	$27.63	$47.20
25	25%	$14.84	$26.16	$45.24	$23.03	$39.33
26	20%	$11.87	$20.93	$36.19	$18.42	$31.46
27	15%	$8.90	$15.70	$27.14	$13.82	$23.60
28	10%	$5.94	$10.47	$18.10	$9.21	$15.73
29	5%	$2.97	$5.23	$9.05	$4.61	$7.87
30-40	**0%**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Tax Favored Accounts

Health Savings Account (HSA)

Deductible Reimbursement (Regence Plan Only)

Health savings accounts (HSAs) are a great way to save money and efficiently pay for medical expenses. HSAs are tax-advantaged savings accounts that accompany high deductible health plans (HDHPs).

HSA money can be used tax-free when paying for qualified medical expenses, helping you pay your HDHP's larger deductible. At the end of the year, you keep any unspent money in your HSA. This rolled over money can grow with tax-deferred investment earnings, and, if it is used to pay for qualified medical expenses, then the money will continue to be tax-free. Your HSA and the money in it belongs to you—not your employer or insurance company.

If you enroll in the Regence Plan, Homes for Good will give you a contribution towards your HSA account as shown below. You may, also, elect an amount to contribute to your HSA account to help you meet this plan deductible. We will continue to partner with Optum Bank for HSA accounts services. If you are not qualified for a contribution to an HSA (typically because you have other medical coverage in addition to the Homes For Good plan) you can have this contribution placed into a Health Reimbursement Arrangement.

HSA Employer Monthly Contribution

- Single Enrollment $1,700 per year; $141.66 per month
- Family Enrollment $3,400 per year; $283.33 per month

How do I get reimbursed for my eligible expenses?

The easiest way to use your HSA dollars is by using your HSA Debit Card at the time you incur an eligible expense. Or you can withdraw money from an ATM. But keep your receipts! You must be able to prove that you were reimbursing yourself for an eligible expense in the event that you are audited. If you use your HSA funds for non-eligible expenses, you will be charged a 20% penalty tax (if under age 65) as well as federal income taxes. You can manage your HSA through www.optumbank.com. Optum Bank provides helpful information about your HSA, including online calculators to help you add up your tax savings and see your HSA's possible future growth. For additional guidelines, please go online or call Optum at 877-462-5039.

Health Reimbursement Account (HRA)

If you enroll in the Regence Plan but are not eligible for contributions into an HSA (See HSA FAQ to determine eligibility), Homes for Good will contribute to a Health Reimbursement Arrangement (HRA). An HRA is a tax-free employer-funded account managed by PacificSource Administrators. By utilizing the Health Reimbursement Arrangement, you could recover a portion of your out-of-pocket expenses covered under your employer-sponsored medical insurance.

This plan reimburses qualified expenses as outlined in IRS Code 213.

Reimbursable expenses may include:

- Deductible Expenses
- Copay Expenses
- Coinsurance Expenses
- Medical Expenses
- Prescription Expenses
- Dental Expenses
- Orthodontia Expenses
- Vision Expenses
- Alternative Care Expenses

HRA Annual Credit Amounts (contributions made monthly)

- Single Enrollment $1,700 per year; $141.66 per month
- Family Enrollment $3,400 per year; $283.33 per month

Interested in signing up for an HSA?

If you enroll in the Regence High Deductible Health Plan, you will receive a form in BambooHR asking you to choose a deductible reimbursement method if you choose the Regence High Deductible Health Plan.

Flexible Spending Account (FSA)

The Flexible Spending Account (FSA) plan with PacificSource Administrators allows you to set aside pre- tax dollars to cover qualified expenses you would normally pay out of your pocket with post-tax dollars. The plan is comprised of a health care spending account and a dependent care account. You pay no federal or state income taxes on the money you place in an FSA. If you enroll in the Health Savings Account, you are not eligible to contribute to the FSA.

How an FSA works:

- Choose a specific amount of money to contribute each pay period, pre-tax, to one or both accounts during the year.
- The amount is automatically deducted from your pay at the same level each pay period.
- As you incur eligible expenses, you may use your flexible spending debit card to pay at the point of service OR submit the appropriate paperwork to be reimbursed by the plan.

Important rules to keep in mind:

- The IRS has a strict "use it or lose it" rule. If you do not use the full amount in your FSA, you will lose any remaining funds.
- Once you enroll in the FSA, you cannot change your contribution amount during the year unless you experience a qualifying life event.
- You cannot transfer funds from one FSA to another.

Please plan your FSA contributions carefully, as any funds not used by the end of the year will be forfeited. Re-enrollment is required each year.

2025 Projected Maximum Annual Election	
Health Care FSA	$3,300
Dependent Care FSA	$5,000

Dental Plan Summaries

cis benefits
cisbenefits.org

CIS Dental Plan II with $1,000 Ortho
Effective January 1, 2025

How to use this dental plan

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

Calendar year maximum, per member*	**$1,500**
Calendar year deductible, per member	**$0**

Service	Benefit Amount
CLASS I - PREVENTIVE [1] - Examination/X-rays - Prophylaxis - Fissure Sealants	**** 1st year - 70%** **2nd year - 80%** **3rd year - 90%** **4th year - 100%**
CLASS II - BASIC [2] - Restorative Dentistry (treatment of tooth decay with amalgam or composite) - Oral Surgery (surgical extractions & certain minor surgical procedures) - Endodontic (pulp therapy & root canal filling) - Periodontics (treatment of tissues supporting the teeth) - Space Maintainers - Repair or reline of dentures and bridges	**** 1st year - 70%** **2nd year - 80%** **3rd year - 90%** **4th year - 100%**
CLASS III - MAJOR [2] - Crowns - Implants - Denture and Bridge Work (construction of fixed bridges, partials and complete dentures)	**50%**
ORTHODONTIA Adult/Child Benefit[2] **- (Lifetime maximum of $1,000)**	**50%**

* Annual dental maximum does not apply to members under age 16.

** Under this plan, benefits start at 70% your first calendar year of coverage. Thereafter, payments increase by 10% each calendar year (up to a maximum benefit of 100%) provided the individual has visited the dentist at least once during the previous calendar year. If in any calendar year the individual fails to receive covered dental services, the percentage for Class I and II services will decrease by 10% the next calendar year, but it will never be reduced below 70%.

[1] Any amount paid by the plan for Preventive services does not apply towards the calendar year maximum.

[2] There is a 12 month waiting period for Late Enrollees. A Late Enrollee is anyone not enrolled when initially eligible.

MEMBER SERVICES

Through the Member Dashboard you can download your member handbook, view claims status and payment information, search for participating providers, order ID cards, view personal information, and email dental customer service. You can access the Member Dashboard at **DeltaDentalOR.com**, or the CIS website at **www.cisbenefits.org**.

Dental Tools is a free resource the Member Dashboard that enables you to assess your risk level for oral health concerns and use that assessment to learn about reducing your risks and treatment costs.

DELTA DENTAL

Delta Dental of Oregon & Alaska

Delta Dental provides dental claims payment services only and does not assume financial risk or obligation with respect to payment of claims.

This is a benefit summary only; any errors or omissions are unintentional. For a more detailed description of benefits, including limitations and exclusions, refer to your member handbook. It can be accessed through your Member Dashboard or by calling Customer Service to request a copy.

Delta Dental Customer Service 844-721-4939 - Delta Dental's website DeltaDentalOR.com

ADVANTAGES

* **Freedom to choose your dentist:** Delta Dental is unique in that we have contracts with more than 2,300 licensed Premier providers in Oregon and 152,000 nationwide. More than 1,200 are also PPO providers in Oregon and 114,000 nationwide.

* **Professional Arrangements:** The Delta Dental Passive PPO plan utilizes a select group of dentists who have contracted with us at a preferred rate. This helps ensure that members who utilize the services of a preferred dentist have lower out-of-pocket costs. While receiving treatment from a Preferred Provider is still the most cost-effective option, your plan allows for services to be rendered by a non-preferred dentist, while still maintaining the same percentage of coverage. Members who utilize Premier and PPO providers will not be balanced billed. Members who utilize non-participating providers will be responsible for charges above the maximum plan allowance.

* **Pre-determination:** As a service to our customers, your dental office can submit a pre-treatment plan to Delta Dental on your behalf, and we will return it to your dentist, indicating the dollar allowance that will be covered by your plan **before** you go forward with treatment.

* **Health through Oral Wellness® program:** Your plan includes access to the Health through Oral Wellness program. This patient-centered program provides enhanced benefits designed to help you maintain better oral health through risk assessment, education and additional evidence-based preventive care.

Delta Dental of Oregon & Alaska

Delta Dental provides dental claims payment services only and does not assume financial risk or obligation with respect to payment of claims.

This is a benefit summary only; any errors or omissions are unintentional. For a more detailed description of benefits, including limitations and exclusions, refer to your member handbook. It can be accessed through your Member Dashboard or by calling Customer Service to request a copy.

Delta Dental Customer Service 844-721-4939 - Delta Dental's website DeltaDentalOR.com

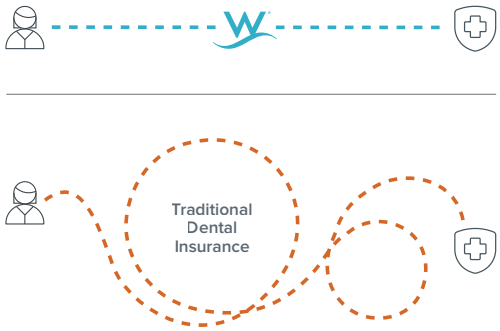
CIS

Willamette Dental Group

DENTAL CARE + INSURANCE TOGETHER AND SIMPLIFIED

Willamette Dental believes insurance should be simple so we've eliminated the guessing game. We blend preventive dental care with broad insurance coverage, making it affordable, with no maximums*, deductibles or waiting periods, and predictable out of pocket costs.

We practice evidence-based dentistry to end the disease-repair cycle by focusing on prevention. Based on the most recent evidence, our dentists offer treatment plans that customize all treatment to the need of each patient, including dental cleanings. Our insurance plans include coverage for as many cleanings as are prescribed, whether that's just one, or perhaps four cleanings, each year.



NEARLY 50 NORTHWEST LOCATIONS

4.6 Average For All Offices

nrc HEALTH

As a member, you'll have access to our top quality dental providers across our convenient dental offices. Learn more about our offices and providers at **willamettedental.com**, complete with unfiltered patient star ratings and comments.

*Benefits for implant surgery have a benefit maximum, if covered.

KEY PLAN FEATURES

- Predictable out of pocket costs with no annual maximums*, no deductibles, and no waiting periods
- Benefits and services are provided at Willamette Dental Group offices
- Easy appointment scheduling – just call 1.855.433.6825
- Extended hours: Monday – Friday 7am – 5:30pm and rotating Saturdays regionally
- Emergency services available in-person in 48 hours or less and by phone 24/7
- Translation services available at all member touchpoints, scheduling and chairside
- All dental specialty services available, including orthodontics for all ages
- No ID cards issued — all information is securely stored with your health record

YOUR BENEFITS EFFECTIVE DATE: 1/1/2025

COVERED SERVICE	BENEFIT
Annual Maximum	No Annual Maximum*
Deductible	No Deductible
General & Ortho Office Visit	You Pay $20 per Visit
Diagnostic & Preventive Services	Covered with Office Visit Copay
Fillings	You Pay a $15 Copay
Porcelain-Metal Crown	You Pay a $200 Copay**
Complete Upper or Lower Denture	Covered with Office Visit Copay**
Bridge (per Tooth)	You Pay a $200 Copay**
Root Canal Therapy – Anterior / Bicuspid / Molar	You Pay a $75 Copay
Osseous Surgery (per Quadrant)	Covered with Office Visit Copay
Root Planing (per Quadrant)	Covered with Office Visit Copay
Routine Extraction (Single Tooth)	Covered with Office Visit Copay
Surgical Extraction	You Pay a $50 Copay
Comprehensive Orthodontia Treatment	You Pay a $2,000 Copay
Dental Implant Surgery	Benefit maximum of $1,500 per calendar year
Nitrous Oxide	You Pay a $10 Copay
Specialty Office Visit	You Pay $30 per Visit
Out of Area Emergency Care Reimbursement	You pay charges in excess of $100

*Benefits for implant surgery have a benefit maximum, if covered.
**Dental implant-supported prosthetics (crowns, bridges, and dentures) are not a covered benefit.
Underwritten by Willamette Dental Insurance, Inc. Please refer to your Certificate of Coverage for limitations and exclusions.

QUESTIONS?

Contact our Member Services team via email at memberservices@willamettedental.com or by phone at 1.855.433.6825.

019-OR(10/23)

OFFICES & SPECIALTY LOCATIONS

Willamette Dental Group

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

OREGON OFFICES

Albany
2225 Pacific Blvd. SE, Suite 201
Albany, OR 97321
General Dentistry

Beaverton
4925 SW Griffith Drive
Beaverton, OR 97005
General Dentistry
Dentures
Orthodontics

Bend
62968 O.B. Riley Road, Suite 12
Bend, OR 97703
General Dentistry
Orthodontics

Corvallis
2420 NW Professional Drive, Suite 150
Corvallis, OR 97330
General Dentistry
Orthodontics

Eugene
2703 Delta Oaks Drive, Suite 300
Eugene, OR 97408
General Dentistry

Grants Pass
702 SW Ramsey Ave, Suite 224
Grants Pass, OR 97527
General Dentistry

Gresham
1107 NE Burnside Road
Gresham, OR 97030
General Dentistry

Hillsboro
5935 SE Alexander Street
Hillsboro, OR 97123
General Dentistry

Lincoln City
1105 SE Jetty Avenue, Suite B
Lincoln City, OR 97367
General Dentistry

Medford
773 Golf View Drive
Medford, OR 97504
General Dentistry
Orthodontics

Milwaukie
6902 SE Lake Road, Suite 200
Milwaukie, OR 97267
General Dentistry

Portland – Jefferson
1933 SW Jefferson Street
Portland, OR 97201
General Dentistry

Portland – Lents
8931 SE Foster Rd.,
Portland, OR 97266
General Dentistry
Dentures
Endodontics
Orthodontics
Pediatric Dentistry

Portland – Stark 1
13255 SE Stark Street
Portland, OR 97233
General Dentistry
Dentures

Portland – Stark 2
405 SE 133rd Avenue
Portland, OR 97233
General Dentistry

Salem – Lancaster
3490 NE Lancaster Drive
Salem, OR 97305
General Dentistry
Dentures
Endodontics
Oral Surgery
Orthodontics

Salem – Liberty
142 Pembrook Street SE
Salem, OR 97302
General Dentistry

Springfield
2510 Game Farm Road
Springfield, OR 97477
General Dentistry

Springfield Specialty
2530 Game Farm Road
Springfield, OR 97477
Endodontics
Oral Surgery
Orthodontics

Tigard
7095 SW Gonzaga Street
Tigard, OR 97223
General Dentistry
Endodontics
Oral Surgery
Periodontics

Tualatin
17130 SW Upper Boones Ferry Road
Durham, OR 97224
General Dentistry

Plan coverage also extends if you are referred to an outside dentist or specialist by your Willamette Dental Group dentist. If referred to an outside dentist or specialist, your copayments remain the same as shown in your Summary of Benefits.

For Appointments or Member Services, please call 1.855.433.6825

OFFICES & SPECIALTY LOCATIONS

Willamette Dental Group

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

WASHINGTON OFFICES

Bellevue
626 120th Avenue NE,
Suite B210
Bellevue, WA 98005
General Dentistry
Orthodontics

Bellingham
4164 Meridian Street, Suite 300
Bellingham, WA 98226
General Dentistry
Endodontics
Orthodontics

Everett
3216 Norton Ave
Everett, WA 98201
General Dentistry
Endodontics
Orthodontics

Kent
510 Washington Ave N
Kent, WA 98032
General Dentistry
Orthodontics

Longview
1461 Broadway Street, Suite A
Longview, WA 98632
General Dentistry

Mountlake Terrace
6505 216th Street SW,
Suite 200
Mountlake Terrace, WA 98043
General Dentistry

Olympia
4550 3rd Ave SE,
Lacey, WA 98503
General Dentistry
Dentures
Endodontics
Implants
Orthodontics
Periodontics

Pullman
1646 S Grand Avenue
Pullman, WA 99163
General Dentistry
Orthodontics

Puyallup
702 South Hill Park Drive,
Suite 201
Puyallup, WA 98373
General Dentistry
Orthodontics

Richland
1426 Fowler Street
Richland, WA 99352
General Dentistry
Implants
Endodontics
Orthodontics
Periodontics

Seattle North
11011 Meridian Ave North,
Suite 104
Seattle, WA 98133
General Dentistry
Endodontics
Implants
Orthodontics
Periodontics

Silverdale
3505 NW Anderson Hill Road
Silverdale, WA 98383
General Dentistry

Spokane – Northpointe
9717 N Nevada
Spokane, WA 99218
General Dentistry

Spokane Valley
9019 E Mission Avenue
Spokane Valley, WA 99212
General Dentistry
Endodontics
Orthodontics

Tacoma
3866 S 74th Street, Suite 200
Tacoma, WA 98406
General Dentistry
Dentures
Endodontics
Implants
Oral Surgery
Orthodontics
Periodontics

Tumwater
6120 SE Capitol Blvd.
Tumwater, WA 98501
General Dentistry

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

Vancouver – Mill Plain
9609 E Mill Plain Blvd.
Vancouver, WA 98664
General Dentistry

Yakima
1200 Chesterly Drive, Ste 230
Yakima, WA 98902
General Dentistry
Orthodontics

IDAHO OFFICES

Boise
607 N. Mitchell St
Boise, ID 83704
General Dentistry
Orthodontics

Coeur d'Alene
943 W Ironwood Drive,
Suite 200
Coeur d'Alene, ID 83814
General Dentistry
Orthodontics

Idaho Falls
2860 Valencia Drive
Idaho Falls, ID 83404
General Dentistry
Orthodontics

Meridian
1075 S Wells Street
Meridian, ID 83642
General Dentistry
Endodontics
Orthodontics

Nampa
16145 N High Desert St
Nampa, ID 83687
General Dentistry

Twin Falls
452 Cheney Drive West,
Suite 150
Twin Falls, ID 83301
General Dentistry
Endodontics
Orthodontics

Plan coverage also extends if you are referred to an outside dentist or specialist by your Willamette Dental Group dentist. If referred to an outside dentist or specialist, your copayments remain the same as shown in your Summary of Benefits.

For Appointments or Member Services, please call 1.855.433.6825

Rev 8.15.24

Employee Assistance Plans

BeyondWell™

cis benefits
cisbenefits.org

Regence Member

Elevate Your Health, One Step at a Time with BeyondWell

BeyondWell is a comprehensive lifestyle program that integrates wellness activities, goals, rewards and more into a single place. The result is a truly personalized well-being experience that is tailored to your unique needs.

Earn up to $150 per year in rewards - act now!

> Gift cards earned must be self-claimed by December 31 each year.
> Unclaimed rewards will be forfeited.

Our BeyondWell program is available now and continues into 2025–and Regence members and eligible spouses can **earn up to $150** in electronic gift cards. Engage throughout each year to maximize your rewards!

Get started today!

Regence members

1. From a computer, log into your CIS Health Manager at **regence.com**
2. Scroll down to the programs listed and **select** BeyondWell.
3. If this is your first year participating, you'll need to **register** and accept the Terms of Use.

   If you are asked for a code during registration | **CODE: CIS**

$5 Beyond Well™

Take your well-being journey with you anywhere, anytime! Download the BeyondWell app now.

Earn up to $150 in rewards for healthy activities:

- Download BeyondWell app
- Connect a device or app
- Verified steps through device
- Personal challenges
- Self-guided programs
- Dental exams
- Vision exams
- Flu shot, COVID-19 vaccinations
- Health assessment
- Preventive screenings
- Regence BabyWise℠ program

Flip to learn more about our 2025 program

2025

Below you'll see all the ways you and your qualified spouse on the Regence health plan can earn up to **$150** each in Amazon.com* electronic gift cards in 2025.

$5 Sync a device or app

Our platform syncs with over 100 different devices. Earn this credit once per year.

$1 Verified steps through device

When steps are logged from your synced device, you earn credit. $1 per 10,000 steps.[1]

$5 Download the BeyondWell app

Download and log in to the BeyondWell app after creating your account online and earn $5.

$5 Register on Regence.com

Register your account on regence.com and earn $5.

$15 Personal challenge

Challenge yourself to improve lifestyle habits and earn $15 per challenge (up to $45 annually).

$20 Flu or COVID-19 Vaccination

Get your flu shot, COVID-19 vaccination or booster and earn $20 once per year.[2]

$25 Health assessment

The health assessment will help personalize your experience. Earn this incentive once per year.

$30 Interactive self-guided program

Complete any interactive self-guided program and earn $30 (up to $60 annually).

$30 Vision exam

Complete a preventive vision exam through CIS VSP and earn $30.[2]

$30 Preventive exam

Get a qualifying preventive exam and earn this incentive once per year.[2,3]

$30 Dental exam

Complete a preventive dental exam through CIS (Delta) Dental, Kaiser Dental, or Willamette Dental and earn $30.[2]

$50 Regence Pregnancy Program

Enroll and participate in the Regence Pregnancy program and earn this incentive once per year.[2]

$50 Chronic condition coaching

Enroll and engage in Chronic Condition Coaching in 2025 and earn a $50 incentive! If you are eligible for the program you will be outreached to directly.

$15 Attend a webinar

Attend a webinar hosted by your EAP or BeyondWell and earn $15 each (up to $60 annually).

EAP Webinars

Healthy Heart, Healthy Mind	*Feb 4 @ 10:00am*
Mindfulness Based Stress Reduction	*Apr 10 @ 1:00pm*
Coping Strategies for Caregivers	*Aug 19 @ 9:00am*
Holiday Stress	*Nov 14 @ 2:00pm*

BeyondWell Webinars

Food For Your Heart	*Feb 11 @ 11:30am*
Health Myths & Facts- Mental Health	*May 15 @ 11:30am*
Eating for Gut Health	*Aug 14 @ 11:30am*
Plan for Good Health	*Dec 11@ 11:30am*

1. $1 per 10,000 steps; max $2 daily. Steps will not carry over from day to day. Max $25 per quarter for this activity.
2. This activity is tracked through claims. There will be processing time for these items, so it may take up to 8 weeks to see the credit in your account.
3. Qualifying preventive exams include: annual well-visit, pelvic exam, colorectal cancer screening, PSA and routine mammogram.

* Amazon.com is not a sponsor of this promotion. Except as required by law, Amazon.com Gift Cards cannot be transferred for value or redeemed for cash. For complete terms and conditions, see www.amazon.com/gc-legal. All Amazon ®, ™ & © are IP of Amazon.com, Inc.

BeyondWell™

BeyondWell™

cis benefits
cisbenefits.org

Kaiser Member

Elevate Your Health, One Step at a Time with BeyondWell

BeyondWell is a comprehensive lifestyle program that integrates wellness activities, goals, rewards and more into a single place. The result is a truly personalized well-being experience that is tailored to your unique needs.

Earn up to $150 per year in rewards - act now!

> Gift cards earned must be self-claimed by December 31 each year.
> Unclaimed rewards will be forfeited.

Our BeyondWell program is available now and continues into 2025–and Kaiser members and eligible spouses can **earn up to $150** in electronic gift cards. Engage throughout each year to maximize your rewards!

Get started today!

Kaiser members

1. From a computer, visit **www.beyondwellhealth.com**.
2. Select **Login/Register** in the top right-hand corner.
3. Log into your existing account or register for a new account and accept the Terms of Use.

BeyondWell Invitation Code*
CIS

$5 Beyond Well™

Take your well-being journey with you anywhere, anytime! Download the BeyondWell app now.

Earn up to $150 in rewards for healthy activities:

- Download BeyondWell app
- Connect a device or app
- Verified steps through device
- Personal challenges
- Self-guided programs
- Dental exams
- Flu shot
- Health assessment
- Select cancer screenings
- Register on KP.org

Flip to learn more about our 2025 program

2025

Below you'll see all the ways you and your qualified spouse on the Kaiser health plan can earn up to **$150** each in Amazon.com* electronic gift cards in 2025.

$5 Sync a device or app

Our platform syncs with over 100 different devices. Earn this credit once per year.

$1 Verified steps through device

When steps are logged from your synced device, you earn credit. $1 per 10,000 steps.[1]

$5 Download the BeyondWell app

Download and log in to the BeyondWell app after creating your account online and earn $5.

$30 Interactive self-guided program

Complete any interactive program and earn $30 (up to $60 annually)

$30 Dental exam

Complete a preventive dental exam through Kaiser Dental, CIS (Delta) Dental, or Willamette Dental and earn $30.[2]

$20 Flu or COVID-19 vaccine

Get your flu shot or COVID-19 vaccination and earn $20 once per year.[2]

$25 Health assessment

The health assessment will help personalize your experience. Earn this incentive once per year.

$15 Personal challenge

Challenge yourself to improve lifestyle habits and earn $15 per challenge (up to $30 annually).

$30 Cancer screenings

Earn an incentive when you get a qualified cancer screening with KP physician.[2,3]

$5 Register on KP.org

Register your account on KP.org and earn $5.[4]

$15 Attend a webinar

Attend a webinar hosted by your EAP or BeyondWell and earn $15 each (up to $60 annually).

EAP Webinars

Healthy Heart, Healthy Mind	*Feb 4 @ 10:00am*
Mindfulness Based Stress Reduction	*Apr 10 @ 1:00pm*
Coping Strategies for Caregivers	*Aug 19 @ 9:00am*
Holiday Stress	*Nov 14 @ 2:00pm*

BeyondWell Webinars

Food For Your Heart	*Feb 11 @ 11:30am*
Health Myths & Facts- Mental Health	*May 15 @ 11:30am*
Eating for Gut Health	*Aug 14 @ 11:30am*
Plan for Good Health	*Dec 11@ 11:30am*

1. $1 per 10,000 steps; max $2 daily. Steps will not carry over from day to day. Max $25 per quarter for this activity.
2. This activity is tracked through claims and will require the completion of a Kaiser Permanente HIPAA authorization form. The form will be available to complete on the BeyondWell site beginning in January 2025.
3. Qualifying preventive exams include: mammogram, colonoscopy, and pelvic exam.
4. This activity requires the participant to log in to their KP.org account and complete the Kaiser Permanente HIPAA Authorization Form. Once complete, it may take up to eight weeks to see the activity credit in your account.

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BeyondWell™

EAP Summary of Services

Helping you get to your happy place

The Employee Assistance Program (EAP) is a **FREE** and **CONFIDENTIAL** benefit that can assist you, your dependents, and household family members with any personal life problems, large or small.

Confidential Coaching and Counseling access to masters-level counselors in person, over the phone, or online for concerns such as:

- **Stress and Burnout**
- **Depression and Anxiety**
- **Relationships and Family**
- **Alcohol and Drug Use**

Work/ Life Balance Services

Canopy will help locate resources related to Eldercare, Childcare, Identity Theft, Housing, Pet Parent Support or anything else you may need.

Legal

Call for a free consultation, and then receive a discount thereafter.

Financial Coaching

Access to unlimited financial coaching to help you develop a plan to improve your financial wellbeing.

Wellbeing Tools

- Fertility Health Support
- Online Legal Tools
- Will Kit Questionnaire
- Life Coaching
- Gym Membership Discounts

EAP Member Site

Access innovative tools, chat for support, view videos and webinars, and more. Access at: **my.canopywell.com**, and register as a new user or log-in. Enter your company name when you register as: **CIS**

WholeLife Directions

Take a confidential survey and get connected to interactive tools to improve the way you feel. Access in the EAP member site or search *WholeLife Directions* in the App Store or Google Play.

Crisis Counselors are available 24/7/365
call: 800-433-2320 text: 503-850-7721 email: info@canopywell.com

canopy

Fertility Health and Family Building

Support for growing families and their journey.

Exclusive access for Canopy members:

- **Free Fertility Health Consultation**
- **Discounted Fertility Health Check**
- **Connection to Fertility Preservation, Care, and Donation Services**
- **Free Educational Webinars and Events**
- **Adoption Resources**
- **Counseling Support**
- **Legal and Financial Guidance**

Access your benefits:
call: 800-433-2320
text: 503-850-7721
email: info@canopywell.com
online: my.canopywell.com

1. **Register or Log In**
    a. Company code is CIS
2. **Select the 'My EAP Benefits' tile**

canopy

Your health plan may not cover Fertility Health and Family Growing services. Please refer to your health plan summary for more information.

Parenting Support For Those With Furry Kids

- Concierge Support
- New Pet Parent Resources
- Pet Insurance Discounts
- Bereavement Support

Access your Pet Parent Benefits:

1. Go to my.canopywell.com
2. Register as a new user or log in
   Use CIS as Company Code
3. Enter *Pet Parent* in the search bar

It's free and confidential

call: 800-433-2320 text: 503-850-7721
visit: canopywell.com

canopy

$0
cost to you

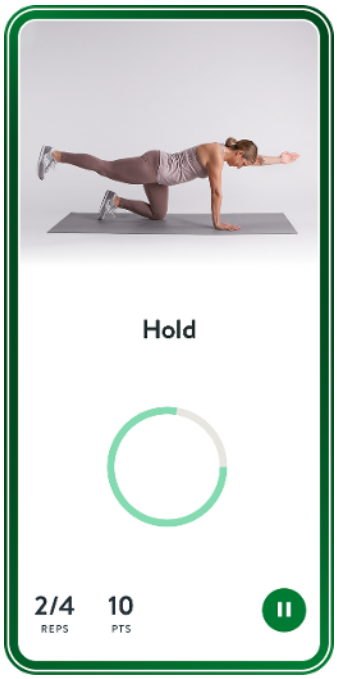
CIS | Hinge Health

Personalized pain care that gets you moving

Relieve joint and muscle pain with personalized exercise therapy **at no cost to you**. On average, participants reduce their pain by 68%.[1]

- **Virtual sessions anytime, anywhere**
- **Unlimited 1-on-1 health coaching**
- **Motion-tracking technology for instant form correction**

Your family may be eligible, too!



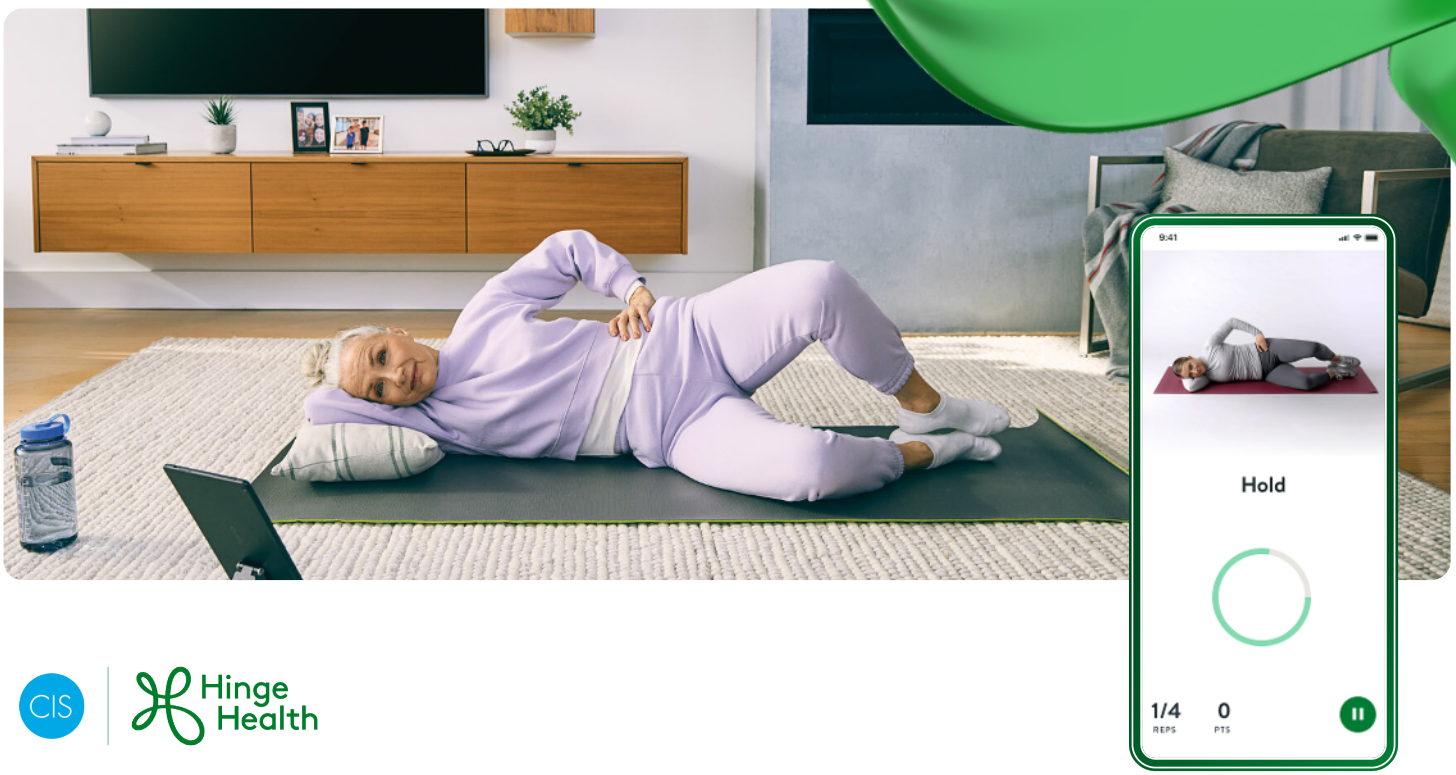
To learn more and apply, scan the QR code or visit
hinge.health/cisoregon

Questions? Call (855) 902-2777

Hinge Health está disponible en español
Alivia los dolores articulares y musculares y previene las lesiones con tus beneficios de salud gratuitos. Únete ahora.

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

[1]After 12 weeks, in a study of chronic knee and back program participants. Bailey JF, et al. Digital Care for Chronic Musculoskeletal Pain: 10,000 Participant Longitudinal Cohort Study. J Med Internet Res 2020;22(5):e18250.



CIS | Hinge Health

Join the Women's Pelvic Health Program

Hinge Health now offers pelvic floor care — available **at no cost to you** through your CIS Oregon through Regence medical plan.

What's your pelvic floor and why should you care?
Your pelvic floor is the group of muscles and tissues attached to the bottom of your pelvis. It supports your pelvic organs, controls your bladder, and more. And it's one of the hardest working muscle groups in your body.

Why join?

- Get personalized exercise therapy for pregnancy and postpartum, bladder control, pelvic muscle strengthening, or pelvic muscle relaxation.
- Work 1-on-1 with a clinical care team that specializes in pelvic floor care.
- Exercise from the privacy of your own home, on your schedule.

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

Participants must be 18+ and enrolled in a CIS Benefits medical plan administered by Regence BlueCross BlueShield of Oregon. Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association.

Hinge Health® is a separate and independent company that provides services for CIS members enrolled in a CIS Benefits medical plan administered by Regence.

Other Benefits Summarized

Life and AD&D Insurance

Homes for Good Housing Agency provides Basic Life and AD&D benefits to eligible employees. The Life insurance benefit will be paid to your designated beneficiary in the event of death while covered under the plan. The AD&D benefit will be paid in the event of a loss of life or limb by accident while covered under the plan. Please see the following benefit summaries for complete details.

Voluntary Life and AD&D Insurance

In addition to the employer paid Basic Life and AD&D coverage, you have the option to purchase additional voluntary life insurance to cover any gaps in your existing coverage that may be a result of age reduction schedules, cost of living, existing financial obligations, etc. through Lincoln Financial Group. Your election, however, could be subject to medical questions and evidence of insurability. Please see the following benefit summary for complete details.

Long-Term Disability Insurance (LTD)

Company in the event you become unable to work due to a non-work-related illness or injury. This benefit covers 66 2/3% of the first $9,000 of monthly earnings, Max Monthly $6,000. Benefit payments begin after 90 days of disability. See Certificate of Coverage for benefit duration. Please see the summary plan description for complete plan details and the following benefit summary.

Allstate Insurance

Accident Insurance

Employees have the option to purchase accident insurance through Allstate. Accidents happen on and off the job and can cause an upset to your financial stability. If a covered accident occurs, Allstate accident insurance policies pay cash benefits for things like x-rays, surgery, hospital fees, follow-up treatments and physical therapy. These benefits can help provide a financial safety net for you and your family.

Critical Illness Insurance

Employees also have the option to purchase critical illness insurance through Allstate. Critical illness coverage helps provide financial support if you are diagnosed with a covered critical illness. If diagnosed with a covered illness, you will receive a cash benefit based on the percentage payable for the condition.

Mandatory Notices

The federal government requires the following notices to be provided to you.

- HIPAA Privacy Notice
- HIPAA Special Enrollment Rights
- Women's Health and Cancer Rights Act of 1998 (WHCRA)
- Medicare Prescription Drug Coverage - Part D
- Children's Health Insurance Program (CHIP)
- Children's Health Insurance Program Reauthorization Act (CHIPRA)
- Health Reimbursement Arrangement (HRA) Waiver Rights

HIPAA Privacy Notice

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) governs how group health plans and other "covered entities" use and disclose "protected health information." CIS is considered a covered entity and is therefore required to notify you of how your protected health information is allowed to be used and your rights related to that information. **The Notice is available on CIS' website at www.cisbenefits.org.**

HIPAA Special Enrollment Rights

The HIPAA legislation also included a "Special Enrollment Rights" provision. Employees who decline to participate in a group health plan may enroll themselves and their dependents within 30 days of these events:

- Losing coverage provided through a group health plan or health insurance, whether coverage is canceled due to job loss, disability, divorce, or death
- Marriage, birth, adoption, or the placement of a child for adoption

Employees have 30 days from the date of the event – the job loss, marriage, birth or placement – to request enrollment in the plan.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

WHCRA includes important protections for breast cancer patients who choose to have breast reconstruction in connection with a mastectomy. The coverage outlined below is included in your medical plan:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.

- Prothesis and treatment of physical complications of all stages of Mastectomy, including lymphedemas; and
- Inpatient care related to the Mastectomy and post-Mastectomy services.

The attending physician and the patient will determine together the manner of treatment. All coverage is subject to any deductibles, copayments, and/or coinsurance according to the provisions of your medical insurance benefits and federal requirements. Please see your benefits booklet for additional information.

Medicare Prescription Drug Coverage - Part D

See the "Important Notice About Your Prescription Drug Coverage and Medicare" notice below. When prescription drug coverage was added to Medicare ("Part D"), it was mandated that employees be told whether their employer's medical coverage is "creditable" or "non-creditable." Creditable means it is, on average, as good as the standard Medicare Part D coverage. Noncreditable means it is not, on average, as good.

For most active employees and some retirees, this notice doesn't apply because you are not yet covered by Medicare. However, **for those who are covered by Medicare or have a dependent covered by Medicare, this information is very important.**

Children's Health Insurance Program (CHIP)

See attached "Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)" Notice. The Notice is required to inform employees of the opportunities that "currently exist" for premium assistance under Medicaid and CHIP for coverage for employees or dependents.

Children's Health Insurance Program Reauthorization Act (CHIPRA) – Special Enrollment Rights

Employees who experience either of the following events have 60 days to enroll in group coverage through their employer.

- The termination of an individual's Medicaid or CHIP coverage due to a loss of eligibility; or
- The individual becomes eligible for a premium assistance subsidy through Medicaid or CHIP.

Health Reimbursement Arrangement (HRA) Waiver Rights

Employees (including former employees) eligible for reimbursement of medical expenses under a Health Reimbursement Arrangement (HRA) can elect each year, and upon termination of employment, to opt-out of and waive future reimbursements from the HRA. This opt-out right is required because the benefits provided by the HRA generally constitutes employer-provided health coverage under the Affordable Care Act. Therefore, this will disqualify the individual from eligibility for a premium tax credit for an insurance policy purchased through the Health Insurance Marketplace.

Important Notice from CIS About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your employer's medical plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare.

You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Regence BlueCross BlueShield (BCBS) and Kaiser have determined that the prescription drug coverage offered by your employer is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from Oct. 15 to Dec. 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?
If you decide to join a Medicare drug plan, you can continue your Regence BCBS medical coverage and benefits will coordinate with Part D coverage.

If you decide to join a Medicare drug plan and drop your Regence BCBS medical coverage, be aware that if you are an active employee you and your dependents **will not** be able to re- enroll until the next open enrollment period. If you are a retiree, you **will not** be able to get this coverage back.

<u>If you are enrolled on a Kaiser medical plan, you are not eligible to enroll in Medicare Part D because of Kaiser's arrangement with Medicare.</u> Doing so will cause your active Kaiser coverage to be terminated.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?
If you drop or lose your current coverage with your employer and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact the organization listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your employer changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: September 30, 2024
Name of Entity/Sender: CIS Benefits
Address: 15875 Boones Ferry Rd., #1469 Lake Oswego, OR 97035
Phone Number: 1-800-922-2684 (within Oregon) or 503-763-3800

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

cis benefits
cisbenefits.org

2024 CIS Benefits

Enrollment & Eligibility Guide:

- Benefit Eligibility
- Who can I cover?
- When can I make a change to my coverage?
- Special Enrollment Rights
- Medicare Eligibility & Retiree Coverage
- Leave of Absence, Loss of Coverage & Continuation Rights

This document defines who is considered an eligible dependent and allowed to be enrolled on your coverage. This document also explains the different types of IRS-qualified family status changes that may allow you to make a change to your coverage during the year.

Notice About Request for Social Security Numbers (SSN)

The Affordable Care Act (ACA) requires providers of employer-sponsored health plans to provide SSNs for individuals covered by the plan to the IRS for tax-reporting purposes.

When an employee enrolls in a CIS plan administered through Regence or a Kaiser plan, CIS has access to the employee's SSN through the employer. When the employee covers dependents (including spouse/partner) in either of these plans, CIS — through the CIS-Connect portal — must ask the employee for the dependent SSNs. There is no penalty for the employee or the plan if the employee does not provide the information.

The IRS uses the SSNs to crosscheck that members had employer-sponsored health coverage during the plan year and that they didn't get a healthcare tax subsidy. The IRS has posted helpful information about this request: **http://tinyurl.com/HealthSSNqa** and **http://tinyurl.com/HealthMayAsk**.

When am I eligible for insurance?
You must enroll for benefits online within 60 days from your date of hire, date of becoming benefit eligible due to increase in hours, or during the annual open enrollment period. As long as you enroll within these time periods, and provide all required documentation, benefits will be effective the first of the month following the waiting period established by your employer (e.g., First After Date of Hire, First After 1 Month, etc.), or on the first day of the new plan year. Supplemental Employee/Spouse Life insurance, if applicable, may be effective at a later date, depending on the date of approval by the carrier.

If new employees or newly benefit eligible employees elect to cover a disabled dependent over age 26, they can only be covered if disabled prior to age 26 and deemed disabled by a medical plan. A copy of the disability documentation from the medical plan must be provided to CIS, along with the birth certificate.

What are my options for enrollment?
Your options are based on the plans selected by your employer. These options will appear in your enrollment event and under Enrollment Materials in CIS-Connect.

If medical insurance is offered, you may opt out of coverage if you have other qualified group coverage (e.g., coverage through a spouse's plan). You may not opt out based on other individual coverage, or individual policies purchased through any state or federal sponsored exchange, Medicaid, Veteran's Administration (VA) Benefits, Medicare, TRICARE, or Tribal Benefit Programs. You must elect the "opt out" option online and you may be required to provide proof of other coverage to your employer.

There is also an option to waive coverage, which lets you decline coverage, even if you don't have other qualified group coverage. If your employer offers dental and you don't want it, you can waive dental. If your employer offers medical and you don't want it, you can waive medical. However, waiving medical automatically waives you from dental as well. If you opt out or waive medical or dental coverage, you are still required to be covered by employer-paid life and/or disability coverage if it's offered through CIS.

If offered dental insurance, you have three options:
1. Waive dental coverage
2. Enroll in employee-only coverage
3. Enroll in employee & dependent coverage.

If you (or an eligible dependent) do not enroll in dental when initially eligible, you will be subject to a late enrollment penalty. Coverage will be limited to preventive services only for the first 12 months.

Who can I cover on my insurance?
The following individuals are considered eligible dependents and can be enrolled on your coverage.

Dependent Type	Documentation Required
Legally Married Spouse An individual whom the employee is currently married to under the laws of the State of Oregon or under the laws of any other state or country.	**Marriage Certificate** that must include: – Name of Employee – Name of the Spouse – Date of Marriage – Certifier's Signature and Official Seal – State, County, or Country of Issuance
Oregon Registered Domestic Partner An unmarried individual who has entered into the State of Oregon's "Declaration of Domestic Partnership" with the employee. – *Employees who cover a registered domestic partner will be charged an imputed value amount. Check with your employer for paycheck deduction questions.*	**Oregon Certificate of Registered Domestic Partnership** that must include: – Name of the Employee – Name of the Registered Domestic Partner – Certificate Date – Certifier's Signature and Official Seal *Not all employers offer coverage to Registered Domestic Partners. Please check with your employer for Registered Domestic Partner enrollment eligibility.
Child Under Age 26 An individual who is the child of employee, child of spouse, child of registered domestic partner, or child for whom the employee, spouse, or registered domestic partner has legal guardianship. – Children don't have to reside with you, be tax dependent, be unmarried, or be attending college to be eligible for coverage. – A child's coverage cannot be terminated mid-year unless the child experiences an IRS-qualified status change (see following pages). – Child will be eligible for coverage through the end of the month they turn age 26.	**One of the Following** • **Government Issued Birth Certificate or Naturalization Certificate/Report of Birth Abroad** for child of employee, stepchild, or child of registered domestic partner that must include: – Name of the Employee, Spouse, or Registered Domestic Partner – Name of the Child – Date of Birth o For a Stepchild or Child of Registered Domestic Partner, a Marriage Certificate or Oregon Certificate of Registered Domestic Partnership is also required in addition to a birth certificate. • **Adoption paperwork** for Adopted child or child placed for adoption prior to the child turning age 18 (only needed if the Employee, Spouse, or Registered Domestic Partner is not listed as a parent on the birth certificate). • **Court Document** for Legal Guardianship or custody dated prior to the child turning age 18. • **Qualified Medical Child Support Order (QMCSO)** for child the employee is obligated to provide benefits.

Dependent Type	Documentation Required
Incapacitated Child An Incapacitated Child is an unmarried child over the age of 26 who is incapable of self-support due to a physical, mental, or developmental disability, that occurred before the child's 26th birthday, and for whom a handicapped dependent certification form has been received and approved by the insurance carrier	Same documentation as stated for Child Under Age 26 and **Medical Carrier Approval**

The documentation required when adding a dependent to your coverage for the first time is outlined on the following pages. Please note that CIS has the right to conduct a dependent-audit at any time.

When can I make a change to my coverage?
Changes to your elections are not allowed during the year unless you experience one of the IRS-qualified family status changes listed below. All mid-year changes must be completed online at www.cisbenefits.org. A description of each event, the allowed changes, and supporting documentation requirements are listed on the following pages. Changes requiring documentation will not be approved until the appropriate documentation has been received.

IRS-Qualified Family Status Changes include:

1. Birth/Adoption
2. Court-Appointed Legal Guardianship or Custody
3. Qualified Medical Child Support Order (QMCSO)
4. Marriage
5. New Registered Domestic Partner
6. Divorce/Annulment/Legal Separation
7. Dissolution/Termination/Legal Separation of Registered Domestic Partnership
8. Employee Gains Other Coverage
9. Dependent Gains Other Coverage
10. Employee Loses Other Coverage
11. Dependent Loses Other Coverage
12. Change in Hours – Increase
13. Change in Hours – Decrease
14. Change in Hours – Already Benefit Eligible
15. Death of a Spouse/Registered Domestic Partner
16. Death of a Child
17. Increase/Decrease in Cost of Dependent Care

In the tables below, "Supp Life" is short for Supplemental Employee/Spouse Life through The Hartford. "Vol Plans" denotes the following voluntary plans: Dependent Life through The Hartford, Identity Theft coverage through Allstate Identity Protection, Critical Illness, Hospital Indemnity and Accident coverage through MetLife, and Trauma coverage through Lloyd's of London. Your eligibility for any of these plans is based on whether your employer elected to offer them.

1. **Birth/Adoption**

Employees have 60 days from the date of birth or adoption to enroll a new child. Medical, dental, and vision coverages are effective as of the date of birth/adoption. Other coverages are effective the following first of the month.

Newborn documentation requirements: A newborn child must be enrolled within 60 days even if a birth certificate or Social Security Number (SSN) is not yet available. A birth certificate must be provided within 60 days of the date of birth, and the SSN must be provided within 6 months. If either is not provided within the specified time period, coverage will be terminated retroactive to the date of birth.

The following changes can be made:

Medical/Dental/Vision	Supp Life[1]/ Vol Plans	Flexible Spending Account[2]	Documentation
Enroll child, self and eligible dependent(s) in coverage	Enroll or increase life coverage for self (subject to medical underwriting); enroll in supplemental spouse life; enroll in voluntary plans	Enroll/increase healthcare or dependent care election	Copy of birth certificate or adoption papers

2. **Court-Appointed Legal Guardianship or Custody**

Employees have 60 days from the date of a court-ordered Legal Guardianship or Custody to enroll a new child. Coverage is effective the first of the month following the date the court order was signed. The following changes can be made:

Medical/Dental/Vision	Supp Life[1]/ Vol Plans	Flexible Spending Account[2]	Documentation
Enroll child	Enroll or increase life coverage for self (subject to medical underwriting); enroll in supplemental spouse life; enroll in voluntary plans	Enroll/increase healthcare or dependent care election	Copy of court order

[1]Effective the first of the month following 30 days from the date of the approval.
[2]Effective the first of the month following the date the election change is made online.

3. Qualified Medical Child Support Order (QMCSO)

Employers will be notified when an employee is required to provide coverage due to a court order. Coverage is effective the first of the month following the date the order was signed. The following changes can be made:

Medical/Dental/Vision	Supp Life/ Vol Plans	Flexible Spending Account[2]	Documentation
Enroll child	No changes allowed	If ordered to pay for medical expenses not paid by insurance, enroll/increase healthcare FSA. If the order requires another person to pay for expenses not paid by insurance, may decrease/terminate healthcare FSA election.	Copy of QMCSO

4. Marriage

Employees have 60 days from the date of marriage to enroll a new spouse. Coverage is effective the first of the month following the date of marriage. The following changes can be made:

Medical/Dental/Vision	Supp Life[1]/ Vol Plans	Flexible Spending Account[2]	Documentation
Enroll spouse, self and eligible dependent(s) in coverage	Enroll or increase life coverage for self (subject to medical underwriting); enroll in supplemental spouse life; enroll in voluntary plans	Enroll/increase healthcare or dependent care election	Copy of marriage certificate

[1]Effective the first of the month following 30 days from the date of the approval.
[2]Effective the first of the month following the date the election change is made online.

5. Newly Registered Domestic Partner

Domestic Partners are only eligible for coverage when an Oregon Certificate of Registered Domestic Partnership has been filed. Employees have 60 days from the date of filing to enroll a new domestic partner. Coverage is effective the first of the month following the date of filing. The following changes can be made:

Medical/Dental/Vision	Supp Life[1]/ Vol Plans	Flexible Spending Account[2]	Documentation
Enroll registered domestic partner, self, and eligible dependent (s) in coverage	Enroll or increase life coverage for self (subject to medical underwriting); enroll in supplemental spouse life; enroll in voluntary plans	No changes allowed; medical expenses for domestic partners are not eligible for reimbursement	Oregon Certificate of Registered Domestic Partnership

6. Divorce/Legal Separation/Annulment

Employees have 60 days from the date of a final divorce/legal separation/annulment to report the event. Coverage terminates the end of the month following the date of divorce. Failure to report this event in a timely manner will result in the loss of COBRA continuation rights. *For legal separation only - if the employee does not want to remove the spouse from enrollment, no action is needed as the spouse is still an eligible dependent*. The following changes can be made:

Medical/Dental/Vision	Supp Life[1]/ Vol Plans	Flexible Spending Account[2]	Documentation
Drop spouse and stepchild(ren)	Increase (subject to medical underwriting) or decrease coverage for self; supplemental spouse life is terminated; voluntary plans should be updated to remove spouse	Enroll/increase healthcare election due to loss of coverage; decrease election (cannot decrease if annual election has been reimbursed)	Copy of divorce decree (first page and last page) or other legal documentation showing date of divorce and judge's signature

[1]Effective the first of the month following 30 days from the date of the approval.
[2]Effective the first of the month following the date the election change is made online.

7. Dissolution/Termination/Legal Separation of Oregon Registered Domestic Partnership

Employees have 60 days from the date of the event to report a final dissolution of registered domestic partnership. Coverage terminates at the end of the month following the date of dissolution. Failure to report this event in a timely manner will result in the loss of COBRA continuation rights. *For legal separation only - if the employee does not want to remove the registered domestic partner from enrollment, no action is needed as the registered domestic partner is still an eligible dependent*. The following changes can be made:

Medical/Dental/Vision	Supp Life[1]/ Vol Plans	Flexible Spending Account	Documentation
Drop registered domestic partner and child(ren) of registered domestic partner	Increase (subject to medical underwriting) or decrease coverage for self; supplemental spouse life is terminated; voluntary plans should be updated to remove registered domestic partner	No changes allowed	Copy of dissolution/termination

8. Employee Gains Other Coverage

Employees have 60 days to report a gain of other coverage and provide proof of that coverage for themselves. Coverage terminates at the end of the previous month if new coverage begins on the 1st of the current month or the end of the current month if coverage begins any day other than the 1st. "Coverage" includes other employer group coverage through spouse/domestic partner, Medicare, or eligibility for federal or state assistance programs. Policies purchased individually or through an Insurance Exchange program do not qualify as group coverage. The following changes can be made:

Medical/Dental/Vision	Supp Life/ Vol Plans	Flexible Spending Account[2]	Documentation
Drop self and any dependents	No changes allowed	Decrease/terminate healthcare election	Documentation showing effective date of other coverage and name of covered individual(s)

[1]Effective the first of the month following 30 days from the date of the approval.
[2]Effective the first of the month following the date the election change is made online.

9. Dependent Gains Other Coverage

Employees have 60 days to report a gain of other dependent coverage and provide proof of that coverage for dependent(s). Coverage terminates at the end of the previous month if new coverage begins on the 1st of the current month or the end of the current month if coverage begins any day other than the 1st. "Coverage" includes other employer group coverage, Medicare, or eligibility for federal or state assistance programs. Policies purchased individually or through an Insurance Exchange program do not qualify as group coverage. The following changes can be made:

Medical/Dental/Vision	Supp Life/ Vol Plans	Flexible Spending Account[2]	Documentation
Drop dependent(s) who gained coverage	No changes allowed	Decrease/terminate healthcare election	Documentation showing effective date of other coverage and name of covered individual(s)

10. Employee Loses Other Coverage

Employees have 60 days to report and submit appropriate documentation of a loss of other employer group coverage for themselves. Coverage is effective the first of the month following the date of loss. "Coverage" includes only other employer group coverage or termination of federal or state assistance programs. The following changes can be made:

Medical/Dental/Vision	Supp Life/ Vol Plans	Flexible Spending Account[2]	Documentation
Enroll self and any dependents	No changes allowed	Enroll/increase healthcare election	Documentation showing date of loss of other coverage and name of covered individual(s)

11. Dependent Loses Other Coverage

Employees have 60 days to report and submit appropriate documentation of a loss of other employer group coverage for their dependents. Coverage is effective the first of the month following the date of loss. "Coverage" only includes other employer group coverage or termination of federal or state assistance programs. The following changes can be made:

Medical/Dental/Vision	Supp Life/ Vol Plans	Flexible Spending Account[2]	Documentation
Enroll dependent(s)	No changes allowed	Enroll/increase healthcare election	Documentation showing date of loss of other coverage and name of covered individual(s)

[2]Effective the first of the month following the date the election change is made online.

12. Change in Hours – Increase Resulting in New Benefit Eligibility

Employees have 60 days to enroll in benefits from the date their work hours increase resulting in becoming benefit eligible. If waiting period has already been met, coverage is effective the first of the month following the date of the hours change. The following changes can be made:

Medical/Dental/Vision	Supp Life[1]/ Vol Plans	Flexible Spending Account[2]	Documentation
Enroll self and eligible dependent(s) in coverage	Enroll in coverage	Enroll in healthcare and/or dependent care	Employer updates hours in Connect and date of change

13. Change in Hours – Decrease Resulting in Loss of Eligibility for Benefits

All coverages terminate at the end of the month the hours change.

14. Change in Hours (Already Benefit Eligible) – Significant Bmployee Cost Change Due to Increase/Decrease in Hours

Employees have 60 days to enroll or disenroll in benefits from the date their work hours increase/decrease. Coverage change is effective the first of the month following the date the hours change. Please contact the CIS Benefits Helpline at 855-763-3829 to discuss coverage options.

15. Death of a Spouse/Registered Domestic Partner

Upon notification of a spouse/registered domestic partner's death, coverage for the deceased individual terminates the end of the month following the death. Coverage change is effective the first of the month following. The following changes can be made:

Medical/Dental/Vision	Supp Life[1]/ Vol Plans	Flexible Spending Account[2]	Documentation
Drop dependent	Increase (subject to medical underwriting) or decrease coverage for self; supplemental spouse life is terminated; voluntary plans should be updated to remove spouse/registered domestic partner	Enroll/increase/ decrease healthcare election (cannot decrease if annual election has been reimbursed)	No documentation is required

[1]Effective the first of the month following 30 days from the date of the approval.
[2]Effective the first of the month following the date the election change is made online.

16. Death of a Child

Upon notification of a child's death, coverage for the child terminates the end of the month following the death. Coverage change is effective the first of the month following. The following changes can be made:

Medical/Dental/Vision	Supp Life[1]/ Vol Plans	Flexible Spending Account[2]	Documentation
Drop dependent	Decrease coverage for self; voluntary plans should be updated to remove child	Decrease healthcare election (cannot decrease if annual election amount has been reimbursed)	No documentation is required

17. Increase/Decrease in Cost of Dependent Care

Employees have 60 days to request a change in their dependent care FSA elections due to increase/decrease in cost. The election change must be consistent with the event. The following changes can be made:

Medical/Dental/Vision	Supp Life/Vol Plans	Flexible Spending Account [2]	Documentation
No changes allowed	No changes allowed	Increase/decrease dependent care due to cost change	No documentation is required

[1]Effective the first of the month following 30 days from the date of the approval.
[2]Effective the first of the month following the date the election change is made online.

Special Enrollment Rights (Medical/Vision & Dental)
There are certain situations when you may enroll yourself and/or your eligible dependents, even though you didn't do so when first eligible, and you do not have to wait for an annual enrollment period.

The following events may allow enrollment within 60 days of the date of the qualifying event and coverage will be effective the first of the month following the coverage end date:

- You and/or your eligible dependents lose coverage under another group or individual Health Benefit Plan due to one of the following:
  - An employer's contributions to that other plan are terminated;
  - Exhaustion of federal COBRA or any state continuation; or
  - Loss of eligibility, for instance, due to legal separation, divorce, termination of domestic partnership, death, termination of employment or reduction in hours.
- You involuntarily lose coverage under Medicare, CHAMPUS/Tricare, Indian Health Service or a publicly sponsored or subsidized health plan (other than the Children's Health Insurance Program (CHIP)).

The following event may allow enrollment within 60 days of the date of the event and coverage will be effective the first of the month following the date of the qualifying event:

- You and/or your dependent(s) become eligible for premium assistance under Medicaid or the Children's Health Insurance Program (CHIP).

Please contact the CIS Benefits Helpline (855-763-3829) if any of these events happen so we can assist in determining eligibility for enrollment.

Medicare Eligibility for Active Employees
If you or a dependent becomes Medicare-eligible while still working and eligible for benefits, the group coverage through CIS is primary and Medicare is secondary. You, or your dependent, can enroll in Medicare Part A (usually available at no cost) and defer Medicare Part B and Part D (prescription drug coverage) until no longer an active employee or no longer covered by an active plan.

Leaves of Absence
Employees are entitled to many different types of leaves of absence, including family medical leave (state and federal), military leave, domestic violence leave and non-medical leave with or without pay. Each type of leave is governed by state and/or federal regulations, and termination/reinstatement of coverage differs for each. Most leaves will allow employees to maintain their existing medical/dental and life/disability coverage for a limited period of time, but specific timelines must be followed. Employees planning on a leave of absence, or returning from a leave, need to discuss their options with their employer.

<u>Medical/Dental Coverage</u>
If coverage terminates due to loss of eligibility, employees may have the option to continue coverage on a self-pay basis through COBRA (see below).

Healthcare Flexible Spending Account (FSA)
For participants enrolled in the Healthcare FSA, deductions continue if the leave is with pay and no changes are allowed. For leave without pay, deductions are discontinued unless the employee elects to continue the account through COBRA. The account is reinstated upon return to work and while election changes may be allowed, they must be consistent with returning from leave.

Dependent Care Flexible Spending Account (FSA)
For participants enrolled in a Dependent Care FSA, dependent care expenses are not eligible for reimbursement while on leave with or without pay. Deductions will be reinstated upon return to work, but election changes can be made.

Hartford Life/Long-Term Disability Coverage
Depending on the type of leave, coverage may be continued for a limited period of time. Check with CIS for your continuation options.

Voluntary Plans: Short-Term Disability, Identity Protection, Critical Illness, Hospital Indemnity, Accident, Trauma
Check with the applicable company for your continuation rights.

Workers' Compensation Claims
If you are not working the minimum hours required by your employer for coverage due to an injury or illness for which you have filed a workers' compensation claim, you may be eligible for continued medical and dental coverage for up to 12 months after your eligibility ends, depending on your employer's policies/procedures. Continuation periods for life and disability coverage are different, based on the insurance policies' provisions. Check with your employer for eligibility on medical/dental continuation options and CIS for life/disability continuation options.

Loss of Coverage – Continuation Rights
Medical/Vision/Dental Coverage
The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires most group health plans to provide continuation of group health coverage when employment terminates.

COBRA requires continuation coverage be offered to you, your spouse, your former spouse, and your dependent children when group health coverage would otherwise be lost due to certain specific events. Those events include your death, termination of employment, reduction in the number of hours per week making you ineligible for benefits, divorce or legal separation from a covered employee, and a child's loss of dependent status (turning 26 years of age).

Oregon state law allows surviving or divorced spouses between the ages of 55-65 and their dependent(s) to extend continuation coverage in their Oregon-based insured health plans once the Federal continuation has been exhausted. The extended coverage can be continued until they become eligible for Medicare or covered under another health benefit plan, as long as the employer continues to sponsor the group health plan.

The premium for continuation coverage is more expensive than the amount you paid as an active employee for group health coverage. This is because your employer paid all or part of your active premium. With COBRA continuation coverage, the full cost, along with a 2% administrative fee, is typically passed on to the individual(s) electing coverage.

Important Note: If your employer will be providing a premium subsidy, you MUST still complete and return the COBRA Enrollment Form to CIS or enroll online within the enrollment timeline. If enrollment is not completed, your coverage will not be continued.

While COBRA continuation coverage must be offered, it only lasts for a limited period of time (18, 29 or 36 months, based on the reason for termination). COBRA coverage can be terminated by the participant at any time during the continuation period. The administrator, however, will terminate coverage due to non-payment of premium on a timely basis, when the participant has gained other coverage, or at the end of the continuation period.

Alternatives to COBRA Continuation Coverage
Under the Affordable Care Act (ACA), individuals who lose employer health insurance coverage have the option to purchase health insurance benefits through an insurance exchange or directly through an insurance carrier, without the risk of being denied for pre-existing conditions. A local insurance agent can assist you in finding and purchasing health insurance coverage that will fit your needs.

Notice Procedures
Upon notification of a termination by your employer, CIS will send a COBRA notice to you using the address on file. If you are moving to a new location, you will need to notify your employer or contact CIS. You are required to return the COBRA Election Form within 60 days of loss of coverage. Continuation coverage will be reinstated to the date active coverage was terminated, as there can be no break in coverage.

If terminating due to retirement, CIS will send both retiree information and COBRA information, as required by law. Most individuals elect retiree coverage because it can be continued until Medicare eligibility, whereas COBRA can only be continued for a limited period of time. Retiree coverage also does not include the 2% administrative fee. If retiree or COBRA continuation coverage is voluntarily terminated or terminated for non-payment, you cannot re-enroll at a later date.

Life/Disability Coverage
Life and disability insurance is not subject to COBRA. If you were covered under your employer's life and/or disability plan, or you elected supplemental life insurance, you may have the option to continue this coverage on a self-pay basis with the life insurance carrier. The Hartford will mail, to your address in CIS-Connect, a letter which will outline your continuation options. You can also contact The Hartford directly at 888-563-1124.

Retiree Coverage
You may be eligible to continue coverage as a retiree if:

- You are not Medicare eligible and
- You are receiving, or are eligible to receive, retirement benefits under the Oregon Public Employees Retirement System or any other retirement system or plan applicable to employees of the local government that employs you.

You must have been enrolled as an active employee in a CIS medical and/or dental plan at the time of retirement to qualify for continued coverage as a retiree. You must enroll within 60 days of your date of retirement. If you had dependents covered when you retired, coverage may also be continued for them.

Eligibility for medical/vision/dental insurance ends for you, your spouse, and any dependent children the last day of the month prior to becoming eligible for Medicare due to age or disability. Even if CIS is not timely notified of Medicare eligibility, coverage will be terminated retroactive to the date you or your dependent became Medicare eligible. Eligibility for dependent children ends when the employee and spouse, if applicable, both become Medicare eligible unless the child(ren) has not yet reached the age of majority (18). Children under 18 can continue coverage until the end of the month in which they turn 26.

For questions regarding coverage options upon retirement, contact the CIS COBRA/Retiree Team at cobraretiree@cisoregon.org or by calling the CIS Benefits Helpline at 855-763-3829.

Administrative and Eligibility Appeals

Administrative appeals relate to decisions made by your employer. Eligibility appeals relate to employees who miss enrollment timelines. Employees may appeal an administrative or eligibility decision by appealing in writing to the CIS Benefits Director within 45 days of the date of denial. The Benefits Director will make a determination and send a written response and explanation within 15 days. If the employee is dissatisfied with the decision, he/she may make a written request for reconsideration to the CIS Executive Director within 45 days of the CIS Benefits Director's denial. The CIS Executive Director may, at their discretion, consult with the Board of Trustees and will respond with notification of status of the request for consideration within 15 days. A final determination response will be sent in writing no later than 30 days from the date the request is received by the CIS Executive Director. The CIS Executive Director’s determination is final, and there are no further appeal rights.

Open Enrollment

Most changes are effective Jan. 1, 2025

cis benefits
cisbenefits.org

START

Open Enrollment begins Sept. 30 and ends Oct. 25 at 5 pm

DO I HAVE TO DO OPEN ENROLLMENT?

YES

NO

WARNING!
Some benefits will roll over if you don't log in, but your flexible spending account will not. You may also miss out on any new benefits your employer may offer.

LOG INTO CISBENEFITS.ORG

DID THAT WORK?

YES

NO

Click on the action item "Open Enrollment" to get started.

You're ready to review your 2025 Benefits Package. It should only take about 10 minutes to complete your enrollment.

DONE!

Make sure you're at the right website, cisbenefits.org.

Did you forget your password?

If you need to reset your password, as a reminder, passwords must contain:

- At least eight characters in length
- At least one uppercase letter
- At least one lowercase letter
- At least one number
- No more than one of the following special characters: !@#$%. *(Other characters aren't acceptable.)*

Still having trouble logging in?

Submit an email to CIS Benefits by clicking on the link that reads "Having trouble logging in? Click here."

Any questions? Call CIS Benefits at 1-855-763-3829, or email cisbenefits@cisoregon.org

cis benefits
cisbenefits.org

Open Enrollment Frequently Asked Questions

How do I log in?

Go to **cisbenefits.org** and sign in as a returning user. If you don't know your username, it's probably your work email. Your employer can tell you what it is too, or you can contact CIS. If you forgot your password, click the “Forgot password?” link to reset it.

How do I know what my benefit options are?

Log in to your account at cisbenefits.org to view the benefits your employer selected to offer.

Who is eligible to be on my plan?

Please refer to the Eligibility Guide. You can access the guide by logging into cisbenefits.org and selecting “Enrollment Materials” from the menu at the top of the screen.

I don’t have my marriage certificate or my baby’s birth certificate. What do I do?

You still need to complete your open enrollment event before the deadline. You have until Nov. 30 to upload your paperwork to the Benefits portal.

I just had a life event (e.g., marriage, baby, divorce). What do I do?

Log into **cisbenefits.org** and process your life event before starting open enrollment.

I completed this year’s open enrollment and then had a life event (e.g., marriage, baby, divorce). What do I do?

Return to **cisbenefits.org** and report the event so that your 2024 employee benefits can be updated. Afterward, you will need to complete the open enrollment process again so that your 2025 benefits also get updated.

Additional questions? Call CIS Benefits at 1-855-763-3829, or email cisbenefits@cisoregon.org.

cis benefits
cisbenefits.org

Open Enrollment Highlights

Open Enrollment is Sept. 30 – Oct. 25

Open enrollment is the time to review your plan options. Your benefits package includes options for you to select as well as choices made by your employer. It's important you understand your options and the value-added benefits/services that come with your selection. We encourage you to visit our carrier partners' websites to review information about programs/services that go well beyond providing treatment for an illness. There are also lifestyle wellness programs that provide incentives as well as discount programs.

In addition to reviewing benefits, it's also your opportunity to add or delete dependents to or from your coverage. The effective dates of your open enrollment changes are:

- Jan. 1 for medical or dental changes. If dependents are added for the first time, you must submit the required documentation by Nov. 30, or your dependents will not be covered.
- Jan. 1 or later for Supplemental Employee/Spouse Life, depending on when you complete your Evidence of Insurability (EOI). The EOI must be completed by Nov. 30, or your open enrollment life election will not be processed. There are many NEW and exciting updates to these plans that are only available to you during Open Enrollment 2025 so please be sure to read more about them below!
- Jan. 1 for the other voluntary plans.

BENEFITS HELPLINE
855-763-3829

If you have issues registering for CIS-Connect, or have benefits questions, you can reach the Benefits Team by calling our Benefits Helpline from 8 a.m. to 5 p.m., Monday – Friday. If you reach the helpline's voicemail when calling, please leave a message. One of the Benefits team will return your call within 24 hours.

855-763-3829
cisbenefits.org

Getting Started on CIS-Connect

First step, go to cisbenefits.org. CIS-Connect is the online enrollment system that you access to view your current benefits and make open enrollment changes. You'll receive weekly reminder emails to complete your enrollment for the first two weeks of the open enrollment period, increasing to daily reminders during the last week until you have completed the process.

Email Address: For most employees, your work email address is what you'll use to access CIS-Connect. If that doesn't work, click on the "Forgot email address" link to find your account. If no account is found, please follow up with your HR department.

Password: If you don't remember your password, click the "Forgot Password?" button and follow the instructions to receive a new password. If you are a new employee, the password you set up must meet the following criteria.

- At least eight characters in length
- Have at least one uppercase letter
- Have at least one lowercase letter
- Have at least one number
- Have **ONLY one** of the following special characters:
  !@#$%
  - If the password is reset successfully, the box will turn green. If it doesn't, you haven't met the requirements listed above.

Completing Open Enrollment: You must click the **"Complete"** button on the last page, or your election changes are not processed. This step also takes you back to the homepage, where you'll see links for any required documentation, if applicable.

IMPORTANT NOTE:
Open enrollment closes on the earlier of (1) the date set by your employer or (2) 5 p.m. PDT on Oct. 25.

Make sure you go online before that date to ensure your benefits are correct, or to make any changes.

Documentation Requirements

- If adding a spouse to medical, dental, or supplemental life coverage, a copy of your marriage certificate/license is required.
- If adding child(ren) to medical or dental coverage, a copy of their birth certificate(s) is required.
- If enrolling in Supplemental Employee/Spouse Life, you must complete Hartford's Evidence of Insurability (EOI).

While it's best to have the documents ready to upload during the open enrollment process, you have until Nov. 30. If the required documentation is not uploaded or completed by Nov. 30, your election changes will not be processed.

Benefit Highlights & Other Important Information

Please note: While some of the open enrollment materials talk about all the benefits CIS offers, not all employers choose to offer every benefit available. You will only see the benefits available to you when going through the open enrollment process. If you opt out of, or waive a medical and/or dental plan, you must do so in CIS-Connect.

HARTFORD – LIFE/DISABILITY PLANS

(Applicable only to employees who are offered CIS' Life/Disability Plans. Plan selections are only available if your employer offers them.)

In 2025, the employee maximum benefit for your Supplemental Life policy will increase from $300,000 to $1,000,000 — and the guaranteed issue amount will increase from $100,000 to $400,000. The Supplemental Spouse maximum benefit will remain $300,000, while the guaranteed issue amount will increase from $20,000 to $30,000.

Because of the benefit enhancement, CIS has negotiated with The Hartford to allow all employees and spouses to be eligible for the new guaranteed issue amounts during the 2025 open enrollment period.

This is a one-time opportunity to increase your coverages to the new guaranteed issue amounts without having to complete Evidence of Insurability, or EOI. After the 2025 open enrollment period, any requested increase to coverage will require EOI and will depend on Hartford's approval.

Please also note, your current elections will not automatically increase to the new guaranteed issue amounts. If you want to increase your supplemental employee or spouse coverages, you must elect the higher amount(s) through the Open Enrollment process.

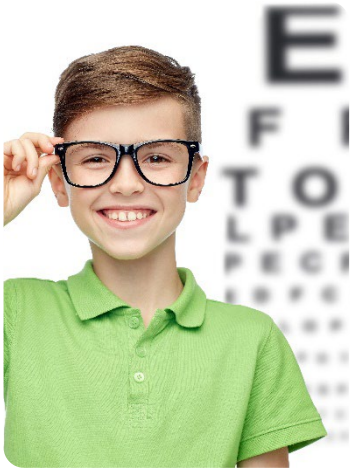
- Be sure to check that your beneficiary designations are correct. Benefits will be paid to whoever is listed in CIS-Connect, even if the beneficiaries are incorrect.
- Please refer to the Life Flyer for rates.

REGENCE BLUECROSS BLUESHIELD OF OREGON ("REGENCE")

- The CIS Health Manager on the Regence website (regence.com) is the customized homepage for members enrolled in a CIS health plan administered by Regence. This site provides you with single sign-on access to the programs that supplement your medical plan, such as Express Scripts (prescription drugs), BeyondWell, MDLive (telehealth), etc.
  - Regence has a smartphone app to access your digital ID card and view coverages and claims information.
- Hinge Health — Members enrolled on a CIS health plan administered by Regence are eligible for a back and joint pain management program through Hinge Health. This virtual program is available to enrolled employees and their eligible family members at no cost. For more information visit hingehealth.com/cisbenefits or call (833) 902-2777.
- SurgeryPlus/Lantern — Starting in 2025 SurgeryPlus will be changing their name to Lantern. This program will connect you with a care advocate who will help you find high-quality surgeons with low complication rates. By utilizing the SurgeryPlus network, members will have lower out-of-pocket costs. More information on how to access this program call (833) 603-0511 or go to surgeryplus.com.
- ID Cards — Unless you add new dependents, or change plans, you will not receive new medical ID cards from Regence. Please retain your current ID for 2025 benefits. However, you will receive a SurgeryPlus/Lantern ID card in January.
- The BeyondWell lifestyle program continues for 2025. You and your covered spouse (if enrolled) can earn up to $150 in Amazon.com gift cards. Be sure to review the BeyondWell flyer for program highlights.

VSP (FOR MEMBERS IN CIS HEALTH PLANS ADMINISTERED BY REGENCE ONLY)

- ID cards are not needed. When making a vision appointment, you should identify yourself as a VSP member, and the provider will verify eligibility at that time. The member ID number is the last four digits of the employee's SSN for all members of the family.
  - All VSP members should visit VSP.com to learn about coverages and discount programs, and to locate providers. Consider signing up for the VSP newsletter.



KAISER MEDICAL & DENTAL

- Kaiser-covered employees and spouses (if enrolled) are eligible for CIS' BeyondWell program and can earn up to $150 in Amazon.com gift cards. Be sure to review the BeyondWell flyer for program highlights.
- Unless you add new dependents, you will not receive new medical ID cards. Please retain your current ID for 2025 benefits.
- Be sure to visit kp.org to access telehealth services, schedule appointments, and access your digital ID cards. Kaiser also has a smartphone app available.

ASIFLEX — HEALTHCARE/DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS (FSA)

(Applicable only to employees who are offered CIS' FSA plan through ASIFlex. Plans are only available to select in CIS-Connect if your employer offers them.)

2025 Plan Year

  - — The Healthcare FSA rollover amount from the 2025 to 2026 plan year is $640. Even if the IRS increases this amount to be higher than this for 2025, ours will remain $640.
  - — The Dependent Care FSA will not be eligible for rollover into the 2025 plan year.
- Mid-year changes to the Healthcare and/or Dependent Care FSA will only be allowed if you experience a qualified status change.
- The Healthcare FSA maximum is $3,200 for 2025.
- The Dependent Care maximum is $5,000 for 2025.
- Refer to the ASIFlex flyer for plan details.
- Enrollment for the 2025 plan year for all pre-tax plans MUST be done online in CIS-Connect during open enrollment.

REMINDER:
If you don't re-enroll in the Healthcare FSA for the 2025 plan year and you have unused carryover dollars from the 2024 plan year, they must be used by the end of 2025, or they will be forfeited. If you re-enroll for the 2025 plan year, the time limitation does not apply.

METLIFE – SHORT TERM DISABILITY

(Applicable only to employees who are offered CIS' Short Term Disability Plans. Plan selections are only available if your employer offers them.)

Short-Term Disability coverage replaces a portion of your income if you're hurt or sick and unable to work. The cost will vary depending upon your age and income. You'll be able to see your cost while completing the Disability section of the Open Enrollment event.

- Short-term disability offsets with Paid Leave Oregon, meaning PLO will pay first and the disability policy will pay the difference between what PLO pays you and 60% of your pre-disability

income. If PLO is paying 60% or more of your pre-disability income during your disability, you will be paid the 10% minimum benefit.

Please note, the disability policy will offset against any PLO payments you are *eligible* for, even if you do not apply for PLO. You may calculate your potential PLO benefits using the Benefits Calculator on the PLO website at paidleave.Oregon.gov. Choosing not to apply for PLO will not increase disability benefits but, if PLO benefits have been exhausted, the disability plan may increase the weekly benefit up to the maximum of 60% of your income, with a maximum weekly benefit of $2,000.

Each employee will want to determine if electing a short-term disability plan will benefit them based on their income and circumstances.

- Please refer to the life flyer for rates.

VOLUNTARY PLANS — IDENTITY THEFT, CRITICAL ILLNESS/HOSPITAL INDEMNITY/ACCIDENT, TRAUMA COVERAGE

(Applicable only to employees who are offered CIS' Voluntary Plans. Plan selections are only available if your employer offers them.)

- Allstate Identity Protection
  - Please refer to the Identity Theft flyer for plan information and rates.
- MetLife Critical Illness, Hospital Indemnity, or Accident
  - You can enroll in any combination of the three plans.
  - Please refer to the Critical Illness, Hospital Indemnity, and Accident coverage flyer for plan information and rates.
- Trauma Coverage offered by Lloyd's of London
  - Please refer to the Trauma flyers for plan information and rates.

Completing the Process

After reviewing the summary page, click on "**Complete**" and then "**I Agree**" or your election changes will not be processed, and the event will show as incomplete. After clicking the two links, you'll see a message that reads "Thank you. You have completed this event. If there are any action items, they are listed below."

This message means you have completed open enrollment. If you have any action items listed, you must upload or complete the required documentation by Nov. 30, or your election changes will not be processed.