cis benefits
cisbenefits.org

Open Enrollment Highlights

Open Enrollment is October 12 - 30

YOUR EMPLOYER MAY HAVE A SHORTER ENROLLMENT PERIOD WITHIN THESE DATES.

Open enrollment is the time to carefully review your plan options so you can get the most out of your benefits choices. Your benefits package includes options for you to select as well as choices made by your employer. It's important you understand your options as well as the value-added benefits/services that come with your selection. We encourage you to visit our carrier partners' websites to review great information about programs/services that go well beyond providing treatment for an illness. There are lifestyle wellness programs that provide incentives as well as many 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, required documentation must be submitted by Nov. 30 or the 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 life election will be deleted.
- Jan. 1 for the new voluntary plans.

BENEFITS HELPLINE
855-763-3829

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

503-763-3800 855-763-3829
www.cisbenefits.org
1212 Court St. NE, Salem, OR 97301

OEH

CIS-Connect

We have a new enrollment system – CIS-Connect. **If you haven't accessed the enrollment system since May 1 — when we went live — you're a new user and must register.** You cannot make changes or enroll in any new benefits without accessing CIS-Connect. CIS-Connect is accessible on the latest versions of Chrome, Firefox, Edge, Safari and Opera. *Internet Explorer is not supported by CIS-Connect and will result in problems.*

Email Address: The email address you enter will likely be your work email, but it can also be a personal email. The email address included in our previous enrollment system was imported into CIS-Connect. The email you enter must match what was uploaded in order to register. If entering one doesn't work, try the other. If you try both and still can't log in or if you want to change your email address, please call the Benefits Helpline at 855-763-3829.

Password: The password you set up must meet the following criteria.

- At least 8 characters in length
- Have at least 1 uppercase letter
- Have at least 1 lowercase letter
- Have at least 1 number
- Have ONLY 1 of the following special characters: !, @, #, $, %

Getting Started

Go to **www.cisbenefits.org** and click the "CIS-Connect Login" button. That will take you to a page with a video or written instructions you can view that walk you through the registration process.

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, the 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. If a benefit is not offered, you won't see it when going through the

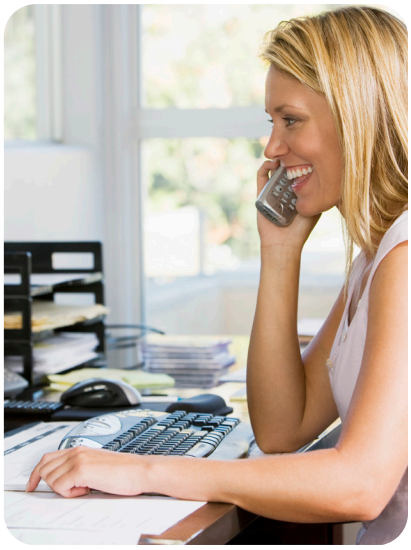
Important note:

Open enrollment closes on the earlier of (1) the date set by your employer or (2) 5:00 p.m. PDT on Oct. 30.

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

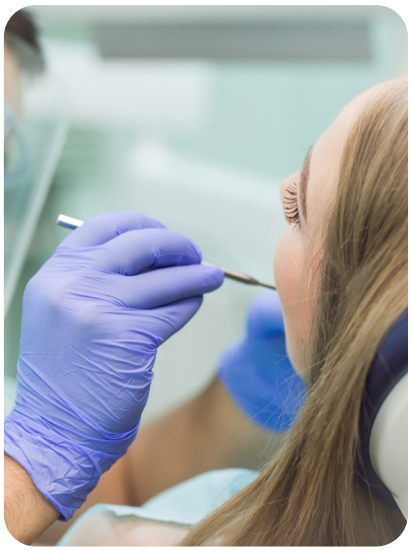
open enrollment process. If you'll be opting out of or waiving the medical and/or dental plans, you must make that election on CIS-Connect.

REGENCE BLUECROSS BLUESHIELD OF OREGON ("REGENCE")



- The CIS Health Manager on the Regence website (www.regence.com) is the customized homepage for Regence members. This site provides you with single sign-on access to the programs that supplement your medical plan, such as Express Scripts (prescription drugs), VSP (vision), BeyondWell, MDLive (telehealth), etc.
- Copay Plan Members – Most employees (excluding some covered by collective bargaining contracts) will see increases in the standard Express Scripts Rx copays and new copay tiers for specialty drugs. Included with your open enrollment materials is a list of specialty drugs that will be impacted by the specialty tier copays. Please see the plan summary for plan details.
    - If eligible, be sure to refill prescriptions in December in order to take advantage of the lower copays."
- High Deductible Health Plan (HDHP) Members – Most employees (excluding some covered by collective bargaining contracts) will see increased deductibles and out-of-pocket maximums. Please see the plan summary for plan details.
- The BeyondWell lifestyle program continues for 2021 and members can earn up to $150 in Amazon.com gift cards. Please see the BeyondWell flyer for program highlights. You can also view a BeyondWell video on the **cisbenefits.org** home page or in CIS-Connect under the Open Enrollment Materials tab at the top of the page.

VSP (REGENCE MEMBERS ONLY)



- Most employees (excluding some covered by collective bargaining contracts) will now be covered by VSP-A. This plan adds office visit copays, but also increases the frame allowance and adds coverage for lens enhancements. Please see the VSP plan summary for plan details.

KAISER MEDICAL & DENTAL

- Kaiser has no benefit changes.
- Kaiser members are eligible for Regence's BeyondWell program and can earn up to $150 in Amazon.com gift cards. Please see the BeyondWell flyer for program highlights. You can also view a BeyondWell video on the cisbenefits.org home page or in CIS-Connect under the Open Enrollment Materials tab at the top of the page.

DELTA DENTAL

- Delta Dental has no benefit changes.

WILLAMETTE DENTAL

- Most employees (excluding some covered by collective bargaining contracts) will be moving to Willamette Dental-A. This plan adds or increases copays for most services. It also adds new coverage for dental implants.

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

(Applicable only to employees who are offered CIS' FSA plan through ASIFlex. Plans will only show if they're offered by your employer.)

- Enrollment for the 2021 plan year MUST be done online during open enrollment.
- The Healthcare FSA maximum for 2021 is $2,750.
- Debits cards are available for the Healthcare FSA plan.
- Please refer to the ASIFlex flyer for plan details and how to request a debit card.

ASIFLEX – COMMUTER (TRANSIT & PARKING)

- Enrollment for the 2021 plan year MUST be done online during open enrollment.
- The monthly maximum amount is $270.
- Please refer to the ASIFlex flyer for plan details.

HARTFORD – LIFE/DISABILITY PLANS

(Applicable only to employees who are offered CIS' Life/Disability Plans. Plans will only show if they're offered by your employer.)

- Due to the transition to CIS-Connect, please be sure to check that your beneficiary designations are correct. Errors can happen when transferring data and benefits will be paid to whoever is listed on CIS-Connect.
- If you are enrolled in Supplemental Employee/Spouse Life, those policies are age-rated based on 5-year bands. If you or your spouse changed age bands during 2020 (e.g., 44 to 45), you will see an increase in premiums with your first deductions for 2021.
- Please refer to the life flyer for rates.
- Short Term Disability (STD)
  - Eligibility for the four options is based on your weekly salary. Be sure only to select the option that provides an amount equal to or less than 60% of your weekly salary. If you enroll in an option you are not eligible for, your benefits will be reduced if a claim is filed.

REMINDER:

If you don't re-enroll in the Healthcare FSA for the 2021 plan year and you have unused carryover dollars (up to $500) from the 2020 plan year, they must be used by the end of 2021 or they will be forfeited. If you do re-enroll for the 2021 plan year, the time limitation does not apply.

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

(Applicable only to employees who are offered CIS' Voluntary Plans. Plans will only show if they're offered by your employer.)

- InfoArmor Identity Theft
  - InfoArmor's name changes to Allstate Identity Protection effective Jan. 1, 2021.
  - Current employees or employees hired prior to Sept. 15 were offered free identity theft coverage from July – Dec. If your employer elected to continue to offer the coverage after Jan. 1, 2021, you can enroll in it for yourself or for family coverage at your cost.

    Note: If you enroll for the first time during open enrollment, you will receive a welcome email and letter in January.
  - If you participated in the free coverage and your employer chose not to continue to offer the coverage after Jan. 1, 2021, you should receive an email from InfoArmor/Allstate notifying you of your continuation options. You'll have 90 days to call them at 800-789-2720 to request continuation on a direct bill basis.
  - Please refer to the Identity Theft flyers for plan information and to access a video link with a program overview. You can also access the video under the Open Enrollment Materials tab at the top of the page.
- 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 flyers for plan information and to access a video link with a program overview. You can also access the video under the Open Enrollment Materials tab at the top of the page.
- Trauma Coverage offered by Lloyd's of London
  - Please refer to the Trauma flyers for plan information and to access a video link with a program overview. You can also access the video under the Open Enrollment Materials tab at the top of the page.

Completing the Process

After reviewing the summary page, click on "Complete" and then "I Agree." You'll then 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.

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2021 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 to individuals covered in the plan to the IRS for tax-reporting purposes.

When an employee enrolls in either Regence or Kaiser, 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 employer — 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 care coverage during the plan year and that they didn't get a health care 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 or during the annual open enrollment period. As long as you enroll within these time periods, and provide any 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.

What are my options for enrollment?
Your options are based on the choices made by your employer. 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 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.

1. A legally married spouse.
2. A same-sex domestic partner included on the employee's Oregon Certificate of Registered Domestic Partnership. *Employees who cover a domestic partner will be charged an imputed value amount.*
3. Child(ren) under the age of 26 who are:
   - The natural child of the employee, spouse or domestic partner;
   - The adopted child of, or child placed for adoption with, the employee, spouse or domestic partner, provided that the child is adopted or placed for adoption prior to attaining age 18;
   - A child for whom the employee, spouse or domestic partner has obtained court-ordered legal guardianship or custody prior to attaining age 18;
   - A child for whom the employee is obligated to provide benefits pursuant to a qualified medical child support order (QMCSO).

   Children don't have to reside with you, be your 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 below).
4. An unmarried child over the age of 26 who has been continuously covered and 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 insurer or administrator.

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 in the table below. 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
4. New Spouse
5. New Domestic Partner
6. Divorce/Legal Separation
7. Dissolution/Termination of 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. Death of a Spouse
15. Death of a Child
16. Increase/Decrease in Cost of Dependent Care

In the tables below, "Supp Life" is short for Supplemental Employee/Spouse Life offered by The Hartford. "Vol Plans" denotes the following voluntary plans: Dependent Life offered by The Hartford; Identity Theft coverage offered by InfoArmor; Critical Illness, Hospital Indemnity and Accident coverage offered by MetLife; and Trauma coverage offered by Lloyd's of London. Your eligibility for any of these plans is based on whether or not 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; health care coverage is effective the date of birth/adoption.

   Newborn documentation requirements: A newborn child must be enrolled within 60 days even if a birth certificate or Social Security Number (SSN) are not yet available. A birth certificate must be provided within 90 days of the date of birth, and a SSN must be provided within 6 months. If either document is not provided within the specified time period, coverage will be terminated retro to the date of birth.

   The following changes can be made:

Medical/Dental/Vision	Supp Life[1] / Vol Plans	Flexible Spending Account	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; health care 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

3. Qualified Medical Child Support Order (QMCSO)
   Employers will be notified when an employee is required to provide coverage due to a court order; health care coverage will be 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	Documentation
Enroll child	No changes allowed	No changes allowed	Copy of QMCSO

[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.

4. Marriage
Employees have 60 days from the date of marriage to enroll a new spouse; health care coverage will be 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/license

5. New 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; health care coverage will be effective the first of the month following the date of following. The following changes can be made:

Medical/Dental/Vision	Supp Life[1] / Vol Plans	Flexible Spending Account	Documentation
Enroll 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 typically eligible for reimbursement	Oregon Certificate of Registered Domestic Partnership

6. Divorce/Legal Separation
Employees have 60 days from the date of a final divorce/legal separation to report the event; health care coverage terminates the end of the month following the date of divorce. Failure to report this event in a timely manner will result in loss of continuation rights. The following changes can be made:

Medical/Dental/Vision	Supp Life[1]/Vol Plans	Flexible Spending Account [2]	Documentation
Drop spouse and step-child(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 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 of Domestic Partnership
Employees have 60 days from the date of the event to report a final dissolution of domestic partnership; health care coverage terminates the end of the month following the date of dissolution. Failure to report this event in a timely manner will result in loss of continuation rights. The following changes can be made:

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

8. Employee Gains Other Coverage
Employees have 60 days to report a gain of other coverage and provide proof of that coverage for themselves; health care 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	Documentation
Drop self and any dependents	No changes allowed	No changes allowed	Documentation showing effective date of other coverage and name of covered individual(s)

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); health care 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	Documentation
Drop dependent(s) who gained coverage	No changes allowed	No changes allowed	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.

10. Employee Loses Other Coverage
Employees have 60 days to report and submit appropriate documentation of an involuntary loss of other employer group coverage for themselves. Health care 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	Documentation
Enroll self and any dependents	No changes allowed	No changes allowed	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 an involuntary loss of other employer group coverage for their dependents; if appropriate documentation is submitted within the 60-day period, health care 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	Documentation
Enroll dependent(s)	No changes allowed	No changes allowed	Documentation showing date of loss of other coverage and name of covered individual(s)

12. Change in Hours - Increase
Employees have 60 days to enroll in benefits from the date their work hours increase resulting in becoming benefit eligible. 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 / Vol Plans	Flexible Spending Account [2]	Documentation
Enroll self and eligible dependent(s) in coverage	Enroll in coverage; enroll in supplemental spouse, or voluntary plans	No changes allowed	None

13. Change in Hours - Decrease
Employees whose work hours decrease, resulting in loss of eligibility for benefits, will have all coverages terminate the first of the month following the date of the hours change.

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

14. Death of a Spouse/Domestic Partner
Upon notification of a spouse/domestic partner's death, coverage will be terminated at the end of the month following the death. 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/domestic partner	Enroll/increase/ Decrease health care election (cannot decrease if annual election has been reimbursed)	No documentation is required

15. Death of a Child
Upon notification of a child's death, coverage will be terminated at the end of the month following the death. The following changes can be made:

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

16. 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:

- 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; or
  - Exhaustion of federal COBRA or any state continuation.
- 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:

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

Coverage will be effective the first of the month following the event, as long as required documentation is provided within 60 days of the event.

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.

Leave 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 are returning from a leave, need to discuss their options with their employer.

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

<u>Healthcare Flexible Spending Account (FSA)</u>
For participants enrolled in a Healthcare FSA, deductions continue if the leave is with pay and no changes are allowed. If the leave is 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/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: 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 details.

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.

If your employer will be providing a premium subsidy, you MUST still complete and return an application to CIS within the enrollment timeline.

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 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. If you were enrolled in medical and dental coverage as an active employee, you cannot continue dental only through COBRA continuation.

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 take retiree coverage because it can be continued until Medicare eligibility, whereas COBRA can only be continued for a limited period of time. If retiree or COBRA continuation coverage is voluntarily terminated, you cannot re-enroll at a future 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. If you are interested in continuing this coverage, contact the CIS Benefits Helpline at 855-763-3829.

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 officers and 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.

If your employer will be providing a premium subsidy, you MUST still complete and return an application to CIS within the enrollment timeline.

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 retro to the date your 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 18.

For questions regarding coverage options upon retirement, contact Melinda Lund (CIS' Retiree/COBRA Coordinator) at mlund@cisoregon.org or 800-922-2684, x3823 or the CIS 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 Executive Director within 45 days of the Benefits Director's denial. The Executive Director may, at his or her discretion, consult with the Board of Trustees and will respond with a notification of status of the request for consideration within 15 days. A final determination response will be sent in writing not later than 30 days from the date the request is received by the Executive Director. The Executive Director's determination is final, and there are no further appeal rights.

BeyondWell™

cis benefits
cisbenefits.org

Regence Member

Supporting your next best step in a healthy life.

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.

Don't leave dollars on the table!

Our 2020 BeyondWell program provides Regence members and eligible spouses with the opportunity to earn up to $150 in gift cards. There is still time to engage and earn these rewards before the end of this year!

Any earned gift cards will be forfeited if not redeemed by December 31, 2020. So act now!

Get started today

Regence members

1. **Log into** your CIS Health Manager at regence.com
2. Scroll down to the programs listed and **select** BeyondWell
3. **Register** and Accept the Terms of Use

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:

- Connect a device or app
- Verified steps through device
- Personal challenges
- Self-guided programs
- Dental exams
- Flu shot
- Health assessment
- Preventive exam
- Regence BabyWise℠ program

Flip to learn more about our 2021 program

New Year, New Rewards

2021

Next year, we are building upon our incentive program. Below you will see all the ways you and your qualified spouse on the Regence health plan can earn up to $150 each in Amazon.com* gift cards:

$5 Sync a device or app

Our new 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 the BeyondWell app after creating your account online and earn $5.

$20 Self-guided program

Participate in one of our six-week programs and earn $20 per program (up to $60 annually).

$40 Dental exam

Complete a preventive dental exam and earn $40 in 2021.

$20 Flu shot

Get your flu 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.

$50 Preventive exam

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

$15 Personal challenge

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

$50 Chronic Condition Coaching

Enroll and engage in Chronic Condition Coaching in 2021 and earn a $50 incentive! If you are eligible for the program you will be outreached to directly.

$50 Regence Babywise

Enroll and participate in the Regence Babywise program in your first or second trimester and earn this incentive once per year.[2]

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™

CHS-329692-19 08/19

Meet all your health information needs in a single solution

The CIS Health Manager on regence.com

You lead a busy life. Now, with COVID-19 among us, life's become more complicated.

With the CIS Health Manager, you have a single solution for beneficial information, customized for you. Use your computer, phone or tablet to easily access health benefits, care-on-demand resources, a COVID-19 symptom tracker and other tools to manage your health care.

Create an account on regence.com and get started.

Regence

CIS
cis benefits
cisbenefits.org

The integration of helpful tools into a single solution

BeyondWell℠

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

Healthy Benefits

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

MDLIVE®

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

VSP®: Vision

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

Telehealth

Now you have another telehealth option. 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.

Regence

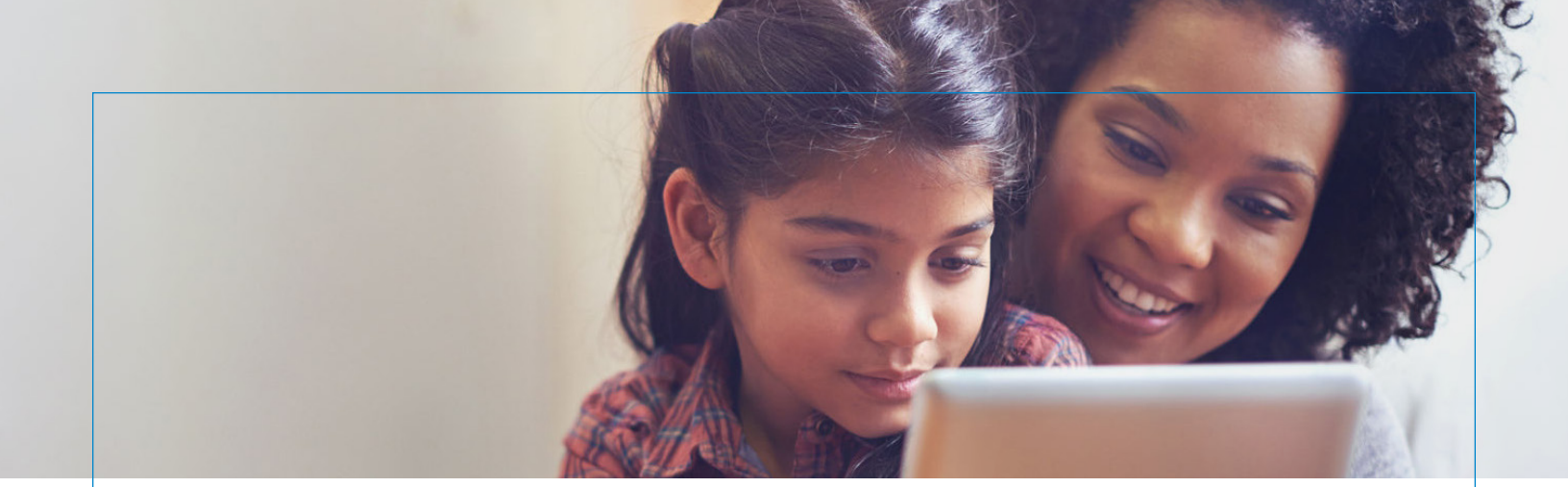
BeyondWell, Express Scripts, MDLIVE and VSP are separate and independent companies that provide services for Regence members.

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

Regence BlueCross BlueShield of Oregon
100 SW Market Street | Portland, OR 97201

REG-453790-20/09-OR

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).



Twice the options for virtual care

These virtual care resources can help you get care wherever you are—and save you time and money.

Telehealth virtual visits are a convenient, affordable alternative for routine care and a modern solution for health care needs. You can chat with a doctor or therapist by phone or video.

Telehealth by MDLIVE®

When you need a quick consult for non-emergency care, MDLIVE appointments are affordable, and you don't even have to leave your home or office.

If you or a covered family member needs support from a counselor or psychiatrist, therapy is available through MDLIVE.

Register now, so you're ready when you need care. To get started, go to your CIS Health Manager on regence.com and look for MDLIVE.

Telehealth with local providers

Many of our in-network providers offer telehealth care to their patients, providing diagnoses and treatment instructions over phone or video chat.

We're partnering with providers to expand your access to virtual visits with doctors you would normally see in person. The cost for a telehealth visit may be lower than an office visit, and telehealth can even save you time. Reach out to your doctor or clinic to find out what virtual options they offer.

COVID-19 care update

Telehealth doctors don't treat COVID-19 but can help assess symptoms. Our **regence.com** COVID-19 page has current information to support you and your family, including convenient ways to access care. You'll also find a symptom checker and helpful answers to the most common questions under our FAQ.

Regence

MDLIVE is a separate and independent company that provides telehealth services for Regence BlueCross BlueShield of Oregon members.

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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
100 SW Market Street | Portland, OR 97201

REG-453793-20/07-OR

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Open Enrollment Annual Notices

The federal government requires the following notices be provided to you each year. Those that are required to be distributed in hard copy are attached.

- 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

- Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas

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 attached "Important Notice About Your Prescription Drug Coverage and Medicare" notice. 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) who are 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, and will therefore 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 October 15 to December 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.

If you are enrolled in a Kaiser medical plan, you are not eligible to enroll in Medicare Part D because of Kaiser's arrangement with Medicare. 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?
You should also know that 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: October 5, 2020
Name of Entity/Sender: CIS Benefits
Address: 1212 Court Street NE, Salem, OR 97301
Phone Number: 1-800-922-2684 (within Oregon) or 503-763-3800 (Salem)

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, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, 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

Regence Copay Plan F
Alternative Care
Benefits Summary
Effective January 1, 2021

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.

Copay Plan F	
Deductible Per Calendar Year	$500 Individual $1,500 Family
Out-of-Pocket Maximum Per Calendar Year **Category 1 & 2** - Preferred and Participating Provider (includes deductible and medical copays but does not include prescription copays)	$2,500 individual $5,500 family
Category 3 - Non-Preferred Provider (includes deductible and medical copays but does not include prescription copays)	$4,500 individual $9.500 family

Medical Services	**Member Pays** **Category 1 - Preferred**	**Member Pays** **Category 2 - Participating** **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 or urgent/immediate care center)*	$20 copay *(deductible waived)*	40%
Outpatient laboratory, radiology, and diagnostic procedures	$0 up to first $400 then 20% *(deductible waived)*	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% after $100 copay *(copay waived if admitted)*	
Inpatient/outpatient surgery and surgeon fees	20%	40%
Inpatient mental/behavioral health & substance use disorder	20%	20% - Category 2 40%- Category 3
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*	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/lifetime*	0% *(deductible waived)*	
Durable Medical Equipment	20%	40%
Weight Management/Nutritional Counseling and Bariatric Surgery: - Weight management and nutritional counseling visits *Four visits per plan year per member*	0% *(deductible waived)*	
- 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% after deductible *(does not accumulate towards the out-of-pocket maximum)*	$1,000 copay then 40% after deductible *(does not accumulate towards the out-of-pocket maximum)*

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 Program (90-day supply)** **Member Pays**
Individual deductible per calendar year	No deductible	
Out-of-pocket maximum each calendar year	$2,500 per person/$7,500 per family	
Generic drugs	$10 copay	$20 copay
Preferred brand drugs	$40 copay	$80 copay
Non-Preferred brand drugs	$100 copay	$200 copay
Specialty Generic	$50 copay	N/A
Specialty Preferred brand drugs	$100 copay	N/A
Specialty Non-Preferred brand drugs	$200 copay	N/A
Limitations and Exceptions	***Out-of-pocket limit*** $2,500 */ claimant / year. 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.* *Specialty medication filled at a retail pharmacy is 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. You are responsible for the difference in cost between a dispensed brand–name drug and the equivalent generic drug, in addition to the **copayment** and/or **coinsurance**, unless your **provider** specifies "dispense as written."*	

Additional Medical Services

Alternative Care Services	
Acupuncture and Chiropractic Spinal Manipulations	No deductible, any provider - $20 Copay – Maximum allowance of $1,000 per member per calendar year. Does not accumulate toward the out-of-pocket maximum.

Other services provided by Regence BlueCross BlueShield	**Contact Information**
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 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.
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 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 and hover on "Programs & Resources", then click on Case Management.
BabyWise (*Childbirth to Newborn resources*).	To learn more, call 1 (888) 569-2229 or sign on to the CIS Health Manager at www.regence.com and hover on "Programs & Resources", then click on Maternity.
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).

Regence

Please note: This benefit summary provides a brief description of your health care plan benefits and is not a guarantee of payment. For a detailed description of your plan benefits, visit www.regence.com on or after January 1, 2021. You must set up an account to review your specific plan booklet.

Regence Vision Plan A (12/12/24)

Benefits Summary
Effective January 1, 2021

Keep your eyes healthy with Regence Vision Plan A, administered by the Vision Service Plan Insurance Company (VSP).

cis benefits
www.cisbenefits.org

Benefit	Description	Copay
Your coverage with a VSP Provider		
WellVision Examination®	• Focuses on your eye health and overall wellness • Every calendar year	$10
Prescription Glasses		
Frame	• $170 allowance for a wide selection of frames ($95 allowance at Costco, Walmart & Sam's Club) • 20% savings on the amount over your allowance • $95 for VSP approved wholesale/retail • Every other calendar year	$25 for materials*
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Lenticular Lenses • Polycarbonate lenses for dependent children • Every calendar year	$25 for materials*
Lens Enhancements	• Standard, premium, and custom progressive lenses • Photo-chromatic, UV Coating, Solid tint, Gradient tint, Scratch protective coating, Anti-reflection and blue-light filter coating • Polycarbonate lenses – Adults • Every calendar year	$50 $0
Contacts (instead of glasses)	• $166 allowance for contact lenses (including the fitting examination and evaluation) • 15% savings on a contact lens exam • Every calendar year	$0
Safety Glasses (Employee-only Coverage)**		
Frame	• $65 frame allowance for safety frames • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection • Every other calendar year	$0 for frame and lenses
Lenses	• Prescription single vision, lined bifocal, and lined trifocal lenses • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection • Every calendar year	$0 combined with frames
Extra Savings and Discounts	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/special offers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP doctor within 12 months of your last WellVision Exam. **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 with Out-of-Network Providers

Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

*****All Balances Below are out-of-network allowances*****

Exam..... up to $50	Lenticular Lenses.....up to $105
Frame..... up to $70	Progressive Lenses..... up to $105
Single Vision Lenses..... up to $35	Elective Contacts..... up to $110
Lined Bifocal Lenses..... up to $55	Necessary Contacts..... up to $215
Lined Trifocal Lenses..... up to $70	

Submit claims for out-of-network providers to: VSP OA Claims; PO Box 385018, Birmingham, AL 35238-5018

Using your Benefits

- **Register at regence.com** Once your plan is effective, review your benefit information.
- **Find any eye care provider who's right for you.** The decision is yours to make—with the largest national network of private-practice doctors, it's easy to find the in-network doctor who's right for you. To find a VSP doctor, visit vsp.com or call 844.299.3041.
- At your appointment, tell them you have VSP and show them your Regence member ID card. Use your member ID and member suffix (e.g. ABC123456789-00).
- The VSP Choice network offers more than 81,000 provider points of access across the country, including both community-based providers as well as the most popular retail chains*, such as Costco®, Walmart®, Sam's Club®, ShopKo®, Visionworks® and any out-of-network provider (lower reimbursement rates).
    - Please note, participation in the VSP network is voluntary; therefore, not all doctors at a retail location may be in the VSP network.

Personalized Care

A VSP doctor provides personalized care that focuses on keeping you and your eyes healthy year after year. Plus, when you see a VSP doctor, you'll get the most out of your benefits, have lower out-of-pocket costs, and your satisfaction is guaranteed.

Choice in Eyewear

- From classic styles to the latest designer frames, you'll find hundreds of options for you and your family.
- Prefer to shop online? Check out all of the brands at **eyeconic.com**, VSP's preferred online eyewear store.

Your vision plan is issued by Regence BlueCross BlueShield of Oregon and insured by CIS but administered by VSP. This means that CIS, not Regence BlueCross BlueShield of Oregon, pays for your covered vision services and supplies.

**The $25 copay only applies once if buying both lenses and frames.*
***Lens enhancements are not covered, but members will receive a 20-25% discount if purchasing an enhancement*

Regence

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 issued by Regence BlueCross BlueShield of Oregon 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?	$500 individual / $1,500 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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain preventive care and those services listed below as "deductible does not apply" or as "No charge."	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?	Preferred & Participating: $2,500 individual / $5,500 family per calendar year. Nonparticipating: $4,500 individual / $9,500 family per calendar year.	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?	Copayments for alternative care, premiums, balance-billed 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 nonparticipating 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 nonparticipating 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)	Nonparticipating 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	$20 copay / office visit, deductible does not apply; 20% coinsurance for all other services	40% coinsurance	40% coinsurance	Coverage includes primary care visits at a retail clinic. Copayment applies to each preferred office visit only. All other services are covered at the coinsurance specified, after deductible. Coverage for alternative care (acupuncture and chiropractic spinal manipulations) is subject to $20 copayment / visit, deductible waived. Limited to $1,000 / year for all alternative care services combined. Copayment for alternative care does not apply to the out-of-pocket limit.
	Specialist visit	$20 copay / office visit, deductible does not apply; 20% coinsurance for all other services	40% coinsurance	40% coinsurance	
	Preventive care/screening/ immunization	No charge	No charge	40% coinsurance	Coinsurance and deductible waived for childhood immunizations from nonparticipating 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)	No charge for the first $400 / year, then 20% coinsurance	40% coinsurance	40% coinsurance	$400 combined for outpatient diagnostic tests and imaging / year for preferred providers
	Imaging (CT/PET scans, MRIs)	No charge for the first $400 / year, then 20% coinsurance	40% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition	Specialty generic drugs & generic drugs	$50 copay / specialty retail prescription $10 copay / retail prescription $20 copay / mail order prescription			Out-of-pocket limit: $2,500 claimant / $7,500 family / year. 30-day supply / retail prescription 90-day supply / mail order prescription

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)	Nonparticipating 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.	Preferred brand drugs	$40 copay / retail prescription $80 copay / mail order prescription			Some prescriptions may be filled for a 90-day supply at participating pharmacies only. Visit Express Scripts website for details. 30-day supply / specialty drug retail prescription Specialty medication filled at a retail pharmacy is 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. No charge for certain preventive drugs, women's contraceptives and immunizations at a participating pharmacy. You are responsible for the difference in cost between a dispensed brand drug and the equivalent generic drug, in addition to the copayment and/or coinsurance, unless your provider specifies "dispense as written."
	Brand drugs	$100 copay / retail prescription $200 copay / mail order prescription			
	Preferred specialty drugs & specialty drugs	$100 copay / preferred specialty retail prescription $200 copay / preferred specialty retail prescription			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance for ambulatory surgery centers; 20% coinsurance for all other facilities	40% coinsurance	40% coinsurance	None
	Physician/surgeon fees	10% coinsurance for ambulatory surgery center physicians; 20% coinsurance for all other physicians	40% 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)	Nonparticipating Provider (You pay the most)	
If you need immediate medical attention	Emergency room care	20% coinsurance after $100 copay / visit	20% coinsurance after $100 copay / visit	20% coinsurance after $100 copay / visit	Copayment applies to facility charge for each visit (waived if admitted), whether or not the deductible has been met.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	None
	Urgent care	Covered the same as **If you visit a health care provider's office or clinic** (Primary care visit or Specialist visit) or **If you have a test** above.			None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay / office visit, deductible does not apply; No charge for all other services	$20 copay / office visit, deductible does not apply; No charge for all other services	40% coinsurance	Copayment applies to each preferred or participating office/psychotherapy visit only. All other services are covered at no charge.
	Inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, 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	40% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	40% coinsurance	180 visits / year
	Rehabilitation services	20% coinsurance	40% coinsurance	40% coinsurance	77 outpatient visits / year for all rehabilitation and habilitation services
	Habilitation services	20% coinsurance	40% coinsurance	40% coinsurance	Includes physical therapy, occupational therapy, speech therapy and neurodevelopmental therapy services. Neurodevelopmental therapy limited to individuals under age 18.

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)	Nonparticipating Provider (You pay the most)	
	Skilled nursing care	20% coinsurance	40% coinsurance	40% coinsurance	120 inpatient days / year
	Durable medical equipment	20% coinsurance	40% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	40% 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	None
	Children's dental check-up	Not covered	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, except congenital anomalies
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

- Abortion
- Acupuncture
- Bariatric surgery
- Chiropractic care, spinal manipulations only
- Hearing aids for individuals up to age 19, or individuals 19 years of age up to age 26 and enrolled in a secondary school or an accredited educational institution
- 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	**$500**
Specialist copayment	**$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	$500
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$2,561**

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

The plan's overall deductible	**$500**
Specialist copayment	**$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	$500
Copayments	$254
Coinsurance	$683
What isn't covered	
Limits or exclusions	$178
The total Joe would pay is	**$1,615**

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

The plan's overall deductible	**$500**
Specialist copayment	**$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	$500
Copayments	$165
Coinsurance	$348
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,013**

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 differently because of race, color, national origin, age, disability, or sex.

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

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

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service
1-800-541-8981 (TTY: 711)

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

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 with our civil rights coordinator below:

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

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 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 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' hódíílnih 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)

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 specially 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.**

Important Note: Due to increased costs, copays for specialty drugs are increasing effective 1/1/21. Please review the Accredo Specialty Drug list included with these materials to determine if the drug(s) you're taking are considered specialty and will be impacted.

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 Regence Plan Booklet.

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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 drug 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.

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EXPRESS SCRIPTS®

Specialty Drug List

Unless otherwise noted, all brand and generic formulations of a product are considered specialty.

ALPHA 1 DEFICIENCY
Aralast NP®
Glassia™
Zemaira®

ANTICOAGULANT
Arixtra®* (fondaparinux sodium)
Fragmin®*
Iprivask®
Lovenox®*(enoxaparin sodium)

ASTHMA & ALLERGY
Dupixent®
Durysta™
Fasenra™
Nucala®
Xolair®

BLOOD CELL DEFICIENCY
Aranesp®
Doptelet®
Epogen®
Fulphila™
Granix™
Leukine®
Mozobil®
Mulpleta®
Neulasta®
Neupogen®
Nivestym™
Nplate®
Procrit®
Promacta®
Retacrit™
Udenyca™
Zarxio™
Ziextenzo®

CANCER
Abraxane®
Adcetris™
Afinitor® (everolimus)
Alecensa®
Alunbrig™
Arranon®
Arzerra®
Avastin®
Belrapzo®
Bendamustine®
Bendeka™
Besponsa®
Bosulif®
Cabometyx™
Cometriq™
Cotellic®
Cyramza™
Dacogen® (decitabine)
Darzalex®
Darzalex Faspro™
Daurismo™
Eligard®
Empliciti™
Enhertu®
Erbitux®
Erivedge™
Erleada™
Farydak®
Firmagon®
Folotyn®
Gazyva™
Gilotrif™
Gleevec® (imatinib)
Halaven™
Herceptin®
Herceptin Hylecta™
Herzuma®
Hycamtin® (capsules)
Hycamtin® (topotecan injection)
Ibrance®
Idhifa®
Imfinzi™
Inlyta®

CANCER (cont'd)
Inrebic®
Intron A®
Iressa®
Istodax® (romidepsin)
Ixempra®
Jakafi™
Jevtana®
Kadcyla™
Kanjinti™
Kepivance®
Kisqali®
Kisqali Femara®
Lartruvo™
Lenvima™
Lonsurf®
Lorbrena®
Lupron Depot®
Lynparza™
Mekinist™
Mvasi™
Nerlynx™
Nexavar®
Ninlaro®
Nubeqa®
Odomzo®
Ogivri™
Ontruzant®
Onureg®
Opdivo®
Pegasys®
Peg-Intron®
Perjeta™
Phesgo™
Piqray®
Polivy™
Pomalyst®
Portrazza™
Proleukin®
Retevmo™
Revlimid®
Rituxan®
Rituxan Hycela®
romidepsin
Rozlytrek™
Rubraca™
Ruxience™
Rydapt®
Sprycel®
Stivarga®
Sutent®
Sylvant™
Tabrecta™
Tafinlar®
Tagrisso™
Talzenna™
Tarceva® (erlotinib)
Targretin® (bexarotene)
Tasigna®
Tecentriq™
Temodar® (temozolomide)
Thalomid®
Torisel® (temsirolimus)
Trazmiera™
Treanda®
Truxima®
Tykerb®
Valchlor™
Valstar®
Vantas®
Vectibix®
Velcade®
Verzenio ™
Vidaza® (azacitidine)
Vitrakvi®
Vizimpro®
Votrient®
Xalkori®
Xeloda®(capecitabine)
Xgeva™
Xtandi®
Yervoy™
Yonsa®
Zaltrap®
Zelboraf™

CANCER (cont'd)
Zirabev™
Zoladex®
Zolinza®
Zometa® (zoledronic acid)
Zydelig®
Zykadia™
Zytiga™ (abiraterone acetate)

CONTRACEPTIVES
Liletta™
Nexplanon®

CYSTIC FIBROSIS
Bethkis®
Cayston®
Kalydeco™
Kitabis Pak™
Orkambi™
Pulmozyme®*
Symdeko™
Tobi® (tobramycin)
Tobi Podhaler™
Trikafta™

ENDOCRINE DISORDERS
Bynfezia Pen™
Crysvita®
Egrifta®
Lupaneta Pack™
Lupron Depot-Ped®
Myalept™
Natpara®
Samsca® (tolvaptan)
Sandostatin® (octreotide acetate)
Sandostatin LAR Depot®
Signifor® LAR
Signifor®
Somatuline Depot®
Somavert®
Supprelin LA®
teriparatide

ENZYME DEFICIENCIES
Aldurazyme®
Carbaglu®
Cerdelga™
Cerezyme®
Elaprase®
Elelyso™
Fabrazyme®
Galafold™
Kanuma™
Kuvan® (sapropterin)
Lumizyme™
Mepsevii™
Naglazyme®
nitisinone
Nityr™
Palynziq™
Ravicti™
Sucraid®
Vimizim™
VPRIV™
Zavesca® (miglustat)

GROWTH DEFICIENCY
Genotropin®
Humatrope®
Increlex®
Macrilen®
Norditropin Flexpro®
Nutropin AQ®
Omnitrope®
Saizen®
Serostim®
Zomacton®
Zorbtive®

HEMOPHILIA
Advate®
Adynovate™
Afstyla®

1. Some products may be dispensed from Accredo and/or Freedom Fertility Pharmacy
2. Xyrem® is distributed through Express Scripts Specialty Distribution Services, Inc.

Disclaimer: Note that additional generic versions of listed medications may be available. Please consult your pharmacist to determine if a generic version of any particular specialty medication is available.

* Your plan may require most specialty medications to be dispensed exclusively by Accredo. Those medications marked by an asterisk (*) may have allowances for one or more retail fills.

accredo®

HEMOPHILIA (cont'd)
Alphanate®
Alphanine SD®
Alprolix™
Benefix®
Corifact®
DDAVP® (desmopressin acetate) (*oral/nasal forms are not specialty)*
Eloctate™
Esperoct®
Feiba NF®
Hemlibra®
Hemofil M®
Humate-P®
Idelvion®
Ixinity®
Jivi®
Koate®
Kogenate FS®
Kovaltry®
Mononine®
Novoeight®
Novoseven RT®
Nuwiq®
Profilnine SD®
Rebinyn®
Recombinate™
RiaSTAP®
Rixubis™
Sevenfact®
Stimate®
Tretten®
Vonvendi™
Wilate®
Xyntha®
Xyntha Solofuse®

HEPATITIS C
Epclusa® (sofosbuvir/velpatasvir)
Harvoni® (ledipasvir/sofosbuvir)
Mavyret™
Ribavirin (Rebetol®, Ribasphere®, Ribapak®, Moderiba™)
Sovaldi®
Viekira Pak®
Vosevi®
Zepatier®

HEREDITARY ANGIOEDEMA
Berinert®
Cinryze®
Firazyr® (icatibant)
Haegarda®
Kalbitor®
Ruconest®
Takhzyro™

HIGH BLOOD CHOLESTEROL
Juxtapid®

HIV
Aptivus®*
Atripla®*
Biktarvy®
Cimduo™
Combivir®* (lamivudine/zidovudine)
Complera®*
Crixivan®*
Delstrigo™*
Descovy®*
Dovato®
Edurant®*
Emtriva®*
Epivir®* (lamivudine)
Epzicom®* (abacavir/lamivudine)
Evotaz™ *
Fuzeon®*
Genvoya®*
Intelence®*
Invirase®*
Isentress®*
Juluca®
Kaletra®* (lopinavir/ritonavir)
Lexiva®* (fosamprenavir)
Norvir®* (ritonavir)
Odefsey®*
Pifeltro™*

HIV (cont'd)
Prezcobix™*
Prezista®*
Rescriptor®*
Retrovir®* (zidovudine)
Reyataz®*(atazanavir)
Rukobia™
Sustiva®*(efavirenz)
Selzentry®*
Stribild®*
SymFi™ (efavirenz/lamivudine/tenofovir disoproxil fumarate)
SymFi Lo™ (efavirenz/lamivudine/tenofovir disoproxil fumarate)
Symtuza™
Temixys™
Tivicay®*
Triumeq®*
Trizivir®*(abacavir/lamivudine/zidovudine)
Trogarzo™
Truvada®*
Tybost®*
Videx®* (didanosine)
Videx EC®*(didanosine DR)
Viracept®*
Viramune®* (nevirapine)
Viramune XR®*(nevirapine ER)
Viread®*(tenofovir disoproxil fumarate)
Vitekta®*
Zerit®* (stavudine)
Ziagen®*(abacavir)

IDIOPATHIC PULMONARY FIBROSIS
Esbriet™
OFEV®

IMMUNE DEFICIENCY
Asceniv™
Bivigam™
Cuvitru™
Cutaquig®
Cytogam®
Gamastan S-D®
Gammagard Liquid®
Gammagard S-D®
Gammaked™
Gammaplex®
Gamunex-C®
Hizentra™
HyQvia™
Panzyga®
Privigen®
Xembify®

INFERTILITY[1]
(oral forms are not specialty)
Bravelle®
Cetrotide®
Chorionic Gonadatropin (brands include Novarel®, Pregnyl®)
Crinone®
Endometrin®
Follistim AQ®
Ganirelix (ganirelix acetate)
Gonal-F®
leuprolide
Menopur®
Ovidrel®
progesterone injection

INFLAMMATORY CONDITIONS
Actemra®
Arcalyst®
Benlysta®
Cimzia®
Cosentyx™
Enbrel®
Entyvio™
Humira®
Ilaris®
Ilumya™
Inflectra™
Kevzara®
Olumiant®
Orencia®
Otezla®
Remicade®
Renflexis™

INFLAMMATORY CONDITIONS (cont'd)
Rinvoq ER™
Siliq™
Simponi™
Simponi Aria®
Skyrizi™
Stelara™
Taltz®
Tremfya™
Xeljanz®
Xeljanz XR®

IRON TOXICITY
Exjade® (deferasirox)
Jadenu™

MISCELLANEOUS DISEASES
Acthar H.P. Gel®
Actimmune®
Apokyn®
Arestin®
Austedo®
Botox®
Botox Cosmetic®
Ceprotin™
Duopa™
Dojolvi™
Dysport®
Enspryng™
Epidiolex®
Gattex®
Givlaari™
Hetlioz™
Inbrija™
Krystexxa®
Makena™ (hydroxyprogesterone caproate)
Myobloc®
Northera™
Nuplazid™
Ocaliva™
Probuphine®
Procysbi™
Sabril® (vigabatrin)
Solesta®
Soliris®
Sublocade™
Tegsedi™
Thyrogen®
Ultomiris™
Vivitrol®
Vyndamax™
Vyndaqel®
Wakix®
Xenazine® (tetrabenazine)
Xeomin®
Xyrem®[2]

MULTIPLE SCLEROSIS
Ampyra® (dalfampridine)
Aubagio®
Avonex®
BAFIERTAM™
Betaseron®
Copaxone® (glatiramer, Glatopa®)
Extavia®
Gilenya®
Lemtrada®
Mavenclad®
Mayzent®
mitoxantrone®
Ocrevus®
Plegridy®
Rebif®
Tecfidera® (dimethyl fumarate)
Tysabri®
Vumerity™
Zeposia®

MUSCULAR DYSTROPHIES
Emflaza™
Spinraza™
Zolgensma®

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OPHTHALMIC CONDITIONS
Beovu®
Eylea®
Iluvien™
Kesimpta Pen®
Lucentis®
Luxturna™
Macugen®
Oxervate™
Ozurdex™
Retisert®
Tepezza™
Visudyne®

OSTEOARTHRITIS
Durolane®
Euflexxa®
Gel-One®
Gelsyn-3™
Hyalgan®
Hymovis®
Monovisc®
Orthovisc®
Supartz FX®
Synvisc®
Synvisc-One®

OSTEOARTHRITIS (cont'd)
Triluron™
Visco-3™

OSTEOPOROSIS
Boniva® (ibandronate) (*oral forms are not specialty)*
Evenity™
Forteo®
Prolia™
Reclast® (zoledronic acid)
Tymlos™

PULMONARY HYPERTENSION
Adcirca® (tadalafil)
Adempas®
Flolan® (epoprostenol)
Flolan Diluent® (epoprostenol diluent)
Letairis® (ambrisentan)
Opsumit®
Orenitram™
Remodulin® (treprostinil)
Remodulin Diluent® (trepostinil diluent)
Revatio® (sildenafil citrate)
Tracleer® (bosentan)
Tyvaso®
Uptravi®
Veletri®
Ventavis®

RESPIRATORY SYNCYTIAL VIRUS
Synagis®

SICKLE CELL DISEASE
Oxbryta™

TRANSPLANT
azathioprine (AZASAN, IMURAN)
Astagraf XL™*
Cellcept®* (mycophenolate mofetil)
Neoral® , Sandimmune®* (cyclosporine, Gengraf®)
Envarsus® XR*
Myfortic®* (mycophenolic acid)
Nulojix®*
Prograf®*(tacrolimus)
Rapamune®*(sirolimus)
Simulect®*
Thymoglobulin®*
Zortress®* (everolimus)

1. Some products may be dispensed from Accredo and/or Freedom Fertility Pharmacy
2. Xyrem® is distributed through Express Scripts Specialty Distribution Services, Inc.

Disclaimer: Note that additional generic versions of listed medications may be available. Please consult your pharmacist to determine if a generic version of any particular specialty medication is available.

* Your plan may require most specialty medications to be dispensed exclusively by Accredo. Those medications marked by an asterisk (*) may have allowances for one or more retail fills.

cis benefits
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Open Enrollment Annual Notices

The federal government requires the following notices be provided to you each year. Those that are required to be distributed in hard copy are attached.

- 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

- Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas

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 attached "Important Notice About Your Prescription Drug Coverage and Medicare" notice. 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) who are 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, and will therefore 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 October 15 to December 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.

If you are enrolled in a Kaiser medical plan, you are not eligible to enroll in Medicare Part D because of Kaiser's arrangement with Medicare. 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?
You should also know that 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: October 5, 2020
Name of Entity/Sender: CIS Benefits
Address: 1212 Court Street NE, Salem, OR 97301
Phone Number: 1-800-922-2684 (within Oregon) or 503-763-3800 (Salem)

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, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, 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

BeyondWell™

cis benefits
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Kaiser Member

Supporting your next best step in a healthy life.

UP TO
$100 PER YEAR
IN GIFT CARDS

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.

Don't leave dollars on the table!

Our 2020 BeyondWell program provides Kaiser members and eligible spouses with the opportunity to earn up to $100 in gift cards. There is still time to engage and earn these rewards before the end of this year!

Any earned gift cards will be forfeited if not redeemed by December 31, 2020. So act now!

Get started today

Kaiser members

1. Visit **www.beyondwellhealth.com**
2. Select **Login/Register** in the top right-hand corner
3. Register your account (your BeyondWell Invitation Code is **CIS**) and accept the Terms of Use.

Beyond Well

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

Earn up to $100 in rewards for healthy activities:

- **Connect a device or app**
- **Verified steps through device**
- **Personal challenges**
- **Self-guided programs**
- **Dental exams**
- **Flu shot**
- **Health assessment**

Flip to learn more about our 2021 program

New Year, More Rewards

2021

Next year, we are building upon our incentive program. Below you will see all the ways you and your qualified spouse on the Kaiser health plan can earn up to $150 each in Amazon.com* gift cards:

$5 Sync a device or app

Our new 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 the BeyondWell app after creating your account online and earn $5.

$20 Self-guided program

Participate in one of our six-week programs and earn $20 per program (up to $60 annually).

$40 Dental exam

Complete a preventive dental exam and earn $40 in 2021.[2]

$20 Flu shot

Get your flu 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).

$50 Cancer Screenings

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

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 2021.
3. Qualifying preventive exams include: mammogram, colonoscopy, and pelvic exam.

* 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™

CHS-329692-19 08/19

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www.cisbenefits.org

KAISER PERMANENTE®

Copay B: Alternative Care & Vision **January 1, 2021 - December 31, 2021**	
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
Primary Care	$20
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 and first postpartum visit	$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 department visit	$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, external prosthetic devices, and orthotic devices	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
Chemical Dependency Services	**You pay**
Outpatient Services (Group visit ½ copay)	$20
Inpatient hospital & residential Services	$200 per day up to $1,000 per admission
Mental Health Services	**You pay**
Outpatient Services (Group visit ½ copay)	$20
Inpatient hospital & residential Services	$200 per day up to $1,000 per admission

Alternative Care*	**You pay**
Alternative care (self-referred)	$20 per visit for acupuncture, chiropractic, and naturopathic visits. $25 per massage therapy visit (up to 12 visits per Calendar Year). $1,000 benefit maximum for all Services combined. Must use Complimentary Healthcare Plan Providers.
Vision Services	**You pay**
Routine eye exam (through first month of age 19)	$0
Vision hardware and optical Services (through first month of age 19)*	No charge for eyeglass lenses or frames or contact lenses every 12 months.
Routine eye exam (age 19 and older)	$20
Vision hardware and optical Services (ages 19 years and older)*	Balance after $150 allowance, once every calendar year

* **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/quitsmoking)**
- **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 http://www.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.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2021-12/31/2021

KAISER PERMANENTE® : **CIS Trust**

Coverage for: Individual / Family | Plan Type: EPO

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest

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
		Select 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	None
	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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Select Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Specialty drugs	Applicable Generic, Preferred, Non-Preferred brand drug cost shares.	Not covered	Up to a 30-day supply (retail). Subject to formulary guidelines, when approved through exception process.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 / visit	Not covered	Prior authorization required.
	Physician/surgeon fees	Included in facility fee	Not covered	Prior authorization required.
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	$40 / visit	Non-participating providers covered when temporarily outside the service area.
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	Included in facility fee	Not covered	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 / visit	Not covered	None
	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	Included in facility fee	Not covered	None
	Childbirth/delivery facility services	$200 / day up to $1,000 / admission	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Select Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special needs	Home health care	No charge	Not covered	130 visit limit / year. Prior authorization required.
	Rehabilitation services	Outpatient: $30 / visit Inpatient: $200 / day up to $1,000 / admission	Not covered	Outpatient: 20 visit limit / 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 ($1,000 limit / year combined for all alternative care services) • Bariatric surgery	• Chiropractic care ($1,000 limit / year combined for all alternative care services) • Hearing aids (under age 18 - 1 aid / ear / 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

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 Services	1-888-877-4894 or www.dfr.oregon.gov
Washington Department of Insurance	1-800- 562- 6900 or www.insurance.wa.gov

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.

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).
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-813-2000 (TTY: 711).
[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-800-813-2000 (TTY: 711).
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-813-2000 (TTY: 711).

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	**$12,800**

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	$1,000
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,050**

[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 civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. 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 **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, or sex, you can file a grievance by mail or phone at: Member Relations, Attention: Kaiser Civil Rights Coordinator, 500 NE Multnomah St. Ste 100, Portland, OR 97232, telephone number: 1-800-813-2000.

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 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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**).

العربية (Arabic) ملحوظة: 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។ ចូរ ទូរស័ព្ទ **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, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-800-813-2000** (TTY: **711**).

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, koji' hódíilnih **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) ATENCIÓN: 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**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-813-2000** (TTY: **711**).

cis benefits
www.cisbenefits.org

Dental Plan III with Ortho
CIS
Effective January 1, 2021

How To Use this Dental Plan

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

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)	**** 1st year - 70%** **2nd year - 80%** **3rd year - 90%** **4th year - 100%**
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, II & III 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. Dental Tools is comprised of a cavities risk assessment, dental health suggestions, and a Savings Optimizer based on a personal survey.

DELTA DENTAL®

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, refer to your member handbook, which can be accessed through Member Dashboard, or by calling Customer Service for a copy.

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

See back for additional information

ADVANTAGES

DELTA DENTAL

* **Freedom to choose your dentist:** Delta Dental is unique in that we have contracts with more than 2,400 licensed Premier providers in Oregon and 156,000 nationwide. More than 1,300 are also PPO providers in Oregon and 112,000 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.

LIMITATIONS

If an eligible person selects a more expensive plan of treatment than is functionally adequate, Delta Dental will pay the applicable percentage of the maximum plan allowance for the least costly treatment. The patient will then be responsible for the remainder of the dental providers' fees.

Class I - Preventive

* **Diagnostic:** Supplementary bitewing x-rays are covered once in any 12-month period. Complete series x-rays or a panoramic film are covered once in any 5-year period.

Class II - Basic

* **Restorative:** A separate charge for general anesthesia and/or IV sedation is not covered when used for non-surgical procedures. A separate charge for anesthesia may be covered when, in our judgment, it is necessary for complex oral surgery or due to the existence of a concurrent medical condition.

Class III - Major

* **Restorative:** If a tooth can be restored by amalgam or composite filling, but another type of restoration is selected by the patient and dentist, the covered expense will be limited to the cost of composite. Crowns and other cast restorations (including onlays and replacement inlays) are covered once in a seven (7) year period on any tooth.
* **Prosthodontic:** A prosthetic device will be covered once in a seven (7) year period provided the tooth has not been crowned within the past seven (7) years. Specialized or personalized prosthetics are limited to the cost of standard devices.

EXCLUSIONS

* Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
* Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing teeth.
* Services started prior to the date the individual became eligible for services under the program.
* Hypnosis, prescribed drugs, premedications or analgesia (e.g. nitrous oxide) or any other euphoric drugs.
* Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
* General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office.
* Plaque control and oral hygiene or dietary instructions.
* Experimental procedures.
* Missed or broken appointments.
* Services for cosmetic reasons.
* Claims submitted more than 12 months after the date of rendition of the services.
* All other services or supplies, not specifically covered.

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

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

Summary of Benefits

Group Number: OR27
Effective Date: January 1, 2021

Willamette Dental Group

CIS Trust Plan A

Annual Maximum	No Annual Maximum*
Deductible	No Deductible
General or Orthodontic Office Visit	You pay $20 per Visit
DIAGNOSTIC AND PREVENTIVE SERVICES	
Routine and Emergency Exams	Covered with the Office Visit Copay
X-rays	Covered with the Office Visit Copay
Teeth Cleaning	Covered with the Office Visit Copay
Fluoride Treatment	Covered with the Office Visit Copay
Sealants (per Tooth)	Covered with the Office Visit Copay
Head and Neck Cancer Screening	Covered with the Office Visit Copay
Oral Hygiene Instruction	Covered with the Office Visit Copay
Periodontal Charting	Covered with the Office Visit Copay
Periodontal Evaluation	Covered with the Office Visit Copay
RESTORATIVE DENTISTRY	
Fillings	You pay a $15 Copay
Porcelain-Metal Crown**	You pay a $200 Copay
PROSTHODONTICS	
Complete Upper or Lower Denture**	Covered with the Office Visit Copay
Bridge (per Tooth)**	You pay a $200 Copay
ENDODONTICS AND PERIODONTICS	
Root Canal Therapy - Anterior	You pay a $75 Copay
Root Canal Therapy - Bicuspid	You pay a $75 Copay
Root Canal Therapy - Molar	You pay a $75 Copay
Osseous Surgery (per Quadrant)	Covered with the Office Visit Copay
Root Planing (per Quadrant)	Covered with the Office Visit Copay
ORAL SURGERY	
Routine Extraction (Single Tooth)	Covered with the Office Visit Copay
Surgical Extraction	You pay a $50 Copay
ORTHODONTIA TREATMENT	
Pre-Orthodontia Treatment	You pay a $150 Copay***
Comprehensive Orthodontia Treatment	You pay a $2,000 Copay
DENTAL IMPLANTS	
Dental Implant Surgery	Implant benefit maximum of $1,500 per calendar year
MISCELLANEOUS	
Local Anesthesia	Covered with the Office Visit Copay
Dental Lab Fees	Covered with the Office Visit Copay
Nitrous Oxide	You pay a $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.*
****Copay credited towards the Comprehensive Orthodontia Treatment copay if patient accepts treatment plan.*

Underwritten by Willamette Dental Insurance, Inc. 6950 NE Campus Way, Hillsboro, OR 97124
Presented are just some of the most common procedures covered in your plan. Please see the Certificate of Coverage for a complete plan description, limitations, and exclusions. Employees can access the benefit summary and Certificate of Coverage online at https://willamettedental.com/cis/.

Exclusions & Limitations

Willamette Dental Group

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

Exclusions

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

Limitations

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

OFFICES & SPECIALTY LOCATIONS

Willamette Dental Group

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

OREGON OFFICES

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

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

Bend
62968 O.B. Riley Road, 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
Dentures

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
Periodontics
Implants

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

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

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

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

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

Portland – Weidler
220 NE Weidler Street
Portland, OR 97232
General Dentistry

Roseburg
2365 NW Stewart Parkway
Roseburg, OR 97471
General Dentistry
Orthodontics

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

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

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
Implants

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

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

Rev 8.3.2020

OFFICES & SPECIALTY LOCATIONS

Willamette Dental Group

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

WASHINGTON OFFICES

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

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

Lynnwood
6101 SW 200th Street, Suite 201
Lynnwood, WA 98036
General Dentistry

Olympia
4550 3rd Ave SE,
Lacey, WA 98503
General Dentistry
Oral Surgery
Periodontics
Implants
Endodontics

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
Endodontics
Orthodontics
Periodontics
Implants

Seattle
133 N Dexter Avenue
Seattle, WA 98109
General Dentistry

Seattle – Northgate
2111 N Northgate Way, Suite 100
Seattle, WA 98133
General Dentistry

Seattle – Northgate Specialty
11011 Meridian Ave North,
Suite 104
Seattle, WA 98133
Endodontics
Orthodontics
Periodontics
Implants

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

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
Endodontics
Oral Surgery
Orthodontics
Periodontics
Implants

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

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
8950 W Emerald Street,
Suite 108
Boise, ID 83704
General Dentistry

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
Oral Surgery
Orthodontics
Implants

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

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

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KAISER PERMANENTE®

Effective January 1, 2021- December 31, 2021

Dental w/orthodontics	
Annual Deductible	None
Annual Benefit Maximum	Unlimited
Dental Office Visit Charge – applies to all visits	$10
Preventive and Diagnostic Care – includes oral examinations and x-rays, teeth cleaning (prophylaxis), fluoride treatments, instruction in the care of your teeth and gums, and prescribed space maintainers	No additional charge
Restorative Services – includes routine fillings, plastic and stainless steel crowns	No additional charge
Simple Extractions	No additional charge
Oral Surgery	No additional charge
Periodontic Procedures – includes diagnosis, evaluation, and treatment of disease of the gums, including scaling and root planning	No additional charge
Endodontic Procedures – includes root canal and related therapy, including diagnosis and evaluation	No additional charge
Major Restorative Services – includes gold or porcelain crowns, inlays, bridge abutments and pontics	$45 for each
Removable Prosthetics – Full and partial dentures Relines Rebasis	 $95 for each partial denture, $65 for each full denture $25 $25
Orthodontic Plan	
Orthodontics	50% covered for adults and children; $1,000 maximum lifetime benefit; must use Plan providers

PLEASE NOTE:

- You will be charged a $25 fee when you miss a dental appointment without calling in advance to cancel.
- You pay $25 for nitrous oxide for adults and children 13 and older.
- You pay 10% of charges for night-guards.

EXCLUSIONS

The following are not covered:

- Service not approved by a Kaiser Permanente dentist. Kaiser Permanente does not pay for unauthorized services from dentists or facilities not affiliated with Kaiser Permanente, except as indicated under "Emergency Treatment."
- Conditions covered by workers' compensation or that are the employer's responsibility.
- Procedures not generally and customarily available in the service area.
- Surgery to correct malocclusion or temporomandibular joint disorders; treatment for problems of the jaw joint, including temporomandibular joint syndrome and craniomadibular disorders; and treatment of conditions of the joint linking the jaw bone and skull and of the complex of muscles, nerves, and other tissues related to that joint.
- Restorative or reconstructive treatment for specific congenital or developmental malformations.
- Full-mouth reconstruction and occlusal rehabilitation including appliances, restorations, and procedures needed to alter vertical dimension or occlusion or to splint or correct attrition or abrasion.
- Cosmetic services.
- Prescription Drugs.
- Experimental or investigational services.
- More than two visits for routine teeth cleaning (oral prophylaxis) in any twelve consecutive month period.
- Conditions covered by government agencies or programs other than Medicaid.
- Genetic testing.
- Dental implants, including bone augmentation and fixed or removable prosthetic devices attached to or covering the implants; all related services, including diagnostic consultations, impressions, oral surgery, placement, removal, and cleaning; and services associated with postoperative conditions and complications arising from implants.
- Removal and replacement, with alternative materials, of clinically acceptable material or restorations for any reason except the pathological condition of the tooth or teeth.
- General anesthesia and intravenous sedation.
- Medical, hospital, and certain dental services.
- Work in progress before your coverage is effective.
- Replacement of prefabricated, non-cast crowns, including stainless steel crowns, that were not placed by a Kaiser Permanente dentist.
- Repair or replacement of fixed prosthetics or removable prosthetic appliances that are less than five years old.

This summary provides a brief description of your dental plan benefits. Any errors or omissions are unintentional. 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 http://www.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.

Flexible Spending Accounts Save You Money!

Flexible Spending Accounts (FSAs) allow you to set aside money from your paycheck on a pre-tax basis to pay for medical and child/elder care expenses. That means you do not have to pay federal, and in most cases, state income tax, or FICA taxes on those dollars…which means you have more money in your pocket! Most people can save at least 25% on each dollar that is set aside, for expenses they are paying for anyway!

The FSA is easy to manage, and you can take advantage of the spending accounts by following three easy steps:

1) Review your expenses for medical and/or child/elder care for the previous year. Make note of what you spend on regular, planned expenses, and what expenses you may incur in the coming year.

2) Sign up for the FSA during open enrollment.

3) Submit claims to ASIFlex for reimbursement of your expenses.

That's it!!

Estimating your annual election amount can be the most difficult part of the process, but even this is pretty easy! ASIFlex offers the following tips and tools to help!

First, take a look at your prior year's expenses, as this is a good indicator of what you might anticipate for next year.

Then make a list of your predictable or recurring expenses that you know you have, such as annual deductible, monthly prescriptions, contact lens supplies or ongoing child care costs. Next, think about any other anticipated expenses you plan to incur next year, such as eyeglasses or orthodontia.

Finally, you can use resources on the ASIFlex website (www.asiflex.com) to help you through the process.

- Review ASIFlex's Eligible Expense list as a reference of the hundreds of eligible expenses.
- Use the ASIFlex expense estimator and the tax savings calculator to see your savings!

Remember that the more you set aside, the more you save, so it is to your advantage to do a thorough review of your expenses.

Have questions? Customer Service Hours: 7:00 am - 7:00 pm CT Monday -Friday; 9:00 am - 1:00 pm CT Saturday

1.800.659.3035 www.asiflex.com asi@asiflex.com

There are two types of accounts

The **Health Care FSA** provides you an opportunity to use pre-tax dollars to pay for out-of-pocket medical, dental, vision and hearing expenses for you, your spouse and any of your dependents (even if they are on a different insurance plan). There are hundreds of eligible expenses, including co-pays, deductibles, over-the-counter medications, prescription drugs and many more. Check the Eligible Expense list at www.asiflex.com for more information.

You can contribute up to $2,750 for health care expenses for 2021. You can use these dollars for eligible expenses you and your eligible dependents incur throughout the year. And, your full annual election is available to you on the first day of your plan year!

The **Dependent Care FSA** is generally used for work-related child care expenses, but you can also use DC FSA money to pay for work-related expenses for older tax dependents who are not capable of self-care. Eligible expenses include daycare, summer day camps (overnight camps are NOT eligible), babysitting, before and after school care, nursery school and pre-kindergarten expenses that are primarily for the protection and well-being of the dependent.

You can contribute up to $5,000 per household, per calendar year ($2,500 if married and filing separate income tax returns).

Don't forget…

Remember that your FSA election is fixed for the next plan year once open enrollment closes – unless you experience a qualified mid-year status change - so please take your time to determine your annual election amount. For the Dependent Care FSA, unused funds are forfeited. For the Healthcare FSA, you can carryover up to $500 of unused healthcare funds into the following plan year (2021). If you do not re-enroll in the Healthcare FSA for the 2021 plan year, any carryover dollars will be forfeited if expenses are not incurred by the end of that year. If you re-enroll, the time limitation for 2021 does not apply. You can avoid forfeitures by planning carefully and setting aside money only for predictable and recurring expenses that you know you will have. So, take your time and make an informed decision regarding how much to set aside in the Health Care and/or Dependent Care FSA.

Remember, the FSA helps you avoid paying taxes which means you have more spendable income in your pocket! If you have questions, contact ASIFlex! We are here to help!

Commuter Benefits

Parking Reimbursement Account

Mass Transit/Vanpool Reimbursement Account

You can save 25% and more on your work-related Transit and Parking expenses!

Transit & Parking FSA enrollment only available if offered by your employer

What are Commuter Benefits?

Commuter Benefit accounts allow you to set aside money from your paycheck pretax to pay for work-related commuting expenses. When you pay less in taxes, you have more money in your pocket. Most people save at least 30 percent on each dollar set aside pretax.

The commuter accounts are month-to-month accounts for parking and mass transit/vanpooling expenses. You can sign up, change your contribution amount, or terminate your account once a month. As you incur expenses, you can submit a claim to be reimbursed with pretax dollars.

What expenses are eligible?

Eligible expenses are those you incur to park at or near your place of employment, or to commute to and from your place of employment.

- **Parking** at or near your place of employment such as a garage or metered street parking, or parking at or near a transit station from which you commute.
- **Mass Transit/Vanpool** Bus, ferry, rail, monorail, streetcar, trolley, train, subway or vanpool.

Vanpool is a highway vehicle with seating capacity of at least six adult passengers. At least 80% of the mileage must be for commuting and the number of employees transported must be at least half of the adult seating capacity. Eligible expenses do not include bicycle or repairs, non-work related parking or transit/vanpool expenses, gas or fuel, tolls, or vehicle repairs.

How much can I contribute to the accounts?

The monthly limits are set by the IRS each year and may change. Limits for 2021 are:

- **Parking Reimbursement Account** - $270 per month
- **Mass Transit/Vanpool Reimbursement Account** - $270 per month

Continued on Back Page

Manage your account

Register your account at ASIFlex.com to see your account statement and balance, submit claims, sign up for email, text alerts and direct deposit.

ASIFlex Customer Service
ASIFlex.com
asi@asiflex.com
P: 800.659.3035
F: 877.879.9038
P.O. Box 6044
Columbia, MO 65205-6044

How do I submit claims and get reimbursed?

As you incur expenses, you can submit a claim to be reimbursed. ASIFlex offers several easy ways to submit claims for reimbursement. You do not have to choose only one option; you can use multiple options throughout the year.

- **ASIFlex Online** Sign in to your online account at ASIFlex.com to submit a claim.
- **Toll-free fax or mail** Download and complete a claim form. Then, submit it with your parking or transit itemized statement. Keep a copy for your records.

Reimbursements will be made to you within three business days following receipt of a complete claim. Log in to your ASIFlex account to sign up for direct deposit reimbursement, email and text alerts.

For more information view the employer plan document or visit ASIFlex.com for general plan information.

The ASIFlex Card Things to Know

WWW.ASIFLEX.COM

Use of the Card is Not Paperless

That's right! **Use of the debit card is not paperless.** In many cases, IRS regulations require you to submit back-up documentation to substantiate certain transactions. Following are some tips regarding use of the card.

How to Use the Card

Co-Pays – The card works great for flat-dollar prescription or office visit co-pays under your employer plan. Keep your prescription pharmacy receipts, and ask for an itemized receipt for office visit co-pays (be sure it says office visit co-pay). You will be asked to submit documentation for percentage co-pay and coinsurance amounts.

Mail-Order Prescriptions –Simply provide the card number and expiration date to the pharmacy benefit manager once, and you're set! Keep your itemized mail order statement.

Know your balance! Check your account balance online or via the mobile app.

Over-the-Counter (OTC) Medicines and Health Care Products – You can purchase many OTC products using the card provided the merchant maintains an inventory system to identify FSA-eligible products. Keep the merchant itemized receipt.

If You Have Insurance – Ask your provider to submit to insurance first. Do not use the card at the time of service. After receiving the insurance plan Explanation of Benefits (EOB) or an itemized bill from the provider, you can use your card to pay the balance provided you do this within the plan year. Keep a copy of the EOB or provider itemized statement of service as you will be asked to provide this information.

Manage your account and read messages sent to you and posted to your secure message center.

If You Do Not Have Insurance – Present your card for payment and ask the provider for an itemized statement of service as you will be asked to submit this information. This itemized statement must include the provider name/address, patient name, date of service, description of the service/product, and the dollar amount owed.

Your Responsibility When Using the Card

Keep Documentation – Always ask for and keep copies of all itemized statements of service (not the credit card receipt) each time you use the card. Health care providers do not automatically provide this, so it is your responsibility to ask for it. IRS regulations require you to provide this information for many expenses including hospital, lab, physician, dental and vision expenses.

Each time you use the card, ask the provider for an itemized statement of service.

Use an envelope or file to store your itemized statements and EOBs. ASIFlex will notify you if this documentation is needed. If you do not provide the requested information, the IRS requires that the card be deactivated and you may have to pay the outstanding amount back to the plan.

You Must Comply with IRS Regulations – Use of the card is regulated by the IRS. You must use the card only for qualifying expenses, and you must submit back-up documentation when requested to do so.

Other Claim Options

If you don't like using the card, you have several ways to submit claims. The choice is yours and you don't have to choose just one!

ASIFlex Mobile App - *Download the free app; snap a picture and submit via the app! You can also check your balance any time!*

ASIFlex Online asiflex.com - *Scan your documentation and sign into your account to submit online! Read your messages here and manage your account preferences.*

Toll-Free Fax or USPS Mail - *Download a claim form, complete and fax or mail with your documentation. Keep a copy for your records*

ASIFlex
PO Box 6044
Columbia, MO 65203

E: asi@asiflex.com
F: 1-877-879-9038

www.asiflex.com
Programs Tab
Debit Card

Insurance Pays First – Do not use the card at the point of service for expenses that may be covered by insurance. Wait until you receive the insurance plan EOB and you can use the card to pay the balance at that time, provided it is within the same plan year. Otherwise, snap or scan a picture of the EOB and submit a claim via mobile app or online.

Read Your Messages – You are responsible for managing your account and reading and responding to messages sent to you and posted in your secure message center. Be sure to create your online account at asiflex.com.

What to Do if You Receive a Request for Documentation

1. Respond as soon as possible. Create your online account and sign in at asiflex.com or via the mobile app and read the secure message.
2. Just follow the instructions and provide the insurance plan EOB or an itemized statement of service. (Do not provide the credit card receipt.)
3. Submit online, via mobile app, toll-free fax or mail as soon as possible.

Reasons the Card May Not Work

Insufficient Funds – If you attempt to use the card for an amount that exceeds your available balance, the card will decline. Know Your Balance! Use the ASIFlex Mobile App or go online at asiflex.com to check your balance from anywhere, anytime!

Deactivated – If you fail to provide documentation when requested, the card may be deactivated. Check your account balance statement to see what transactions require back-up documentation. Transactions needing back-up documentation are highlighted in yellow, pink or red on your account balance statement.

Invalid Merchant – The card is limited-use and accepted at health care providers that accept VISA®. It is not valid at gas stations, restaurants, department stores, etc.

Merchant Problem – The merchant may encounter problems with their own terminal or may be using a merchant code that is something other than health care. For example, some teaching hospitals use an educational merchant code which would cause the card to decline.

Never Activated – If you did not activate the card when received, it will decline.

Create Your Online Account

If you have not done so, be sure to set up your online account! Just go to asiflex.com and click on the "Online Access/Account Detail" Tab, then click "Participant/Account Detail", then "Create an Account" and follow the instructions. You can submit claims, check your account balance, view your account balance statement, and change your settings for direct deposit, email or text alerts right from your account!

To order a debit card, just click on the card image and locate the "FSA Debit Card Application" form. Fill out and submit the form to ASIFlex. A set of two cards are mailed to your home address within 2-3 weeks.

Remember that you are responsible for managing your account and reading and responding to messages sent to you.

Get the ASIFlex Mobile App

Once you create your online account, download the ASIFlex Mobile App. It's free and available online at asiflex.com, or through Google Play or the App Store.

You can check your account balance statement right from your phone or mobile device 24/7! You can also submit claims right from the doctor's office or from the pharmacy! It's fast! It's easy!

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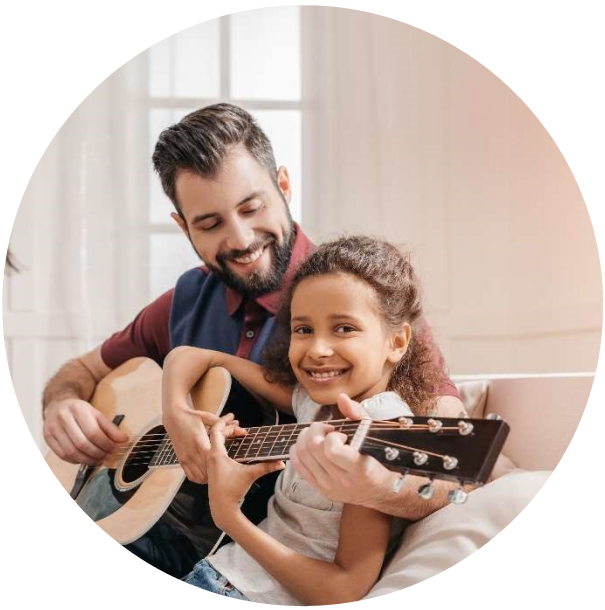

Supplemental Life & Voluntary Dependent Life Coverage 2021

CIS offers life and disability coverage through The Hartford. Employers pay for basic coverage, and choose whether to make available optional employee-paid Supplemental Employee/Spouse/Domestic Partner (DP) Life and/or Voluntary $10,000 Dependent Life coverage. ***If either of these options are offered by your employer, you will see these plans online.***

Supplemental Employee/Spouse/DP Life

Employees and/or spouses can elect amounts from $10,000 to $300,000 in $10,000 increments. Any amount elected for supplemental life during open enrollment requires completion of Hartford's Personal Health Application (PHA).

If electing coverage, a link to the Hartford PHA will be provided at the end of your enrollment. If enrolling in coverage for yourself only, you can click on the link and complete the PHA immediately. If enrolling in coverage for you and your spouse, the PHA will include questions for both of you and must be completed at the same time.

If you cannot complete the PHA at the time of enrollment, or you wish to complete at a later date, you will need to do so no later than November 30, 2020.

Please Note: You may be required to provide documentation if your spouse is not currently an approved dependent in CIS-Connect and you are enrolling him/her for Supplemental Spouse Life for the first time.

Personal Health Application (PHA)

If you prefer to complete the PHA by hardcopy, click on the PHA link and it will take you to the online version. You must complete the first two pages of the form and then on the third page (Health Questions) you will see a link to print out the form (Print Personal Health Application).

It will be pre-populated with the information provided on the first two pages. Then answer the questions and mail the completed form to The Hartford.

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To complete the PHA at a later date, log into CIS-Connect to access the Hartford link from your homepage. All coverage approved before Dec. 1 will be effective Jan. 1, 2021. Coverage approved after that will have a Feb. 1 or later effective date. If you wish to discontinue Supplemental Life, you must elect the waive option.

Supplemental Employee/Spouse/DP Life Rates

Rates will adjust on January 1 for employees and/or spouses/DPs who changed age categories during the previous calendar year. Your first paycheck after January 1 will reflect the new rates (see below).

Age	Employee Cost/$1K	Spouse Cost/$1K
0-29	$0.030	$0.035
30-34	$0.039	$0.044
35-39	$0.053	$0.061
40-44	$0.075	$0.087
45-49	$0.106	$0.122
50-54	$0.166	$0.192
55-59	$0.310	$0.358
60-64	$0.476	$0.549
65-69	$0.898	$1.035
70-74	$1.413	$1.629
75 & Older	$4.354	$5.022

Example: If you elect $100,000 for employee coverage and are 45 years old your premium would be: $0.106 x 100 = $10.60. This amount would be the monthly payroll deduction.

Voluntary $10,000 Dependent Life

You can elect the $10,000 Dependent Life coverage during open enrollment on a guarantee issue basis. Coverage is $2.66 per month and will cover a spouse/DP and/or children under the age of 26. If you wish to discontinue Voluntary Dependent Life, you must choose the waive option.

ARE YOUR BENEFICIARY DESIGNATIONS CORRECT?

As a follow-up to transitioning to the new enrollment system – CIS-Connect – we encourage you to confirm that your Beneficiary Designations are correct. Errors can happen when transferring data. The beneficiary(ies) we have listed are the ones who will receive your life insurance benefits.

You are automatically the beneficiary for the Supplemental Spouse/DP Life and the Voluntary $10,000 Dependent Life. Beneficiaries for Basic Life, Supplemental Employee Life and Statutory Life need to be designated online. You will be offered the opportunity to assign a beneficiary during the enrollment process.

IDENTITY THEFT PROTECTION

cis benefits
cisbenefits.org

Digital thieves constantly discover new ways to extract your personal information, open credit accounts in your name, sell your sensitive data on the dark web, and take over your financial accounts.

We offer comprehensive Identity Theft Protection that safeguards multiple gateways into your identity and credit.

PROTECTION SERVICES INCLUDE:

- Enhanced Identity Monitoring
- Dark Web Monitoring
- High-Risk Transaction Monitoring
- Account Activity Alerts
- Financial Activity Monitoring
- Social Media Monitoring
- IP Address Monitoring
- Lost Wallet Protection
- Solicitation Reduction
- Digital Exposure Reports
- Credit Monitoring and Alerts
- Data Breach Notifications
- Credit Assistance
- Sex Offender Registry
- Identity Theft Insurance
- Stolen Fund Reimbursement up to $1 Million

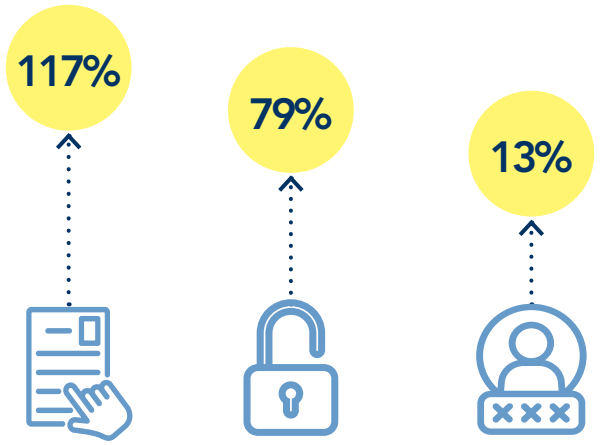
$1.48 Billion

Total losses from identity theft fraud in the U.S. in 2018.

Federal Trade Commission,
Consumer Sentimental Network Data Book, 2019

INCREASING DIGITAL THREATS

Percentage increase from 2017-2018



Formjacking
stealing credit card information from online payment forms

Account Takeovers

New Account Fraud
opening accounts using the victim's name

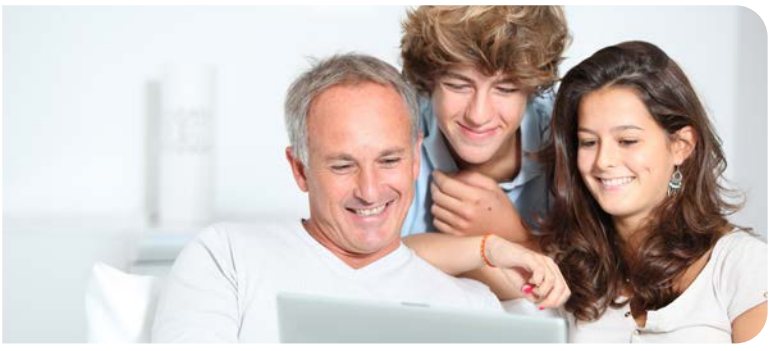
Symantec, Internet Security Report, 2019

For more information, call **1-800-789-2720** or CLICK HERE for a video with plan details. Rates will be available during Open Enrollment.

MONITOR YOUR CHILD'S CREDIT REPORT

A child's Social Security number gives ID thieves a fraudulent "clean slate."

Monitor you child's credit report as often as your own.



NOTE: This statement is intended to provide a summary of your benefits. The actual determination of your benefits is based solely on the plan documents provided by the carrier of this plan. These policies or their provisions may vary or be unavailable in some states. The policies have exclusions and limitations which may affect any benefits payable. This summary is not legally binding, is not a contract, and does not alter any original plan documents.

PrivacyArmor

Protect today.
Thrive tomorrow.

Get complete identity protection with PrivacyArmor Plus® so you can focus on what matters most.

Your identity is made up of more than your Social Security number and your bank accounts. That's why PrivacyArmor Plus does more than monitor your credit reports and scores. We safeguard your personal information, the data you share, and the relationships you treasure.

And now PrivacyArmor Plus is better than ever. We've teamed up with Allstate to provide the next generation of protection. Our new proprietary tools stay one step ahead — allowing us to catch fraud as it happens. In the event of wrongdoing, you have a dedicated Privacy Advocate® available 24/7 to fully manage your recovery and restore your identity.

- ✓ Identity monitoring and alerts
- ✓ Full-service remediation
- ✓ Identity theft reimbursement†
- ✓ iOS and Android app

Elect during Open Enrollment to continue your Identity Protection Coverage for 2021

MyPrivacyArmor.com

Questions?

1.800.789.2720

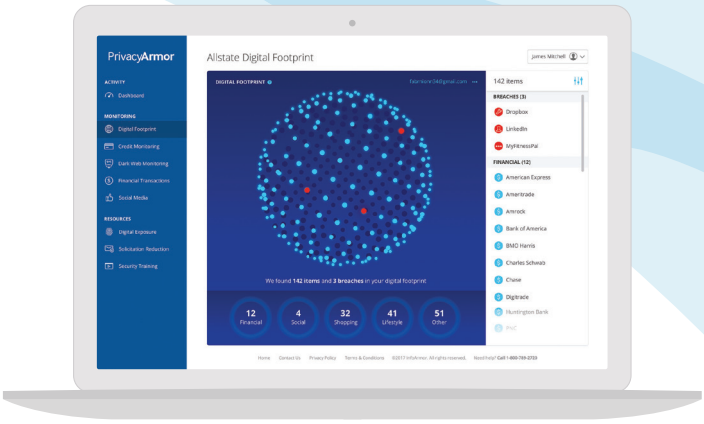
Plans and pricing

PrivacyArmor Plus
$9.95 per person / month
$17.95 per family / month

InfoArmor
an Allstate company

The most comprehensive identity protection plan available

- Run your personalized Allstate Digital Footprint and see your digital exposure
- Check your identity health score
- View, manage, and clear alerts in real time
- Monitor your credit scores and reports for any changes or errors
- Receive alerts for cash withdrawals, balance transfers, and large purchases from any linked bank account
- Monitor linked social media accounts for questionable content and signs of account takeover
- Reduce solicitation attempts by opting out of credit card offers, telemarketing calls, commercial mail and email, and unrequested coupons
- Protect your account with biometric authentication security in iOS and Android
- Get reimbursed for stolen 401(k) & HSA funds; we'll also advance fraudulent tax returns†



NEW!
Allstate Digital Footprint™

All the incredible things you can do online require something from you — data. A "digital footprint" is a collection of all the data you've left behind that might expose your identity. Our new tool offers a simple way for you to see and secure your information, and help stop identity theft before it starts.

How it works

1 Enroll in PrivacyArmor Plus
You're protected from your effective date. Our auto-on credit monitoring alerts, and support require no additional setup.

2 Get to know us
Explore additional features in our easy-to-use portal. The more we monitor, the safer you can be.

3 We're on the job
Our human operatives see more — like when your personal information is sold on the dark web. If you've been compromised, we alert you.

4 We'll do the heavy lifting
In the event of identity theft or fraud, Privacy Advocates® are available 24/7. They won't stop until you're in the clear.

5 We've got your back
Our $1 million identity theft insurance policy covers out-of-pocket costs associated with identity restoration.†

†Identity theft insurance underwritten by insurance company subsidiaries or affiliates of Assurant. The description herein is a summary and intended for informational purposes only and does not include all terms, conditions and exclusions of the policy described. Please refer to the actual policy for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions.

PrivacyArmor is offered and serviced by InfoArmor, Inc., a subsidiary of The Allstate Corporation.

InfoArmor
an Allstate company

Accident Insurance

Coverage that helps pay for expenses that may not be covered under your medical plan.

citycounty insurance services

What is accident insurance?

Accident insurance works to supplement your medical coverage — and pays in addition to what your medical plan may or may not cover. It's coverage that helps provide a financial cushion for life's unexpected events by providing you with a lump-sum payment when your family needs it most. The payment you receive is yours to spend however you like. It pays for the expenses of medical tests, services, treatments or care for one of more than 150 covered events, as defined in your group certificate. This includes hospitalization resulting from an accident, and accidental death or dismemberment.[1]

Q. How does the payment work?

A. We make payments directly to you. The amount you receive will be in addition to any other insurance you might have, and you can spend it however you like. You might use it to help pay for medical plan deductibles and co-pays, out-of-network care, or even for your family's everyday living expenses. Whatever you need while recovering from an accident or injury, accident insurance is there to make life a little easier.

Q. Am I eligible to enroll for this coverage?

A. Yes, you can enroll both yourself and eligible family members. All you need to do is enroll during your enrollment period and be actively at work.

Q. I have a medical plan at work, so why do I need accident insurance?

A. Accidents can happen anytime, anywhere and always when you least expect them. What's more they can be costly.

Even the best medical plans can leave you with extra expenses to pay for services that just aren't covered. Things like plan deductibles, co-pays, extra costs for out-of-network care, or extra costs non-covered services. Many people aren't prepared to handle these extra costs, so having this extra financial support when the time comes may mean less worry for you and your family.

Accident insurance is a way for you to supplement your health care plan.

MetLife

ADF# AI1815.17

Accident Insurance

Q. Can I enroll for this insurance without having a medical exam?

A. Yes. Your accident coverage is guaranteed,[2] regardless of your health. You just need to be actively at work to be covered. There are no medical exams to take and no health questions to answer, so the whole process might be easier than you first thought.

Q. How much will it cost?

A. Accident insurance may cost less than you think. It's designed to be an way to supplement your health care plan. Exact rates can be found in the enrollment materials provided by your employer.

Q. How do I pay for my coverage?

A. You pay premiums through payroll deductions, so you don't have to worry about writing any checks or missing payments.

Q. When does my coverage begin?

A. Right away — your coverage starts on the effective date of your coverage. There are no waiting periods for it to begin.

Q. Are benefits paid directly to me or my health care provider?

A. Payments will be paid directly to you, not to the doctors, to the hospitals or to any other health care providers; the check is made payable to you. There's no need to coordinate this coverage with any other insurance you may have. Benefits are paid no matter what your other insurance plans may cover.

Q. If my employment status changes, can I take my coverage with me?

A. Yes. This coverage is portable, meaning you can take it wherever you go. Your coverage will only end if you stop paying your premium or if your employer offers you similar coverage with a different insurance carrier.[3]

Q. Can I use the benefit payment on anything I need?

A. Yes, you can use your payment as you see fit. Use it to help cover your medical insurance deductibles, co-pays, or household bills.

Q. Is the claims process simple?

A. Yes. Once we receive all the information, claims are generally processed within 10 business days. You only need one claim form per accident, and every claim is reviewed by a claims professional.

Have other questions?

Please call MetLife directly at
1 800 GET-MET8
1 800 438-6388
and talk with a benefits consultant.

1. Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See MetLife's Disclosure Statement or Outline of Coverage/Disclosure Document for full details.
2. Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents to be covered are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Additional restrictions apply to dependents serving in the armed forces or living overseas.
3. Eligibility for portability through the Continuation of Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.

METLIFE'S ACCIDENT INSURANCE IS A LIMITED BENEFIT GROUP INSURANCE POLICY. The policy is not intended to be a substitute for medical coverage and certain states may require the insured to have medical coverage to enroll for the coverage. The policy or its provisions may vary or be unavailable in some states. There is a preexisting condition limitation for hospital sickness benefits, if applicable. MetLife's Accident Insurance may be subject to benefit reductions that begin at age 65. And, like most group accident and health insurance policies, policies offered by MetLife may contain certain exclusions, limitations and terms for keeping them in force. For complete details of coverage and availability, please refer to the group policy form GPNP12-AX or contact MetLife.

Benefits are underwritten by Metropolitan Life Insurance Company, New York, New York. Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See MetLife's Disclosure Statement or Outline of Coverage/Disclosure Document for full details.

MetLife

Metropolitan Life Insurance Company | 200 Park Avenue | New York, NY 10166

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AX12-AX16

Critical Illness Insurance

Coverage that helps you and your family have the financial support to pay for some of the expenses of a serious illness that may not be covered by your medical plan.

citycounty insurance services

What is critical illness insurance?

Critical illness insurance works to supplement your medical coverage — and pays in addition to what your medical plan may or may not cover. It's coverage that helps provide financial support when you or a loved one becomes seriously ill. Upon verified diagnosis, it provides you with a lump-sum payment of $10,000, $20,000 or $30,000 in initial benefits. In the event that you or a loved one experience more than one covered condition, the total benefit amount available is 3 times that of the initial benefit amount, which is $30,000, $60,000 or $90,000. The payment you receive is yours to spend however you like.

Q. What's covered under this plan?

A. If you meet the group policy and certificate requirements, **critical illness insurance provides you with a lump-sum payment upon verified diagnosis of these conditions:**

- Full Benefit Cancer[1]
- Partial Benefit Cancer[1]
- Heart Attack
- Stroke[2]
- Kidney Failure
- Coronary Artery Bypass Graft[3]
- Alzheimer's Disease[4]
- Major Organ Transplant[5]
- 22 Listed Conditions[6] (see your Outline of Coverage for details)

Q. What happens if I have a recurrence?

A. Your plan pays an additional benefit (Recurrence Benefit) if a medical condition reoccurs for: a Heart Attack, a Stroke, a Coronary Artery Bypass Graft, Full Benefit Cancer, and Partial Benefit Cancer. A recurrence benefit is only available if the initial benefit has already been paid for the covered condition. And there is a benefit suspension period (or waiting period) between recurrences.[7]

Payments may be used to help pay for expenses generally not covered by medical and disability income coverage.

Q. Am I eligible to enroll for this coverage?

A. Yes, you can enroll both yourself and your eligible family members.[8] All you need to do is enroll during the enrollment period and be actively at work.

Q. I have a medical plan at work, so why do I need critical illness insurance?

A. One of the hardest parts of managing illnesses like Cancer, Heart Attack, or Stroke is providing the support and comfort your family needs beyond the cost of care.

Even the best medical and disability income plans can leave you with extra expenses like medical plan deductibles and co-pays or extra costs for out-of-network care. And if you're out of work because of a disability, it might be that only a portion of your pre-disability income is being paid to you. The average family spends thousands of dollars in times of critical illness and recovery.[9] Many people aren't prepared to handle these extra costs, so having this extra cash lump sum payment may mean less worry for you and your family.

MetLife

ADF# CI543.14

Critical Illness Insurance

Q. Can I enroll for this insurance without having a medical exam?

A. Yes. Your critical illness coverage is guaranteed,[10] regardless of your health. You need to be actively at w ork to be covered. There are no medical exams to take and no health questions to answ er, so the w hole process might be easier than you think.

Q. Are there any other benefits payable under this critical illness insurance plan?

A. Yes. Early detection of a serious illness is important to your recovery. We provide you with an extra $50 annual benefit per calendar year on top of your total benefit amount when you see your physician for eligible health screenings or prevention measures.[11]

Q. How do I pay for my coverage?

A. You pay premiums through payroll deductions, so you don't have to w orry about w riting any checks or missing payments.

Q. How much will it cost?

A. Critical illness insurance may cost less than you think. It's designed to be a w ay to supplement your health care and disability plans. Exact rates can be found in the enrollment materials provided by your employer.

Q. Are benefits paid directly to me or my health care provider?

A. Benefits w ill be paid directly to you, not to the doctors, to the hospitals or to any other health care providers. There's no need to coordinate w ith any other insurance you may have. Benefits are paid no matter w hat your other insurance plans may cover or pay.

Q. If my employment status changes, can I take my coverage with me?

A. Yes. This coverage is portable, meaning you can take it w herever you go. Your coverage w ill only end if you stop paying your premium or if your employer offers you similar coverage w ith a different insurance carrier.[12]

Have other questions?

Please call MetLife directly at
1 800 GET-MET8
1 800 438-6388
and talk w ith a benefits consultant.

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1. Please review the Disclosure Statement or Outline of Coverage/Disclosure Document for specific information about cancer benefits. Not all types of cancer are covered. Some cancers are covered at less than the Initial Benefit Amount. For NH-sitused cases and NH residents, there is an initial benefit of $100 for All Other Cancer.
2. In certain states, the Covered Condition is Severe Stroke.
3. In NJ-sitused cases, the Covered Condition is Coronary Artery Disease.
4. Please review the Outline of Coverage for specific information about Alzheimer's disease.
5. MetLife offers several different product variations. For certain products, the Major Organ Transplant Benefit is included within the Total Benefit Amount. With others, the benefit is payable in addition to the Total Benefit Amount. Please contact MetLife for additional information.
6. MetLife Critical Illness Insurance will pay 25% of the Initial Benefit Amount when a covered person is diagnosed with one of the 22 Listed Conditions. A Covered Person may only receive one benefit payment of a Listed Condition in his/her lifetime. The Listed Conditions are: Addison's disease (adrenal hypofunction); amyotrophic lateral sclerosis (Lou Gehrig's disease); cerebrospinal meningitis (bacterial); cerebral palsy; cystic fibrosis; diphtheria; encephalitis; Huntington's disease (Huntington's chorea); Legionnaire's disease; malaria; multiple sclerosis (definitive diagnosis); muscular dystrophy; myasthenia gravis; necrotizing fasciitis; osteomyelitis; poliomyelitis; rabies; sickle cell anemia (excluding sickle cell trait); systemic lupus erythematosus (SLE); systemic sclerosis (scleroderma); tetanus; and tuberculosis.
7. We will not pay a Recurrence Benefit for a Covered Condition that Recurs during a Benefit Suspension Period. We will not pay a Recurrence Benefit for either a Full Benefit Cancer or a Partial Benefit Cancer unless the Covered Person has not had symptoms of or been treated for the Full Benefit Cancer or Partial Benefit Cancer for which we paid an Initial Benefit during the Benefit Suspension Period.
8. Eligible Family Members means all persons eligible for coverage as defined in the Certificate.
9. MetLife Accident and Critical Illness Impact Study, October 2013.
10. Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Additional restrictions apply to dependents serving in the armed forces or living overseas.
11. The Health Screening Benefit is not available in all states. See your certificate for any applicable waiting periods. There is a separate mammogram benefit for MT residents and for cases sitused in CA and MT.
12. Eligibility for portability through the Continuation of Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.

MetLife

Metropolitan Life Insurance Company | 200 Park Avenue | New York, NY 10166

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Hospital Indemnity Insurance

Coverage to help offset hospitalization expenses that may not be covered under your medical plan.

citycounty insurance services

What is hospital indemnity insurance?

Hospital indemnity insurance works to complement your medical coverage — and pays in addition to what your medical plan may or may not cover. It's coverage that can help safeguard your finances for life's unexpected events by providing you with a lump-sum payment (one convenient payment all at once) when your family needs it most. The payment you receive is yours to spend however you like. It typically pays, as long as the policy and certificate requirements are met, a flat amount upon your hospital admission and a daily amount paid from each day of your stay (confined to the hospital).[1] It also provides payment if you're admitted to or have to stay in an Intensive Care Unit (ICU), as well as payment for receiving other services too.[2]

Q. How does the payment work?

A. We make payments directly to you. The amount you receive will be on top of any other insurance you might have and you can spend it however you like. You might use it to help pay for medical plan deductibles and copays, for out-of-network care, or even for your family's everyday living expenses. Whatever you need while recovering from an illness or accident, hospital indemnity insurance is there to make life a little easier.

Q. Am I eligible to enroll for this coverage?

A. Yes, you can enroll both yourself and eligible family members. All you need to do is enroll during the enrollment period and be actively at work. Some dependents may not be subject to medical restrictions as outlined in the Certificate, but there are a couple of things to bear in mind. Some states require the insured to have medical coverage and some additional restrictions apply to dependents serving in the armed forces or living overseas.

Q. I have a good medical plan at work, so why do I need hospital indemnity insurance?

A. Hospital stays can be pricey, and often unexpected. Even the best medical plans can leave you with extra expenses to pay or services that just aren't covered. Things like plan deductibles, copays, extra costs for out-of-network care, or non-covered services. Many people aren't prepared to handle these extra costs, so having

Hospital indemnity insurance is designed to be an economical way for you to supplement your health care plan.

MetLife

ADF# HI1814.17

Hospital Indemnity Insurance

this extra financial support when the time comes may mean less worry for you and your family.

Q. Can I enroll for this insurance without having a medical exam?

A. Yes. Your hospital indemnity coverage is guaranteed,[3] regardless of your health. You just need to be actively at work. There are no medical exams to take and no health questions to answer, so the whole process might be easier than you first thought.

Q. How much will it cost?

A. Hospital indemnity insurance may cost less than you think. It's designed to be an economical way for you to supplement your health care plan. Exact rates can be found in the enrollment materials provided by your employer.

Q. How do I pay for my coverage?

A. It's easy to pay **premiums through payroll deductions,** so you don't have to worry about writing any checks or missing payments.

Q. When does my coverage begin?

A. Right away — your coverage starts on the effective date of your coverage. There are no waiting periods for it to begin.

Q. Are benefits paid directly to me or my health care provider?

A. Payments will be paid directly to you, not to the doctors, hospitals or any other health care providers. And to make things even easier, the check is made payable to you. There's no need to work it around any other insurance you may have. Benefits are paid no matter what your other insurance plans may cover.

Q. If my employment status changes, can I take my coverage with me?

A. Yes. This coverage is portable, meaning you can take it with you wherever you go. Your coverage will only end if you stop paying your premium or if your current employer chooses to cancel the group hospital indemnity insurance policy.[4]

Q. Is the claims process simple?

A. Yes. Once we've received all the necessary information, claims are generally processed within 10 business days. You only need one claim form per admission or hospital stay and every claim is reviewed by a professional.

Have other questions?

Please call MetLife directly at
1 800 GET-MET8
1 800 438-6388
and talk with a benefits consultant.

1. Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See your Disclosure Statement or Outline of Coverage/Disclosure Document for full details.
2. Covered services/treatments must be the result of an accident or sickness as defined in the group policy/certificate. See your Disclosure Statement or Outline of Coverage/Disclosure Document for more details.
3. Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents to be covered are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Additional restrictions apply to dependents serving in the armed forces or living overseas.
4. Eligibility for portability through the Continuation of Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.

MetLife

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cis benefits
cisbenefits.org

VOLUNTARY BENEFIT OPTIONS

CIS offers excellent medical plan options, however, no plan covers all the costs of a serious illness or injury. If a major health event occurs, deductibles and coinsurance can add up to thousands of dollars. We are offering three voluntary benefit options that allow you to greatly reduce this financial exposure and help bridge the gaps when the unexpected occurs – Critical Illness Insurance, Accident Insurance, and Hospital Indemnity Insurance.

CRITICAL ILLNESS INSURANCE

Critical Illness Insurance pays a lump-sum benefit directly to you in the event you or a covered family member are diagnosed with a covered condition such as a heart attack, stroke, or cancer. You can use this benefit any way you choose, to help pay for deductibles and coinsurance, or simply to replace lost earnings from being out of work. You choose a benefit amount of $10,000, $20,000, or $30,000 when you enroll. No medical underwriting is needed.

Critical Illness Plan Features

PORTABLE COVERAGE
You can take your policy with you if you change jobs or retire.

FAMILY COVERAGE
Coverage options are available for your spouse and children.

PAYROLL DEDUCTION
Premiums are paid through convenient payroll deductions.

GUARANTEED ISSUE
There are no health questions or physical exams required.

ACCIDENT INSURANCE

Accidents happen. You can't always prevent them, but you can take steps to reduce the financial impact. Accident Insurance pays you or your covered dependents benefits for specific injuries and events resulting from a covered accident, both on and off the job. The amounts paid depend on the type of injury and care received. Benefits are available for injuries like concussions, broken tooth, eye injury, lacerations, burns, dislocations, fractures, and more.

Accident Plan Features

PORTABLE COVERAGE
You can take your policy with you if you change jobs or retire.

FAMILY COVERAGE
You can elect to cover your spouse and children.

24/7 COVERAGE
Benefits are paid for accidents that happen on and off the job.

GUARANTEED ISSUE
There are no health questions or physical exams required.

SEE REVERSE SIDE

HOSPITAL INDEMNITY INSURANCE

Even with medical insurance, a hospital stay can cost you thousands of dollars in deductibles and coinsurance. Hospital Indemnity Insurance pays a benefit directly to you if you or a family member receives hospital care. You receive a benefit for being admitted to the hospital and then for each day you are confined. Additional benefits are paid based on the type of services you receive. Emergency room services are also eligible.

Hospital Indemnity Plan Features

PORTABLE COVERAGE

You can take your policy with you if you change jobs or retire.

FAMILY COVERAGE

You can elect to cover your spouse and children.

PAYROLL DEDUCTION

Premiums are paid through convenient payroll deductions.

GUARANTEED ISSUE

There are no health questions or physical exams required.

HEALTH SCREENING BENEFIT

Each of these voluntary benefits provides a $50 Health Screening Benefit per covered person per calendar year if you or your covered dependents complete a covered health screening test such as a physical exam, total cholesterol blood test, mammogram, lipid panel and more. If you enroll in all three plans, you are eligible for three times the benefit.

For more information, call **1-800-GET-MET8** (1-800-438-6388) and mention CIS Open Enrollment, or CLICK HERE for a video with plan details. Rates will be available during Open Enrollment.

NOTE: This statement is intended to provide a summary of your benefits. The actual determination of your benefits is based solely on the plan documents provided by the carrier of these plans. These policies or their provisions may vary or be unavailable in some states. The policies have exclusions and limitations which may affect any benefits payable. This summary is not legally binding, is not a contract, and does not alter any original plan documents.

Trauma Coverage

EMPOWERING RECOVERY

Trauma Coverage® was created to empower the recovery of individuals and families with financial security, physical recuperation, and emotional well-being after a traumatic incident. Covered incidents include injuries anywhere in the United States as the result of an aggravated assault, sexual assault, mass shooting or act of terror. Coverage is extended to provide benefits for witnessing a violent act, or contracting an infectious disease while working.

Trauma Counseling

Trauma Counseling is therapy re-invented for the way we live. A confidential, measurement-based program empowering recovery after every day and workplace incidents. Talk with a Master's level therapist 24/7 via video conferencing on multiple devices.

Recovery Care

Reimbursement for out of pocket expenses. This includes copays and deductibles for medical, dental, vision, hearing, and pharmaceuticals. Family members providing supportive services can also receive 100% of their regular pay as a part of this benefit.

Financial Security

Receive 100% of your regular pay while you're unable to work due to a trauma without a waiting period to receive benefits. Beneficiaries of each insured will receive their policy maximum due to their loss of life from an accidental death.

SEE PAGE 2 FOR PLAN OPTIONS ›

TAKING TIME TO HEAL

Mary's Story

"I was assaulted while out with friends. I went to the hospital and was treated for injuries and tested for diseases. I needed time to deal with everything...it was all just too much."

Mary needed time to heal and feel secure but, like most people, she couldn't afford the additional out of pocket costs for trauma recovery care or afford to miss work and survive on the reduced pay from disability insurance.

Trauma coverage provided Mary with inancial security–100% of her normal pay and reimbursement for the out of pocket medical costs. It also provided Mary with trauma counseling and provided lost wages to her mother for supportive services.

BRONZE $10.00	SILVER $15.00	GOLD $20.00	FAMILY $25.00
$5,000 Individual and family counseling	**$5,000** Individual and family counseling	**$5,000** Individual and family counseling	**$5,000 / Insured** Individual and family counseling
$5,000 Maximum in lost wages[1]	**$10,000** Maximum in lost wages[1]	**$15,000** Maximum in lost wages[1]	**$20,000 / Insured** Maximum in lost wages[1]
$5,000 Maximum for expense reimbursement[2] or lost wages of a family member	**$10,000** Maximum for expense reimbursement[2] or lost wages of a family member	**$15,000** Maximum for expense reimbursement[2] or lost wages of a family member	**$20,000 / Insured** Maximum for expense reimbursement[2] or lost wages of a family member
$50,000 Accidental death benefit	**$100,000** Accidental death benefit	**$150,000** Accidental death benefit	**$200,000[3]** Accidental death benefit
$50,000 Maximum benefit per policy period (1 year)	**$100,000** Maximum benefit per policy period (1 year)	**$150,000** Maximum benefit per policy period (1 year)	**$200,000 / Insured** Maximum benefit per policy period (1 year)

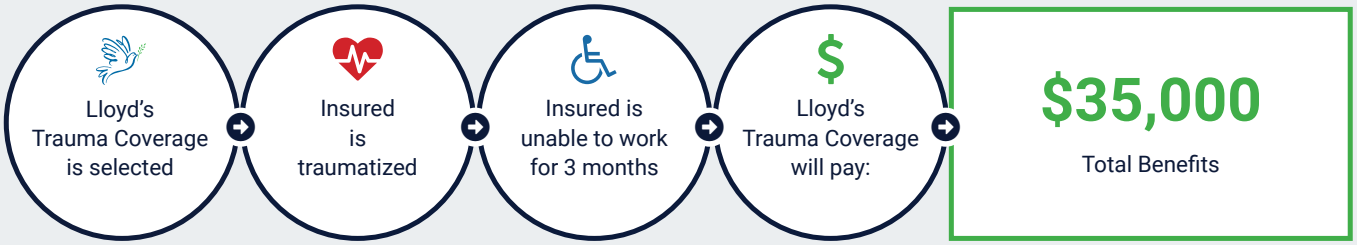
Prices are monthly and inclusive of premium, taxes and fees. There is no waiting period to receive benefits which are payable per insured per incident up to your policy maximum during any one (1) year policy period.

[2] Expense reimbursement includes any medical, dental, vision, hearing, pharmaceutical, and addiction to prescribed drugs expenses

[3]The accidental death benefit for the Family Plan is up to $200,000 ($150,000 for employed Insureds and $25,000 for non-employed Insureds)

Family Plan Added-benefit: Family coverage includes the insured; spouse (if applicable); and dependent, unmarried children to age 19 (26 if full-time students). This includes the relationship created by a domestic partnership. Newborn children are automatically insured from the moment of birth. A dependent child must be under the age of 19 at the time of application to be eligible for coverage. In addition, the Family Plan provides families of traumatized students with $100 in financial assistance per day while the student is unable to attend school due to a trauma.

For illustrative purposes, below please find an example of maximum benefits paid to an Insured who experiences an assault and unable to work for 3 months while undergoing recovery care and counseling. If regularly earnings are $60,000 a year ($165 a day), a Trauma Coverage Gold Plan would provide them $15,000 in recovery benefits, $15,000 in financial benefits, and $5,000 of trauma counseling for them and all of their immediate family members.



UNDERWRITING

Guaranteed issue
No age limitations for coverage
Approved in and limited to the 50 United States
Coverage is underwritten by Lloyd's of London

POLICY ISSUANCE

Policy periods are one (1) year
No waiting period to receive trauma benefits

POLICY & CLAIM ADMINISTRATION

Trauma Coverage Administration
c/o International Specialty Insurance
Winston-Salem, NC 27103
110 Oakwood Dr., Suite 420

Monday–Friday 8 A.M. to 5 P.M. Central
(Excluding U.S. Holidays)
admin@traumacoverage.com
855-631-1421

TRAUMA COVERAGE®
EMPOWERING RECOVERY™

cis benefits
cisbenefits.org

TRAUMA COVERAGE

Experiencing a traumatic incident can have dramatic and lasting effects on you and your loved ones. Trauma Coverage helps empower your recovery by providing financial security, physical recuperation and emotional wellbeing.

TRAUMA COVERAGE PROVIDES BENEFITS TO THOSE WHO ARE:

- Sexually or Physically Assaulted
- Traumatized at work or school
- Infected by a disease at work or school
- A victim of a Mass Shooting or a Terrorist Act

BENEFITS INCLUDE:

- **Financial Security** – Receive 100% of your regular pay while you are unable to work due to a trauma without a waiting period to receive benefits. Beneficiaries of each insured will receive their policy maximum due to their loss of life from an accidental death. *Policy maximums vary based upon the plan option selected either $50,000, $100,000, $150,000 or $200,000.*

- **Recovery Care –** Reimbursement for out-of-pocket expenses including copays and deductibles for medical, dental, vision, hearing, and pharmaceuticals. Family members providing supportive service can also receive 100% of their regular pay as part of this benefit.

- **Trauma Counseling –** This confidential, measurement-based program empowers recovery after traumatic incidents. Counseling sessions are available via phone, video, and text.

Plan Features

GUARANTEED ISSUE

There are no health questions or physical exams required.

FAMILY COVERAGE

Coverage options are available for your spouse and children.

NO WAITING PERIOD

No waiting period or age limitations for coverage.

Call **1-855-631-1421** to schedule a time to discuss your questions about Trauma Coverage, or CLICK HERE for a video with plan details. Rates will be available during Open Enrollment.

NOTE: This statement is intended to provide a summary of your benefits. The actual determination of your benefits is based solely on the plan documents provided by the carrier of this plan. These policies or their provisions may vary or be unavailable in some states. The policies have exclusions and limitations which may affect any benefits payable. This summary is not legally binding, is not a contract, and does not alter any original plan documents.