cis benefits
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2024 CIS Benefits

Enrollment & Eligibility Guide:

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

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

Notice About Request for Social Security Numbers (SSN)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IRS-Qualified Family Status Changes include:

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

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

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

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

   The following changes can be made:

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

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

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

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

3. Qualified Medical Child Support Order (QMCSO)

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

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

4. Marriage

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

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

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

5. Newly Registered Domestic Partner

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

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

6. Divorce/Legal Separation/Annulment

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

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

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

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

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

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

8. Employee Gains Other Coverage

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

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

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

9. Dependent Gains Other Coverage

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

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

10. Employee Loses Other Coverage

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

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

11. Dependent Loses Other Coverage

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

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

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

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

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

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

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

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

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

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

15. Death of a Spouse/Registered Domestic Partner

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

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

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

16. Death of a Child

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

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

17. Increase/Decrease in Cost of Dependent Care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Administrative and Eligibility Appeals

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

Mandatory Notices

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

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

HIPAA Privacy Notice

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

HIPAA Special Enrollment Rights

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

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

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

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

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

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

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

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

Medicare Prescription Drug Coverage - Part D

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

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

Children's Health Insurance Program (CHIP)

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

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

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

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

Health Reimbursement Arrangement (HRA) Waiver Rights

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

Important Notice from CIS About Your Prescription Drug Coverage and Medicare

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: Oct. 3, 2023
Name of Entity/Sender: CIS Benefits
Address: 15875 Boones Ferry Rd., #1469 Lake Oswego, OR 97035
Phone Number: 1-800-922-2684 (within Oregon) or 503-763-3800

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

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

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	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: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
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	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

CIS High Deductible Health Plan 5 w/ HSA - Alternative Care

Benefits Summary
Effective January 1, 2024

cis benefits
www.cisbenefits.org

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

HDHP-5 w/ HSA	
Deductible Per Calendar Year	$2,500 Individual $5,000 Family
Out-of-Pocket Maximum Per Calendar Year **Category 1, 2, & 3** – Preferred, Participating, Non-Preferred Providers (includes deductible, medical copays and prescription copays*)	5,000 Individual $10,000 Family
****Important Note:*** If an individual satisfies the $5,000 calendar year individual out-of-pocket maximum, his/her eligible services will be covered at 100% for the remainder of the calendar year. The family out-of-pocket maximum for a calendar year is satisfied when two or more family members' deductible and coinsurance for covered services for that calendar year total and meet the family's out-of-pocket maximum amount.	

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

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

Additional Medical Services

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

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

A Look at Your VSP Vision Coverage

With VSP and CIS TRUST, your health comes first.

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

vsp vision care | CIS

Value and savings you love.

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

Provider choices you want.

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

vsp PREMIER PROGRAM

Preferred private practice and retail in-network choices

private practice doctors

Visionworks

Quality vision care you need.

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

Using your benefit is easy!

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

More Ways to Save

Extra

$20

to spend on Featured Brands†

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

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

+

Up to

40%

Savings on lens enhancements‡

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

Your VSP Vision Benefits Summary

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

PROVIDER NETWORK:
VSP Choice
EFFECTIVE DATE:
01/01/2024

vsp vision care

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

YOUR COVERAGE GOES FURTHER IN-NETWORK

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

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

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

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

Welcome to Express Scripts

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

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

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

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

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

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

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

Accredo, your specialty pharmacy

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

Accredo offers many patient support services, including:

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

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

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

EXPRESS SCRIPTS®

Network retail pharmacies

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

To find an in-network pharmacy near you, go to **express-scripts.com/CIS11** and select **Locate a Pharmacy**. Search results will indicate whether a pharmacy is eligible to dispense up to a 3-month supply. You may also log in at **express-scripts.com** and choose **Find a Pharmacy** from the menu under **Prescriptions** or call Express Scripts at 800.496.4182.

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

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

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

Manage your prescription

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

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

Formulary

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

Note that certain medications are excluded from your formulary, which means they're not covered. An equally effective and safe alternative may be available. To check pricing and coverage for a medication, visit express-scripts.com/CIS11. Drug classes with excluded medications include Autonomic and Central Nervous System, Cardiovascular and Dermatological.

EXPRESS SCRIPTS®

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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,500 individual (single coverage) / $5,000 family per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Certain preventive care and those services listed below as "deductible does not apply."	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?	$5,000 individual (single coverage) / $10,000 family* per calendar year. *An individual on family coverage will not have their out-of-pocket limit exceed $5,000.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://regence.com/go/OR/Preferred or call 1 (888) 370-6159 for a list of network providers.	You pay the least if you use a provider in the preferred network. You pay more if you use a provider in the participating network. You will pay the most if you use a non-participating provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use a non-participating provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

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

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
		20% coinsurance for all other physicians			
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	20% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge / first 3 upfront visits / year; 20% coinsurance after 3 upfront visits	20% coinsurance	40% coinsurance	First 3 upfront visits combined for primary care and behavioral health services.
	Inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	40% coinsurance	130 visits / year
	Rehabilitation services	20% coinsurance	20% coinsurance	40% coinsurance	77 visits / year for all habilitation and outpatient rehabilitation services Includes physical therapy, occupational therapy, speech therapy and neurodevelopmental therapy services. Neurodevelopmental therapy limited to individuals under age 18.
	Habilitation services	20% coinsurance	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	20% coinsurance	40% coinsurance	120 inpatient days / year

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
	Durable medical equipment	20% coinsurance	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	20% coinsurance	40% coinsurance	14 respite inpatient or outpatient days / lifetime
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	

Excluded Services & Other Covered Services:

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

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

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

- Abortion
- Acupuncture, 12 visits / year
- Bariatric surgery, 1 surgery / lifetime
- Chiropractic care, 20 visits / year
- Hearing aids (individuals up to age 19, or individuals 19 years of age up to age 26 and enrolled in a secondary school or an accredited educational institution), 1 per ear / year
- 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	**2,500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,460**

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

The plan's overall deductible	**$2,500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

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

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

The plan's overall deductible	**$2,500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,560**

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, koji' 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)

Guided Access to Excellent Surgical Care

What is SurgeryPlus?

SurgeryPlus provides you with access to excellent and affordable care for many planned surgical procedures. It's already included in your CIS Benefits medical plan administered by Regence at no additional cost to you.

Did you know...

- PPO Plans: There will be no cost for your surgery.
- HDHP Plans: The cost of your surgery will be significantly reduced.

The SurgeryPlus Difference

Excellent Care

Access to our network of thousands of highly qualified surgeons

Impactful Savings

Your surgery will be at little or no cost to you when you use your SurgeryPlus benefit

Guided Support

Your personal Care Advocate will support you every step of the way through your care

Here's what's covered

In partnership with CIS Benefits, we cover the most expensive costs associated with surgery, so you'll pay less for your procedure when you use your SurgeryPlus benefit. Your coverage includes:

- Consults and appointments with your SurgeryPlus surgeon
- Anesthesia
- Procedure and facility (hospital) fees
- Dedicated support and guidance

Commonly Covered Procedures

- Spine
- Orthopedic
- Ear, Nose & Throat
- Cardiac
- Gynecology
- General Surgery
- Gastrointestinal
- Spine and Ortho Injections
- Bariatrics

Your medical coverage may require you to use your SurgeryPlus benefit for specific procedures. Call to learn more.

You deserve excellent and affordable surgical care.

Call us to learn more at 833.603.0511

Email: CISBenefits@SurgeryPlus.com
Website: CISBenefits.SurgeryPlus.com

cis benefits
cisbenefits.org

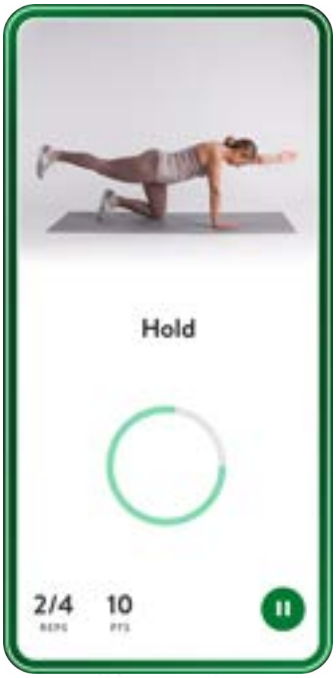
Surgery Plus

Hinge Health

Ready, set, enroll!

Open enrollment is here!

Join Hinge Health for exercise therapy without leaving home. No copays. No office visits. Reduce your back and joint pain in just 15 minutes a day. Best of all, there's no cost to you — **your Hinge Health benefit is 100% covered by CIS Oregon.**



Join Hinge Health to:

- Overcome pain or limited movement
- Recover from a recent or past injury
- Keep your joints healthy and pain free

Scan the QR code to enroll now!
hinge.health/cisoregon-oe
Questions? Call (855) 902-2777

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

Your one-stop-shop for managing your health

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

BeyondWell℠

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

MDLIVE

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

Healthy Benefits

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

VSP: Vision

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

Telehealth

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

Express Scripts

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

Mental health support

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

Pregnancy program

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

Hinge Health

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

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

Start with your CIS Health Manager!

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

Regence

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

cis benefits
cisbenefits.org

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-OR-860116-23-23/09

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).

Know your behavioral health options

If you or your loved one is facing a behavioral health challenge, we want to make it as easy as possible to get care. You can find in-network providers at regence.com. (Some services aren't available on narrow network plans.)

Help is available. No referral is needed.

Thoughts of suicide? Call 988—National Suicide and Crisis Lifeline—available 24/7.

Go to regence.com to find a doctor and look for these in-network options:

- Private practitioners with a variety of expertise, such as psychiatrists, psychologists, social workers, licensed counselors and more
- Inpatient care
- Outpatient programs

Also available are:

- AbleTo Therapy+ for a unique, 8-week series of one-on-one therapy sessions by phone or video, with digital tools for support between sessions: **AbleTo.com** or 1-866-287-1802
- Charlie Health telehealth for treating teens and young adults with behavioral health needs: **charliehealth.com**
- Equip telehealth for treatment of all eating disorders as well as co-existing conditions like anxiety and depression for ages 6 to 24: **equip.health**
- NOCD for app-based care specializing in treatment of obsessive-compulsive disorders: **treatmyocd.com**
- Talkspace for app-based care specializing in counseling for general behavioral health needs: **talkspace.com**

If your company offers an EAP program for urgent help, this may be a good place for you to start to get care. Talk to your Human Resources representative for further information.

You can also turn to these in-network providers for substance use disorder support:

- Boulder Care for inpatient and outpatient treatment: **boulder.care** or 1-866-901-4860
- Eleanor Health for outpatient treatment: **eleanorhealth.com** or 1-781-487-1070 (only available in Washington)
- Hazelden Betty Ford for inpatient and outpatient treatment: **hazeldenbettyford.org** or 1-877-859-2124

Only available in Washington:

- Quartet is a platform that can make it simpler to find the correct provider for your needs: **Quartethealth.com**
- Headway connects you to in-person and virtual providers within your network: **headway.co**

Commonly treated behavioral health issues:

Behavioral health issues often involve more than one concern that affect overall health and happiness. Experts can help sort through what can be the most effective treatment path for the following:

- Substance use and abuse
- Trauma and post-traumatic stress disorder (PTSD)
- Anxiety and depression
- Eating disorders
- Obsessive compulsive disorder (OCD)

Customer Service

You can call our award-winning team, Monday through Saturday, at the phone number listed on the back of your member ID card.

We're here to help you:

- Understand your benefits
- Check claim status or get an explanation of benefits
- Find an in-network provider

Regence

Resource information is current as of April 2023.

Boulder Care is a separate company that provides substance abuse and addiction treatment services. AbleTo and Talkspace are separate companies that provide mental health telehealth services.

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-OR-104078-23/04

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Regence

MDLIVE

Easy, convenient quality healthcare

With MDLIVE you and your covered family members have 24/7 access to board-certified doctors who are specially trained in virtual care.

Our doctors have more than 15 years' experience and are ready to help you with a variety of minor medical conditions, when and where it is convenient for you.

Talk to a doctor or schedule a visit today.

OUR DOCTORS TREAT OVER 50 MINOR MEDICAL CONDITIONS DAILY

- Allergies
- Common Cold
- Constipation
- Cough
- Diarrhea
- Ear Pain
- Fever
- Flu
- Headaches
- Insect Bites
- Nausea
- Pink Eye
- Rash
- Respiratory Issues
- Sore Throat
- Sinus Infections
- Urinary Tract Infection (Female, 18+)
- Vomiting
- And more

STEP 1

FIND A VIRTUAL DOCTOR

You can see a doctor right away or schedule your appointment for a time that works best for you.

Search through our network of board-certified doctors and choose the one that's right for you. You can see doctor photos, bios, and specialty.

STEP 2

START YOUR VISIT

Speak to a doctor on the phone or via video.

You'll be asked for photos, if appropriate, of your condition and to fill out a short questionnaire before your visit. Then your doctor will talk to you about your symptoms and recommend a treatment.

They will even send a prescription to your pharmacy, if appropriate.

STEP 3

FEEL BETTER

Our goal is to get you back on your feet faster.

You can have a virtual doctor visit at a time that's convenient for you, get your prescription filled quickly, and start on your path to being symptom-free.

Download the app.
Join for free. Visit a doctor.

MDLIVE.com/regence-or
888-725-3097

Regence

OREGON

REGENCE PREGNANCY PROGRAM

Get ready for baby with the Regence Pregnancy Program

We're here to help you get the information and support you need to prepare for delivery and care for your new baby. Download the Regence Pregnancy Program app (find it in the App Store or on Google Play) to track milestones and find answers to all your pregnancy and new-parent questions.

With the Regence Pregnancy Program, you'll receive:

Seasonal pregnancy newsletters

A maternity nurse care manager who'll be there to support you every step of the way

Help understanding and following your doctor's or midwife's advice

24/7 access to our toll-free maternity nurse advice line

Download the Regence Pregnancy Program app to get the information and support you need for your pregnancy and your new baby.

Get the Regence Pregnancy Program app and you can:

Read helpful articles and watch videos about pregnancy, caring for your baby and child development

See your weekly to-dos for each trimester

Write down questions to ask your doctor or midwife (and share those notes with loved ones)

Use helpful tools for pregnancy and after delivery, including feeding and growth trackers

Track your baby's development milestones from ages 0-2

Want more information? Email us at CaseManagement@regence.com or call 1 (888) JOY-BABY (1-888-569-2229).

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

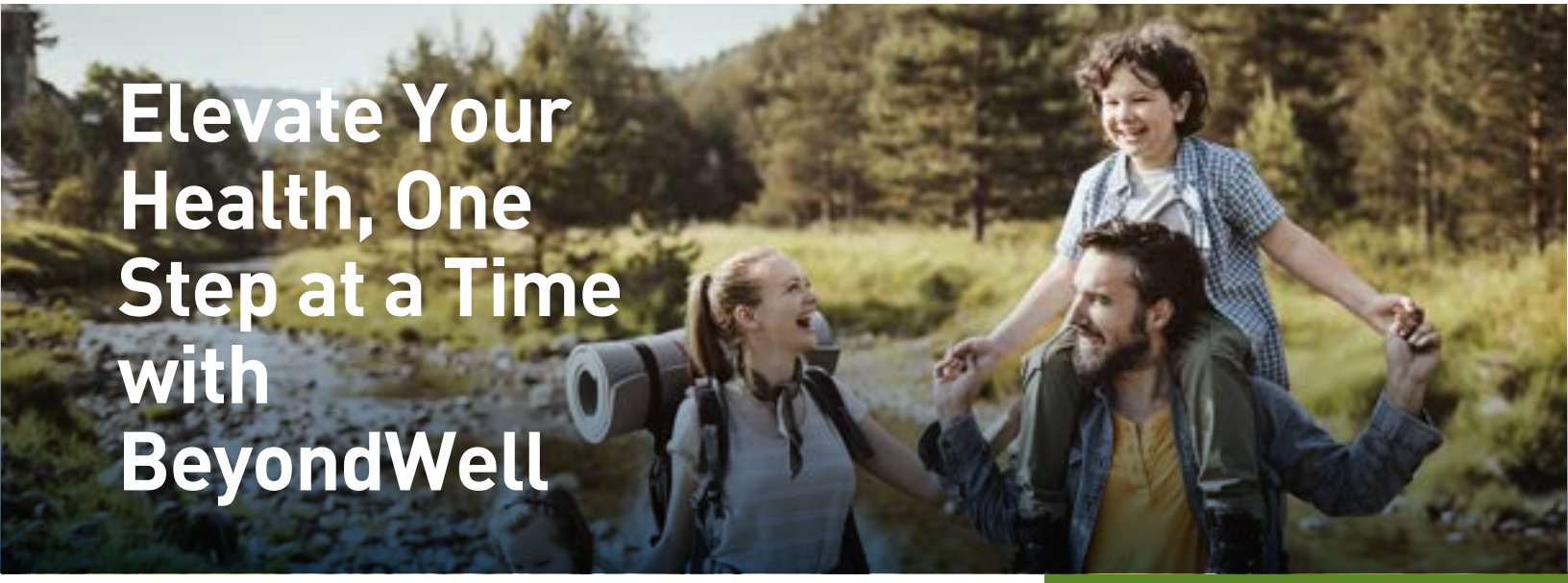
Regence BlueCross BlueShield of Oregon
100 SW Market Street | Portland, OR 97201

REG-OR-924180-22/11-Member-Flyer

BeyondWell™

cis benefits
cisbenefits.org

Regence Member



Elevate Your Health, One Step at a Time with BeyondWell

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

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

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

Our BeyondWell program is available now and continues into 2024–and Regence members and eligible spouses can **earn up to $150** in electronic gift cards. Engage throughout each year to maximize your rewards!

Get started today!

Regence members

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

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

$5 BeyondWell™

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

Earn up to $150 in rewards for healthy activities:

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

Flip to learn more about our 2024 program

2024

Below you'll see all the ways you and your qualified spouse on the Regence health plan can earn up to **$150** each in Amazon.com* electronic gift cards in 2024.

$5 Sync a device or app

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

$1 Verified steps through device

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

$5 Download the BeyondWell app

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

$5 Register on Regence.com

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

$15 Personal challenge

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

$20 Flu or COVID-19 Vaccination

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

$25 Health assessment

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

$30 Interactive self-guided program

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

$30 Vision exam

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

$30 Preventive exam

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

$30 Dental exam

Complete a preventive dental exam and earn $30.[2]

$50 Regence Pregnancy Program

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

$50 Chronic condition coaching

Enroll and engage in Chronic Condition Coaching in 2024 and earn a $50 incentive! If you are eligible for the program you will be outreached to directly.

$15 Attend a webinar

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

EAP Webinars

Intro to Emotional Intelligence	*Jan16 @ 10am*
Eating for Mind & Body Health	*Apr 4 @ 1pm*
Work/Life Balance	*Aug 27 @ 9am*
Stress Management	*Nov14 @ 2pm*

BeyondWell Webinars

Make Your Heart Beet	*Feb 8 @ 11:30am*
Movement for Improvement	*Jun13 @ 11:30am*
Health Myths & Facts	*Aug22 @ 11:30am*
Holiday Treats & Sweets	*Oct24 @ 11:30am*

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

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

BeyondWell™

CHS-670343-21/09-REG

cis benefits
cisbenefits.org

CIS Dental Plan II
Effective January 1, 2024

How to use this dental plan

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

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

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

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

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

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

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

MEMBER SERVICES

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

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

DELTA DENTAL
Delta Dental of Oregon & Alaska

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

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

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

ADVANTAGES

* **Freedom to choose your dentist:** Delta Dental is unique in that we have contracts with more than 2,300 licensed Premier providers in Oregon and 153,000 nationwide. More than 1,200 are also PPO providers in Oregon and 114,000 nationwide.

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

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

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

DELTA DENTAL

Delta Dental of Oregon & Alaska

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

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

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

DELTA DENTAL®

Quality coverage for your smile

When all you need is dental insurance, we've got you covered.

With the Delta Dental of Oregon plan, you get great benefits with access to one of the nation's largest provider networks.

By connecting you to thousands of quality dentists in Oregon and nationwide, you have the freedom to choose dentists from the Delta Dental PPO™ or Delta Dental Premier® network. Plus, when you choose an in-network provider, you'll **save more** and pay less out-of-pocket for your dental care.

Delta Dental PPO™ Network

1. More cost control
2. One of the largest PPO networks in Oregon and nationwide
3. Access 1,200+ dentists in Oregon and 113,000+ nationwide

Delta Dental Premier® Network

1. Broader choice of providers
2. One of the largest dental networks in Oregon and nationwide
3. Access 2,300+ dentists in Oregon and 153,000+ nationwide

Save when you stay in network

Delta Dental dentists agree to provide services at our contracted fees. This means they cannot charge you more than the fee they've agreed to. As a result, when you see an in-network dentist you save money and pay less out-of-pocket for your care. If you see providers outside the network, you may pay more for care.

Get extra care!

When it comes to oral health, we know some people need more care than others. CIS plans include special programs like Health through Oral Wellness®, which offers extra benefits to members with a greater risk for oral diseases.

Using a clinical oral health assessment to find out your risk of tooth decay, gum disease and oral cancer, you may qualify for oral hygiene or nutritional counseling, fluoride treatments, and tobacco cessation counseling.

Visit **deltadentalor.com/oralwellness/members** to learn more about the program and take a free oral health risk self-assessment.

Questions?

For questions about the Delta Dental of Oregon plan, please call our customer service team at **844-721-4939** (TTY users, dial 711).

DELTA DENTAL®

Health through Oral Wellness®

When it comes to oral health, we know some people need more care than others. Delta Dental of Oregon's Health through Oral Wellness® program offers extra benefits to members who have a greater risk for oral diseases.

The program uses an oral health assessment to find out your risk of tooth decay, gum disease and oral cancer. Based on your risk score, you may qualify for additional cleanings, fluoride treatments, sealants and periodontal maintenance.*

With extra benefits and related care, you can:

- Take charge of your oral health
- Prevent oral health issues before they happen
- Access resources to manage your oral health
- Learn how to achieve and maintain better oral wellness

Ready to get started?

Follow these simple steps to see if you qualify:

1. Visit deltadentalor.com/oralwellness/members to learn more about the program and take a free oral health risk self-assessment. You can choose to share your results with your dentist to start the conversation.
2. Talk to your dentist about the program. If they're not registered, ask them to call our toll-free Health through Oral Wellness provider line at 844-663-4433. Once registered, they can perform an oral health risk exam and can let you know if you qualify.
3. To look for providers registered with the program, go to modahealth.com and choose Find Care. Dental providers registered with Health through Oral Wellness will have a badge icon next to their name.

Registered provider badge icon

Still have questions?

We're here to help. Contact our customer service team toll-free at 844-721-4939. TTY users, please call 711. Or visit deltadentalor.com to learn more.

** All enhanced dental benefits are subject to your plan's annual maximum and other limitations.*

Delta Dental is part of the Moda, Inc. family of companies.

Our mission is the same as it was more than 60 years ago — to find a better way to health, every day, for the people and communities we serve.

As a founding member of the Delta Dental Plans Association, we offer affordable, quality dental coverage to people in the Pacific Northwest and beyond.

Delta Dental of Oregon and Alaska

moda

deltadentalor.com

45254112 (10/18)

DELTA DENTAL®

MEMBER DASHBOARD

Get your benefits on the go

As a member, you have a personalized Member Dashboard that puts the information you need at your fingertips.

What's in the Member Dashboard?

The Member Dashboard is a one-stop resource for all you need to get the most out of your plan, including:

- ID cards
- Provider search - including DentaQual provider ratings
- Explanation of Benefits (EOBs)
- Benefits overview
- Claim status
- Customer service contact information
- Healthcare cost estimator

If you don't have a Member Dashboard account, creating one is easy. Go to DeltaDentalOR.com/memberdashboard and click on "Create an Account". Be sure to have your member ID card handy.

OVER →

Access the Member Dashboard on your smartphone

The easiest way to open the Member Dashboard is to add a shortcut on your phone. Anytime you want to access your benefits or resources, just tap the Member Dashboard icon.

On an iPhone

1. Open the browser on your phone and go to DeltaDentalOR.com/memberdashboard
2. From the login screen, tap the Share icon in the menu at the bottom of the screen
3. From the Share menu (scroll right to see more options), choose "Add to Home Screen"
4. Tap "Add" to confirm

Your phone will now have an icon that says "Login|Member Dashboard.

On an Android device:

1. On your phone, go to DeltaDentalOR.com/memberdashboard
2. Using the menu (three vertical dots) at the top of the screen, choose "Add to Home screen"
3. Tap "Add" to confirm
4. On the next screen, choose "ADD AUTOMATICALLY" so the icon will be placed on your phone

Your phone will now have an icon that says "Login|Member Dashboard."

Questions?

We're here to help. Call us toll-free at 844-721-4939. TTY users, please call 711.

DELTA DENTAL®

Quality coverage for your smile

When all you need is dental insurance, we've got you covered.

With the Delta Dental of Oregon plan, you get great benefits with access to one of the nation's largest provider networks.

By connecting you to thousands of quality dentists in Oregon and nationwide, you have the freedom to choose dentists from the Delta Dental PPO™ or Delta Dental Premier® network. Plus, when you choose an in-network provider, you'll **save more** and pay less out-of-pocket for your dental care.

Delta Dental PPO™ Network

1. More cost control
2. One of the largest PPO networks in Oregon and nationwide
3. Access 1,200+ dentists in Oregon and 113,000+ nationwide

Delta Dental Premier® Network

1. Broader choice of providers
2. One of the largest dental networks in Oregon and nationwide
3. Access 2,300+ dentists in Oregon and 153,000+ nationwide

Save when you stay in network

Delta Dental dentists agree to provide services at our contracted fees. This means they cannot charge you more than the fee they've agreed to. As a result, when you see an in-network dentist you save money and pay less out-of-pocket for your care. If you see providers outside the network, you may pay more for care.

Get extra care!

When it comes to oral health, we know some people need more care than others. CIS plans include special programs like Health through Oral Wellness®, which offers extra benefits to members with a greater risk for oral diseases.

Using a clinical oral health assessment to find out your risk of tooth decay, gum disease and oral cancer, you may qualify for oral hygiene or nutritional counseling, fluoride treatments, and tobacco cessation counseling.

Visit **deltadentalor.com/oralwellness/members** to learn more about the program and take a free oral health risk self-assessment.

Questions?

For questions about the Delta Dental of Oregon plan, please call our customer service team at **844-721-4939** (TTY users, dial 711).

DELTA DENTAL®

DELTA DENTAL NETWORKS - OREGON

Use Find Care to locate a dental provider near you

Our provider directory tool can help you save money when seeking care.

Find Care, our online provider directory tool, makes it easy for you to locate an in-network provider by name, provider type, specialty, network, location, gender identity and more. Plus, finding an in-network dental provider that's right for you can also save you out-of-pocket costs.

How to find a provider

1. Visit DeltaDentalOR.com.
2. Under the "Online Tools" drop-down menu, select "Find a dentist".
3. Choose the "In Oregon or Alaska" link or "Outside of Oregon and Alaska" link depending on the state you live in.
4. Under network, choose the Delta Dental PPO or Delta Dental Premier network, which can be found on your member ID card.
5. Under location, enter in a city, state or zip code, and then search.

Save costs when you choose in-network care

Getting quality care is easier and more affordable when you see "in-network" dental providers. These providers agree to accept your insurance at lower rates and meet quality standards. Choosing an in-network dental provider keeps your out-of-pocket costs low.

In-and out-of-network costs

It's important to know you may pay more for services from out-of-network dental providers than from in-network providers. If you choose an out-of-network provider, your benefits only cover a percentage of the maximum plan allowance for these services. Out-of-network providers may also bill you for the difference between the maximum plan allowance and their billed charges. This is known as balance billing. In-network dental providers can't do this. Please see you plan summary or your Member Handbook to learn more about in-network and out-of-network benefits and costs.

Questions?

We're here to help. For questions or help finding a provider, please contact the Delta Dental Customer Service team at 844-721-4939.

DELTA DENTAL®

PREVENTIVE CARE

Think preventive first when it comes to your dental care

Seeing your dentist regularly helps prevent serious and expensive services down the road. As a Delta Dental member, your employer offers a preventive first dental plan.

Under these plans, preventive services do not apply to your annual maximum.

Preventive services may include:

- Routine exams/X-rays
- Regular cleanings
- Periodontal maintenance

By saving on preventive care, you can use your annual maximum for services including:

- Treatment of diseases of the gums
- Fillings
- Oral surgeries
- Crowns
- Dentures and bridges

With your Delta Dental preventive first plan, your employer helps you get greater value out of your dental benefits.

Questions?

We're here to help. For questions, call our dental services team toll-free at 844-721-4939.

Delta Dental Plan of Oregon

DeltaDentalOR.com

DELTA DENTAL®

Know the mouth-body health connection

Research shows that many diseases in our bodies are linked to the health of our mouths. The good news is we can reduce our risk of heart disease, diabetes, cancer and stroke with good oral hygiene.

Prevention is key

When it comes to keeping your mouth and body healthy, regular dental checkups can help you prevent and more easily manage these diseases:

- **Diabetes** — Diabetics need to pay special attention to the health of their mouths. If you have gum disease, you are more likely not to have control of your blood sugar levels. Staying on top of this will help you control diabetes
- **Heart disease** — Studies show that the bacteria that causes periodontal disease are the same bacteria that create hardening of the arteries (plaque buildup)

Bleeding gums are not normal

Bleeding gums are a sign that you need your teeth cleaned, are not cleaning them efficiently, or that there is something else going on in your body that needs attention. When bleeding gums occur, it's time to visit your dentist.

Foods that contribute to cavities

What you eat can contribute to cavities. The following shows how certain foods can impact the health of your mouth:

- **Sticky foods** – Foods that stick into the grooves of our teeth like sticky candy, dried fruit, chips and crackers feed the bacteria that can cause cavities
- **After-meal tips** – Each time you eat or drink, the pH in your mouth becomes acidic for up to 40 minutes. Follow these tips after meals and snacks:
  - Swish your mouth with water after you drink sugary drinks or eat food
  - Tap water is the best drink for your teeth and for hydrating your body

Get extra dental benefits

Delta Dental's **Health through Oral Wellness®** program offers extra preventive care to people with a greater risk for oral diseases.

Learn more at
deltadentalor.com/oralwellness/members

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DELTA DENTAL®

Health through Oral Wellness

When it comes to oral health, we know some people need more care than others. Delta Dental of Oregon's Health through Oral Wellness® program offers extra benefits to members who have a greater risk for oral diseases.

The program uses an oral health assessment to find out your risk of tooth decay, gum disease and oral cancer. Based on your risk score, you may qualify for additional cleanings, fluoride treatments, sealants and periodontal maintenance.

With extra benefits and related care, you can:

- Take charge of your oral health
- Prevent oral health issues before they happen
- Access resources to manage your oral health
- Learn how to achieve and maintain better oral wellness

Ready to get started?

Follow these simple steps to see if you qualify:

1. Visit deltadentalor.com/oralwellness/members to learn more about the program and take a free oral health risk self-assessment. You can choose to share your results with your dentist to start the conversation.
2. Talk to your dentist about the program. If they're not registered, ask them to call our toll-free Health through Oral Wellness provider line at 844-663-4433. Once registered, they can perform an oral health risk exam and can let you know if you qualify.
3. To look for providers registered with the program, go to modahealth.com and choose Find Care. Dental providers registered with Health through Oral Wellness will have a badge icon next to their name.

Registered provider badge icon

Still have questions?

We're here to help. Contact our customer service team toll-free at 844-721-4939. TTY users, please call 711. Or visit deltadentalor.com to learn more.

** All enhanced dental benefits are subject to your plan's annual maximum and other limitations.*

Delta Dental of Oregon and Alaska

OVER →

deltadentalOR.com

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DELTA DENTAL®

PASSPORT DENTAL℠

Take your smile on the road

No matter where in the world you roam, Passport Dental℠ gives you access to great care through your dental plan.

In the states

Wherever you go, your dental plan benefits go with you. Our network, Delta Dental, lets you access over 2,300 dentists in Oregon and over 153,000 dentists across the country. You can choose any licensed dentist, but if you work with a dentist in the network, you'll get great care and better plan benefits.

To find a dentist in the U.S., visit our website and click Find Care. Then, search for dentists in all other states. Or, you can call AXA Assistance toll-free at 888-558-2705, 24 hours a day, seven days a week. Just say you're a Delta Dental plan member. An operator will connect you with a dentist in a flash.

Beyond borders

Whether you're traveling to Australia or Zimbabwe, AXA Assistance is there to help you find quality care. Call them collect at 312-356-5971 any time and tell them you're a Delta Dental plan member.

Please keep in mind that dentists outside of the U.S. are not considered contracted dentists. Nonparticipating and/or out-of-network coverage limits will apply.

OVER →

DELTA DENTAL®

Find a dentist

Inside the U.S.:
Call toll-free at 888-558-2705

Outside the U.S.:
Call collect at 312-356-5971 and tell the operator your are a Delta Dental member.

How do I submit a claim?

When traveling outside the U.S., pay for your treatment and request an itemized receipt. Submit your receipt to us for reimbursement after you get home. For faster payment, make sure you include:

- The dentist's name and address, including country
- Member's name and date of birth
- A description of services performed
- Tooth number(s) and tooth surface(s) treated
- Individual charge for each service, and whether those charges were billed in U.S. dollars or another currency

You'll be paid back according to your plan benefits. Please check your Member Handbook for benefit details.

Questions?

We're here to help. Call our dental services team toll-free.
Oregon: 844-721-4939

MetLife | Accident Insurance

Why Accident Insurance matters

Accidents can happen anytime, anywhere and when you least expect them. While you can't plan for the unexpected, you can **be better prepared financially** with MetLife Accident Insurance.

You've got medical, dental and vision insurance — and possibly a flexible spending account just in case. If you have an accidental injury, you're financially covered, right?

Not entirely. Even the best health insurance may leave you with unexpected costs or medical debt, especially if you have a high deductible health plan or limited network. When faced with these kinds of costs, supplemental coverage from MetLife provides you with additional financial protection.

Help protect yourself, your family and your budget from the financial impact of unexpected injuries.

An example of how accident insurance can help

*Accident Insurance helped Kathy pay some of her bills after she was involved in a hit-and-run. The great thing is that it was paid directly to her — she could use it how she wanted. She needed it especially for gas and the cost of a rental car. Kathy's advice is to always look ahead. It's better to have insurance and not need it, than not have it and need it. We all go through bad things, and hindsight is always 20-20. Take action, don't wait. **

* This is a hypothetical example for informational purposes only. Your costs and savings could vary based on your plan design, where you live, and whether your plan requires a deductible or coinsurance. Please see your Plan Summary for details about your coverage.

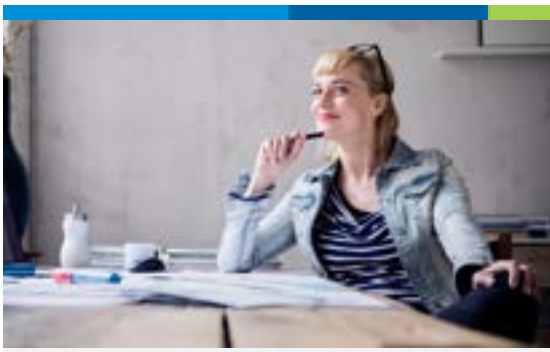
Help supplement your healthcare coverage with Accident Insurance protection.

Receive benefit payments directly and use the funds however you wish

Financial support so you can focus on getting well.

Many people may not be financially prepared to handle extra costs like plan deductibles, co-pays for emergency room care, testing, supplies and out-of-network care. For a covered event,[1] accident insurance provides you with a benefit payment paid directly to you — not to your doctors, hospitals or healthcare providers.

You can spend the funds on anything you need, such as those extra bills when you may most need additional support. It can also help pay for expenses you may not think of, like childcare and transportation to your appointments. These costs can cut into your budget — and make it a challenge to manage your everyday expenses.



When it comes to accidents…

For less than your daily coffee habit,[2] you can gain coverage for you and your family.

Your benefits in action

If you've been involved in an accident,[1] submitting a claim doesn't have to be difficult. Here's what to expect:

Visit **metlife.com/mybenefits** or download the MetLife Mobile App to view your certificate of insurance and initiate your claim.

Answer a few simple questions about what happened and upload your medical documentation to support your claim. Once we have everything, claims are typically processed within 10 business days. You only need one claim form per accident and every claim is reviewed by a claims professional.

Once your claim is approved, you'll receive a check made out to you to use however you like.

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Supplement your healthcare coverage with MetLife Accident Insurance.

Product overview	Accident Insurance pays out a lump sum if you incur an injury as a result of an accident.
Why needed?	These benefits may supplement both health and disability insurance. A benefit payment can be used to pay for expenses that your health insurance doesn't cover — or it can provide additional financial support if a covered event causes you to lose income due to being out of work.
Who is covered	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. • Employee Only • Employee & Spouse • Employee & Child(ren)[3] • Employee & Family
Covered services	**Pays for different injuries, including:** • Fractures[4] • Dislocations[4] • Eye injuries • Skin grafts • Broken teeth • Concussions • Cuts or lacerations • Second- and third-degree burns • Coma **Includes an array of medical services and treatments:[1]** • Ambulance • Emergency care • Inpatient surgery • Outpatient surgery • Medical testing benefits (including X-rays, MRIs, CT scans) • Physician follow-up visits • Transportation • Home modifications • Therapy services (including physical, occupational and speech therapy) **Please see your Plan Summary for details.**
Guaranteed coverage	You and your family members are guaranteed[5] coverage as long as you are actively at work. There are no medical exams to take and no health questions to answer.

Frequently Asked Questions

How does the payment work?

A. **We make benefit payments directly to you —** not to doctors, hospitals or healthcare providers. The amount you receive is paid regardless of any other insurance you might have.

You can spend your benefit payment however you like. Use it to help pay for medical plan deductibles and co-pays, out-of-network care, or even your family's everyday living expenses. Whatever you need while recovering from an accident or injury, Accident Insurance is there to help make life a little easier.

I have a good medical plan at work, so why do I need Accident Insurance?

A. Even the best medical plans can leave you with extra expenses to pay for services that aren't covered, like plan deductibles, co-pays and costs for out-of-network care. Having this extra financial support may mean less worry for you and your family.

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

A. **Yes. Your accident coverage is guaranteed**[5] 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.

How much will it cost?

A. **Accident Insurance may be more affordable than you think.** It is designed to be an economical way to supplement your healthcare plan. Exact rates can be found in the enrollment materials provided by your employer.

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 a check or missing payments.

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.

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.[6]

Enroll in Accident Insurance during annual enrollment.

Please see your Plan Summary for more information.

1. 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.
2. https://www.numbeo.com/cost-of-living/country_result.jsp?country=United+States. Copyright 2023.
3. Children may be covered to age 26.
4. Chip fractures are paid at 25% of Fracture Benefit and partial dislocations are paid at 25% of Dislocation Benefit.
5. 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.
6. 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

ADF# AI2642.21

MetLife | Accident & Health

citycounty insurance services

Discover your Health Screening Benefits

Health screenings are an important part of managing your health. That's why your Accident Insurance, Critical Illness Insurance, and Hospital Indemnity Insurance coverage from MetLife provides a $50 Health Screening Benefit[1] (HSB) for covered screenings and tests. Now, everyone who's enrolled — you, your spouse, and dependent children — can earn a benefit just for taking care of his or her health.

At least 68% of the annual colorectal cancer deaths in the U.S. could be prevented with recommended screenings.[2]

For women in their 40s and 50s, **annual mammogram screenings decrease breast cancer deaths** by 15 to 29%.[3]

Examples of covered screening and prevention tests may include **a blood test to determine total cholesterol, a blood test to determine triglycerides, an endoscopy, or a colonoscopy**. For a complete list of what's covered, please see a copy of your certificate.

Here's an example of how it works.

Susan's doctor conducts a blood test to determine total cholesterol, which is one of the many screenings or tests covered by MetLife.
Afterward, Susan contacts MetLife by calling 1-800-GET-MET8 to submit her HSB claim. All Susan needs to provide is her physician's name, phone number and address, plus the test and the date it was completed. A check for Susan's HSB benefit payment is on the way within a few business days once her claim is processed. It's that easy!

Claiming your Health Screening Benefit (HSB) is as simple as 1-2-3.

1. Visit MyBenefits at www.metlife.com/mybenefits or call 1-800-GET-MET8 (800-438-6388) 8am-8pm EST. You can also file a claim using the MetLife Mobile App!

2. Provide a few details, including:

- The name of the Insured, SSN or EEID, Group Name, Certificate Number
- What date did you have your test?
- What was the test you had completed?

3.Receive your HSB payment. (If submitting via MyBenefits, payment can be made via EFT. Checks are typically issued within a few business days once your claim has been processed)

You can submit claims for your spouse and/or dependent children. No hard copy proof is ever required! Please refer to your certificate of coverage for details on the health screening benefit and which tests are applicable based on your coverage.

Add claiming your MetLife Health Screening Benefit to your annual good health to-do list.

For complete details, including covered screenings and tests, please see your insurance coverage certificate on the *MyBenefits* portal at www.metlife.com/mybenefits, or the MetLife Mobile App.

1. For Accident Insurance and Hospital Indemnity Insurance only -- The Health Screening Benefit is not available in all states. For Texas sitused policies and Texas residents covered under policies sitused in other states, when the Health Screening Benefit is included in an Accident-only plan, the covered screening measures are: physical exam, blood chemistry panel, complete blood count (CBC), chest x-rays, electrocardiogram (EKG), and electroencephalogram (EEG).The Health Screening Benefit is not available in all states. Covered screening measures vary by state. See your insurance certificate for details, including any applicable waiting periods. For Critical Illness Insurance only -- The Health Screening Benefit is not available in certain states. Please review your Disclosure Statement or Outline of Coverage/Disclosure Document for specific state variations and exclusions around this benefit.
2. Center for Disease Control and Prevention. Cancer, Colorectal. https://www.cdc.gov/cancer/colorectal/ Source date: February 17, 2022.
3. Mayo Clinic. Test and Procedures: Mammogram. Sandhya Pruthi, M.D. June 25, 2021. http://www.mayoclinic.org/tests-procedures/mammogram/expert-answers/mammogram-guidelines/faq-20057759

MetLife

MetLife | Critical Illness Insurance

Help protect yourself, your family and your budget from the financial impact of a critical illness.

Why Critical Illness Insurance matters

Contrary to what many people believe, medical insurance may only cover a portion of the expenses associated with treating a serious illness. Plus, additional costs that often come with recovering, like childcare, transportation, and grocery delivery, may be left up to you. Critical Illness Insurance can provide you with a benefit that can help you pay for unexpected costs, such as those that your existing medical insurance may not cover.

Handling the emotions that come up when experiencing illnesses such as a cancer[1] diagnosis, heart attack,[2] or stroke[3] is difficult enough. Worrying about your financial stability on top of this can obviously be overwhelming. With Critical Illness Insurance, MetLife can help you and your family have the financial stability necessary to completely focus on healing during a difficult time.

When critical illness affects your family, you'll have the financial support when it matters most.

An example of how Critical Illness Insurance can help.

*"Tricia never would have expected to suffer a heart attack. But one day while teaching English class, she felt an intense shortness of breath and pain in her jaw. Luckily, the school nurse called 911. The last thing Tricia needed was to worry about finances — she just had to focus on getting better. Critical Illness Insurance helped Tricia pay for things that medical insurance didn't cover, like specialist co-pays and extra help around the house, while she recovered.**

Enroll in Critical Illness Insurance during annual enrollment.

Help supplement your healthcare coverage with Critical Illness Insurance.

Receive benefit payments directly and use the funds however you wish.

Financial support so you can focus on getting well.

Critical Illness Insurance is coverage that can help safeguard your finances by providing you with a lump-sum benefit payment — one convenient payment all at once — when you or your family may need it most. The extra money can help you focus on getting back on track — without worrying about finding the money to cover some of your expenses.

And best of all, the benefit payment is made directly to you, and is made regardless of any other insurance you may have. It's yours to spend however you like, including for your or your family's everyday living expenses.

While recovering, Critical Illness Insurance is there to help make things a little easier.

When it comes to critical illnesses…

For less than the cost of your daily coffee,[4] you can get coverage for you and your family.

Get financial support when you or a loved one becomes seriously ill.

Your benefits in action

If you experience a critical illness, submitting a claim doesn't have to be difficult. Here's what to expect:

Call, visit **metlife.com/mybenefits**, or download the MetLife Mobile App to view your certificate of insurance and initiate your claim.

Answer a few simple questions about what happened and upload your medical documentation to support your claim. Once we have everything, claims are typically processed within 10 business days. You only need one claim form per critical illness and every claim is reviewed by a claims professional.

Once your claim is approved, you'll receive a check made out to you to use however you like.

Supplement your healthcare coverage with MetLife Critical Illness Insurance.

Benefit overview	Critical Illness Insurance is coverage that can help safeguard your finances by providing you with a lump-sum payment — one convenient payment all at once — when you or your family may need it most.
Why needed	Pay for whatever you need, such as expenses that may not be covered by your main medical plan(s). For example: co-pays, deductibles, childcare, mortgage, groceries and experimental treatments.
Who is covered	You can enroll both yourself and eligible family members.[5] All you need to do is enroll during your enrollment period and be actively at work.[6] • Employee Only • Employee & Eligible Family Members
Covered conditions	If you meet the group policy and certificate requirements, **Critical Illness Insurance provides you with a lump-sum payment upon a verified diagnosis of conditions including**: • Cancer[1] • Kidney failure • Heart attack[2] • Stroke[3] **Please see your Plan Summary for details.**
Guaranteed coverage	You and your family members are guaranteed[6] coverage as long as you are actively at work. There are no medical exams to take and no health questions to answer.

Frequently Asked Questions

I have a medical plan at work, so why do I need Critical Illness Insurance?

A. 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. Many people aren't prepared to handle the extra costs that can come with a critical illness, so having this extra cash as a lump-sum payment may mean less worry for you and your family.

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

A. **Yes. Your critical illness coverage is guaranteed,**[6] regardless of your health. You 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 think.

Are benefits paid directly to me or my healthcare provider?

A. **Benefits will be paid directly to you,** not to the doctors, to the hospitals, or to any other healthcare providers. There's no need to coordinate with any other insurance you may have. Benefits are paid no matter what your other insurance plans may cover or pay.

When does my coverage begin?

A. **Your coverage starts on the effective date.** There are no waiting periods for Critical Illness Insurance benefits to begin.

How do I pay for my coverage and how much will it cost?

A. **You pay premiums through payroll deductions,** so you don't have to worry about writing any checks or missing payments. **Critical Illness Insurance may be more affordable than you think.** It's designed to be a way to supplement your healthcare and disability plans. Exact rates can be found in the enrollment materials provided by your employer.

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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.[7]

Enroll in Critical Illness Insurance during annual enrollment.

Please see your Plan Summary for more information.

* This is a hypothetical example for informational purposes only. Your costs and savings could vary based on your plan design, where you live, and whether your plan requires a deductible or coinsurance. Please see your Plan Summary for details about your coverage.

1. Please review the certificate for specific information about cancer benefits. In most states, not all types of cancer are covered.
2. The Heart Attack Covered Condition pays a benefit for the occurrence of a myocardial infarction, subject to the terms of the certificate. A myocardial infarction does not include sudden cardiac arrest.
3. In certain states, the Covered Condition is Severe Stroke.
4. https://www.numbeo.com/cost-of-living/country_result.jsp?country=United+States. Updated July 2021.
5. Eligible Family Members means all persons eligible for coverage as defined in the Certificate.
6. 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.
7. 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 CRITICAL ILLNESS INSURANCE (CII) IS A LIMITED BENEFIT GROUP INSURANCE POLICY. Like most group accident and health insurance policies, MetLife's CII policies contain certain exclusions, limitations and terms for keeping them in force. Product features and availability vary by state. There may be a preexisting condition exclusion. There may be a Benefit Reduction Due to Age provision. There may be a Benefit Suspension Period between recurrences of the same Covered Condition or occurrences of different Covered Conditions. MetLife offers CII on both an Attained Age basis, where rates will increase when a Covered Person reaches a new age band, and an Issue Age basis, where rates will not increase due to age. Rates are subject to change. MetLife reserves the right to raise premium rates for Issue Age CII on a class-wide basis. A more detailed description of the benefits, limitations, and exclusions applicable to MetLife's CII product can be found in the applicable Disclosure Statement or Outline of Coverage/Disclosure Document available at time of enrollment. For complete details of coverage and availability, please refer to the group policy form GPNP07-CI, GPNP09-CI, GPNP10-CI, GPNP14-CI, GPNP19-CI or contact MetLife for more information. Please contact MetLife for more information. Benefits are underwritten by Metropolitan Life Insurance Company, New York, New York.

MetLife's Critical Illness Insurance is not intended to be a substitute for Medical Coverage providing benefits for medical treatment, including hospital, surgical and medical expenses. MetLife's Critical Illness Insurance does not provide reimbursement for such expenses.

MetLife

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

ADF# CI2655.21

MetLife | Hospital Indemnity Insurance

Why Hospital Indemnity Insurance matters

Hospital[1] stays can be pricey and often unexpected. Studies show that the average cost of a three-day hospital stay in the U.S. is $30,000.[2] Even quality healthcare plans don't cover all expenses, so taking steps to help protect yourself can make a big difference.

While in the hospital, it's likely you'll need various treatments, tests and therapies to get up and about again. Expenses like plan deductibles, co-pays for doctor visits and extra costs for out-of-network care can add up fast. Having help with the financial support you may need when the time comes means less worry for you and your family.

In addition, unexpected hospital bills can be difficult to manage when you lose your income or when your income becomes seriously reduced because of an injury or illness. Household expenses like your mortgage or rent payments, car payments, childcare payments, or household maintenance costs may become even harder to keep up with while you focus on recovering.

Help protect yourself, your family and your budget from the financial impact of a hospital stay.

How Hospital Indemnity Insurance can help.

*I was driving to work when I was hit by a large truck. My car was totaled, I was injured, and an ambulance had to take me to the emergency room. I was admitted to the Intensive Care Unit and, after two days, moved to a standard room for five more days. I was then transferred for inpatient care at a rehab facility[3] for a week. I was panicking about how I was going to pay my hospital, ambulance and other medical bills not covered by my health insurance. But luckily, the lump sum payment I received from my Hospital Indemnity Insurance helped me pay for those costs, plus other expenses like rent and groceries.**

Help supplement your healthcare coverage with Hospital Indemnity Insurance.

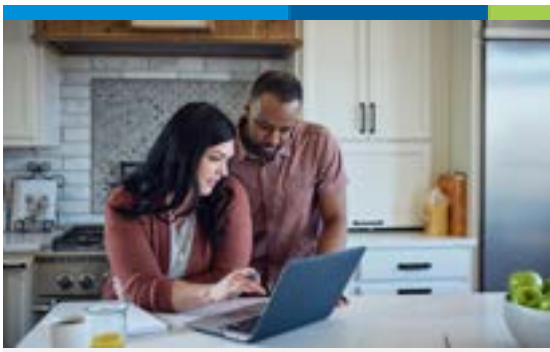
Receive benefit payments directly to help prevent financial stress.

How this coverage works

Hospital Indemnity Insurance can help safeguard your finances by providing you with a lump-sum benefit payment — one benefit payment all at once — when you or your family may need it most. A flat amount is usually paid for a hospital admission[4] and a per-day amount for your entire hospital stay[5].

And best of all, the payment is made directly to you regardless of any other insurance you may have. It's yours to spend however you like, including for your or your family's everyday living expenses.

Whatever you need while recovering from a hospital stay, Hospital Indemnity Insurance is there to help make life a little easier.



When it comes to hospital stays…

For less than the cost of your daily coffee,[6] you can get coverage for you and your family.

Your benefits in action

If you are admitted to the hospital, submitting a claim doesn't have to be difficult. Here's what to expect:

Visit **metlife.com/mybenefits** or download the MetLife Mobile App to view your certificate of insurance and initiate your claim.

Answer a few simple questions about what happened and upload your medical documentation to support your claim. Once we have everything, claims are typically processed within 10 business days.[7] You only need one claim form per hospital admission and every claim is reviewed by a claims professional.

Once your claim is approved, you'll receive a check made out to you to use however you like.

Coverage to help pay for expenses associated with hospitalizations that may not be covered under your medical plan.

Supplement your healthcare coverage with MetLife Hospital Indemnity Insurance.

Benefit overview	Hospital Indemnity Insurance pays you benefits when you are confined to a hospital, whether for planned or unplanned reasons.[4]
Why needed?	This benefit may be used to supplement both health insurance and disability insurance if a covered incident causes you to have expenses that your health insurance doesn't cover regardless of any other insurance you may have — or causes you to lose income due to being out of work.
Who is covered	Choose which plan best suits you: • Employee • Employee + 1 Dependent Employee + 2 or more Dependents
Covered services	This plan provides benefits for hospitalization due to accidents and sicknesses,8 such as: • Admission to a hospital4 • Hospital stays A flat amount is paid for the day that you're admitted to a hospital, and a per-day amount is paid for each day of a covered hospital stay, from the very first day of your stay or if your plan includes an Admission benefit, confinement begins on Day 2.5 **Please see your Plan Summary for details.**
Guaranteed coverage	You and your family members are guaranteed[9] coverage as long as you are actively at work. There are no medical exams to take and no health questions to answer.

Frequently Asked Questions

I have a medical plan at work, so why do I need Hospital Indemnity Insurance?

A. **Hospital stays can be pricey and are often unexpected.** Even the best medical plans can leave you with extra expenses to pay or with services that just aren't covered such as plan deductibles, co-pays and extra costs for out-of-network care. Having this extra financial support when the time comes may mean less worry for you and your loved ones.

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

A. **Yes. Your coverage is guaranteed,**[9] 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.

How much will coverage cost and how do I pay for it?

A. Hospital Indemnity Insurance may be more affordable than you think. It's designed to be a way for you to supplement your healthcare plan. Exact rates can be found in the enrollment materials provided by your employer. **You pay premiums through payroll deductions,** so you don't have to worry about writing any checks or missing payments.

When does my coverage begin?

A. **Your coverage starts on the effective date.** There are no waiting periods for it to begin.

Are benefits paid directly to me or my healthcare provider?

A. **Payments go directly to you,** not to the doctors, to the hospitals or to any other healthcare providers. And to make things even easier, the check is made payable to you. There's no need to coordinate with any other insurance you may have. Benefits are paid no matter what your other insurance plans may cover.

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 so long as you continue paying your premiums.[10]

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.[7]

Enroll in Hospital Indemnity Insurance during annual enrollment.

Please see your Plan Summary for more information.

* Benefit amount is based on sample plan design. Actual plan design and plan benefits may vary.

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. Why health insurance is important: protection from high medical costs. https://www.healthcare.gov/why-coverage-is-important/protection-from-high-medical-costs/. Accessed September 2022.
3. Inpatient Rehabilitation Unit Benefit is standardly applied for covered Accidents only. It is available as an add-on for Sickness.
4. The Admission Benefit is not payable for Emergency Room treatment or outpatient treatment. The payment of the admission benefit requires a Confinement. Hospital Confinement requires the assignment to a bed as a resident inpatient in a Hospital (including an Intensive Care Unit of a Hospital) on the advice of a Physician or confinement in an observation area within a Hospital for a period of no less than 20 continuous hours on the advice of a Physician. Please consult your Certificate for details.
5. When plan incudes an Admission Benefit, the Confinement begins on Day 2.
6. https://www.numbeo.com/cost-of-living/country_result.jsp?country=United+States Accessed September 2022.
7. Applies only to "clean" claims. A clean claim is a claim submitted with all the required information necessary to process the claim — no missing information requiring additional follow up with the subscriber. It generally takes 10 business days to process "clean" claims.
8. Covered services/treatments must be the result of a covered accident or sickness as defined in the group policy/certificate. There is a pre-existing exclusion for covered sicknesses. See your Disclosure Statement or Outline of Coverage/Disclosure Document for full details.
9. 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 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.
10. 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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Video Links

Product Videos:

Accident

Critical Illness

Hospital Indemnity

On Demand Presentations:

MyBenefits

How to File an Accident & Health Claim

MetLife

Accident | Critical Illness | Hospital Indemnity

CIS
citycounty insurance services

How to submit a MetLife Accident, Hospital Indemnity or Critical Illness claim

Submitting an Accident, Hospital Indemnity or Critical Illness claim doesn't have to be challenging. Below you'll find the information and tools you need to make the process as smooth as possible.

How to submit an Accident, Hospital Indemnity or Critical Illness claim online
Submitting a claim is as simple as 1-2-3:

1

Visit **mybenefits.metlife.com** or download the **MetLife Mobile App** to view your certificate of insurance and to initiate your claim* or call 866-626-3705 to obtain a claim form*.

2

Answer some questions about your claim and upload your medical documentation to support your claim. The whole process takes just minutes!

3

Visit **MyBenefits** or your **MetLife Mobile App** frequently to check claim status, letters and benefit payments.

*For Critical Illness claims, a Physician Statement, which is available on **MyBenefits**, needs to be completed by your physician.

What happens next
A MetLife claims specialist will review your information, request any additional medical information (if necessary), and notify you in writing of a claim decision.

Online claim submission can be hassle-free!
You can register at www.mybenefits.metlife.com or on the MetLife Mobile App. See reverse fordetails.

MyBenefits: easy online claim submission

Benefits of registering to process claims online:

- Faster processing time
- Less paper waste
- Claims can be submitted 7 days a week

MyBenefits is the web portal for MetLife group participants. Once registered, you can log in to:

- Submit a claim and upload medical documentation
- See claim status, history, and payments
- Set up direct deposit of benefits
- Read correspondence from MetLife
- Download claim forms
- View your certificate of insurance and designate beneficiaries

MetLife Mobile App

Employees can also submit and access claim information on-the-go. Our mobile app has the same features as the MyBenefits web portal — employees can register and submit claims online, view claim status, letters and benefit payments.

Download on the App Store | GET IT ON Google Play

Download the MetLife app from the iTunes App Store or Google Play

[Hospital Indemnity Insurance Disclaimer:]
METLIFE'S HOSPITAL INDEMNITY 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. Prior hospital confinement may be required to receive certain benefits. There may be a preexisting condition limitation for hospital sickness benefits. MetLife's Hospital Indemnity Insurance may be subject to benefit reductions that begin at age 65. 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, GPNP13-HI, GPNP16-HI or GPNP12-AX-PASG, or contact MetLife. Benefits are underwritten by Metropolitan Life Insurance Company, New York, New York. In certain states, availability of MetLife's Group Hospital Indemnity Insurance is pending regulatory approval.

[Critical Illness Insurance Disclaimer:]
METLIFE CRITICAL ILLNESS INSURANCE (CII) IS A LIMITED BENEFIT GROUP INSURANCE POLICY. Like most group accident and health insurance policies, MetLife's CII policies contain certain exclusions, limitations and terms for keeping them in force. Product features and availability may vary by state. The plan may include a pre-existing condition exclusion. After a covered condition occurs, there is a benefit suspension period during which benefits will not be paid for a recurrence, except in the case of individuals covered under a New York certificate. MetLife offers CII with either Attained Age or Issue Age rates. Attained Age rates are based on 5-year age bands and will increase when a Covered Person reaches a new age band. MetLife's Issue Age CII is guaranteed renewable, and may include a Benefit Reduction Due to Age provision. Premium rates for MetLife's Issue Age CII are based on age at the time of the initial coverage effective date and will not increase due to age; premium rates for increases in coverage, including the addition of dependents' coverage, if applicable, will be based on the covered person's age at the time of the initial coverage effective date. Rates are subject to change for MetLife's Issue Age CII on a class-wide basis. A more detailed description of the benefits, limitations, and exclusions applicable can be found in the applicable Disclosure Statement or Outline of Coverage/Disclosure Document available at time of enrollment. For complete details of coverage and availability, please refer to the group policy form GPNP07-CI, GPNP09-CI, GPNP10-CI, GPNP14-CI or contact MetLife for more information. Benefits are underwritten by Metropolitan Life Insurance Company, New York, New York. MetLife's Critical Illness Insurance is not intended to be a substitute for Medical Coverage providing benefits for medical treatment, including hospital, surgical and medical expenses. MetLife's Critical Illness Insurance does not provide reimbursement for such expenses.

1. The MetLife Cancer Insurance plan is based on the MetLife Critical Illness Insurance (CII) policy. MetLife Cancer Insurance includes only the Cancer Covered Conditions.

[Accident Insurance Disclaimer:]
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 are benefit reductions that begin at age 65, if applicable. Like most group accident and health insurance policies, policies offered by MetLife may include waiting periods and 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, NY. 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. The policy or its provisions may vary or be unavailable in some states. There is a preexisting condition exclusion for hospital sickness benefits, if applicable. There are benefit reductions that begin at age 65

cis benefits
cisbenefits.org

Short-Term Disability 2024

Short-Term Disability

What is it?

CIS offers Short-Term Disability coverage through MetLife. Employers choose whether to make this coverage available to employees. ***If this option is offered by your employer, you will see this plan available to you in CIS-Connect.***

Short-Term Disability (STD) coverage replaces a portion of your income if you're hurt or sick and unable to work. The cost will vary depending on your age and income.

Benefit Overview

This plan will pay a benefit when an employee loses income due to a qualified sickness or accidental injury. Benefits will begin after a fourteen-day elimination period for up to 13 weeks. The benefit amount payable is 60% of the employee's income with a maximum weekly benefit of $2,000. Benefits will be reduced by income from other sources including, but not limited to: Paid Leave Oregon and any other state or federal retirement or disability program. Benefits will not be offset by employer paid sick or vacation leave.

Elimination (waiting) period: You must be disabled and unable to work for 14 days before benefits are payable.

Benefit duration: Benefits are payable for a maximum of 13 weeks.

QUESTIONS?

Call the CIS Benefits Helpline at 855-763-3829 or email us at cisbenefits@cisoregon.org. CIS Benefits staff are available to help you between 8 a.m. and 5 p.m., Monday through Friday. We will return voicemails and respond to emails within 24 hours.

855-763-3829
cisbenefits@cisoregon.org
www.cisbenefits.org

Other benefits:

- Guaranteed issue at every annual open enrollment — no medical questions asked!
- Telephonic or online claim intake — no paper claims.

How much do I need?

To help you make the right choices, here are some important questions you should ask yourself:

1. Am I eligible for Paid Leave Oregon (PLO) and how much pay am I qualified for through PLO?
    a. You may calculate your potential PLO benefits on the PLO website at https://paidleave.oregon.gov/employees/benefits-calculator.html
2. Keeping in mind my weekly expenses, percent of weekly pay I expect from PLO, and lifestyle, how much incoming pay is an absolute must if I cannot work and collect my regular paycheck?
3. What conditions would I be most likely to experience (e.g., pregnancy, surgery, injury, etc.), and how long might I be out of work?
4. Do I expect to experience more than one PLO event in a 52-week period, with one or more instances of disability?

Why do I need it?

STD insurance is designed to help protect your income. Based on that, consider:

- Health insurance only covers medical bills; it won't pay for groceries or rent.
- Accidents are not the only cause of disability. Back pain, heart disease, and other illnesses are reasons for long-term absences and can happen to anyone.
- Whatever the cause, a disability can mean months being out of work without a paycheck.
- STD insurance can help protect your income and continue to provide for you and your loved ones.

When is coverage effective?

Coverage elected during open enrollment is effective Jan. 1.

Are pre-existing conditions covered?

This plan has a pre-existing clause you should review before electing to enroll. Benefits will not be paid for a disability that results from a pre-existing condition* if the employee has not been actively at work for less than 12 consecutive months after the date their disability insurance takes effect.

***Pre-existing Condition Definition**

A sickness, pregnancy, or accidental injury, for which the employee, in the 6 months before insurance takes effect:

- Received medical treatment, consultation, or care; or
- Took prescription medication or prescribed medication.

Please Note: *The pre-existing conditions clause is waived for those currently enrolled on The Hartford STD plan terminating Dec. 31, 2023.*

What disabilities are not covered?

Benefits will not be paid for any disability:

1. Unless you are under the regular care of a physician;
2. That is caused or contributed to by war or act of war, whether declared or not;
3. Caused by your commission of or attempt to commit a felony;
4. Caused or contributed by being engaged in an illegal occupation;
5. Caused or contributed to by an intentionally self-inflicted injury;
6. For which workers' compensation benefits are paid, or may be paid, if duly claimed; or
7. Sustained as a result of doing any work for pay or profit for another employer, including self-employment.

Short-Term Disability Rates

Rates will be based on your age on Jan. 1, 2024. Rates increase every Jan. 1 if your age category changes during the prior calendar year. **Rates, and benefit payouts, will be calculated based on the salary your employer has reported in CIS-Connect.** Please review your reported salary as listed under the "My Profile" tab in CIS-Connect.

*Rates are based on your age as of Jan. 1, 2024.

Age	Employee Cost/$10
< 44	$0.06
45-49	$0.08
50-54	$0.09
55-59	$0.12
60-64	$0.14
65+	$0.16

Example: If you are 29 years old and your salary is $1,000 weekly your premium would be: $0.06 x 100 = $6.00. This amount would be the monthly payroll deduction.

Plan Certificate

This flyer is for informational purposes only. Please refer to your plan certificate for detailed plan information, definitions, and claims payment information.

As noted above, benefits will offset with the new Paid Leave Oregon (PLO) program. Employees will want to determine if electing a short-term disability plan will benefit them based on their income and circumstances.

You may calculate your potential PLO benefits on the PLO website at https://paidleave.oregon.gov/employees/benefits-calculator.html. Per state law and the MetLife Plan Certificate, when disabled the weekly combined income between PLO and the STD plan cannot be greater than 100% of an employee's income at the time of the disability. Additionally, the STD plan will offset against any PLO payments an employee is eligible for, even if they do not apply for PLO. Choosing not to apply for PLO will not increase STD benefits. However, if PLO benefits have been exhausted, the STD plan may increase the weekly benefit up to the maximum 60% of the employee's income, with a maximum weekly benefit of $2,000.

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Supplemental Life & Voluntary Dependent Life Coverage 2024

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 your employer offers any of these options, you will see these plans online in CIS-Connect.***

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), unless your employer added this plan for the first time in which case you can elect up to $100,000 for yourself and $20,000 for a spouse without completing the application

If electing coverage, a link to The Hartford PHA will be included on your homepage in the Action Items box. 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.

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 then 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.

If you can't complete the PHA at the time of enrollment or wish to complete it later, you will need to do so no later than Nov. 30, 2023. To complete it, log into CIS-Connect (www.cisbenefits.org) to access the Hartford link from your homepage. All coverage approved before Dec. 1 will be effective Jan. 1, 2024. 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

If enrolling in Supplemental Employee/Spouse Life for the first time, rates will be based on you and your spouse's/DP's age (if you enrolled for spouse coverage) on Jan. 1. After that, rates will increase every Jan. 1 for employees and/or spouses/DPs who changed age categories during the previous calendar year. Your first paycheck after Jan. 1 will reflect the new rates (see below).

Age	Employee Cost/$1K	Spouse Cost/$1K
0-29	$0.027	$0.032
30-34	$0.035	$0.040
35-39	$0.048	$0.055
40-44	$0.068	$0.078
45-49	$0.095	$0.110
50-54	$0.149	$0.173
55-59	$0.279	$0.322
60-64	$0.428	$0.494
65-69	$0.808	$0.932
70-74	$1.272	$1.466
75 & Older	$1.854	$1.854

Example: If you elect $100,000 for employee coverage and are 45 years old your premium would be: $0.095 x 100 = $9.50. This amount would be the monthly payroll deduction.

Voluntary $1o,ooo Dependent Life

You can elect the $10,000 Dependent Life coverage during open enrollment on a guaranteed 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?

We encourage you to confirm that your Beneficiary Designations are correct every year during open enrollment, as errors can happen. It's an important step since the beneficiary (or beneficiaries) listed in CIS-Connect 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 have the opportunity to assign or change beneficiaries during the enrollment process.

EAP Summary of Services

A benefit for you and your family members provided by CIS Trust

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

Counseling with an EAP Professional

Five (5) counseling sessions face to face, over the phone, or virtually for concerns such as:

- **Relationship conflict**
- **Conflict at work**
- **Depression**
- **Stress management**
- **Family relationships**
- **Anxiety**
- **Alcohol or drug misuse**
- **Grieving a loss**
- **Professional development**

Resources for Life

Canopy will help locate resources and information related to childcare, eldercare, caregiving, and anything else you may need.

Legal Consultations/Mediation

Contact Canopy for a free thirty-minute office or telephone consultation. A 25% discount from the attorney's/mediator's normal hourly rate is available thereafter.

Financial Coaching

Coaches will provide unlimited financial coaching to help develop better spending habits, reduce debt, improve credit, increase savings, and plan for retirement.

Identity Theft

Up to 60-minute free consultation with a Fraud Resolution Specialist™ (FRS) who will conduct emergency response activities and assist with restoring their identity, good credit, and dispute fraudulent debts.

Home Ownership and Housing Support

Assistance and discounts for buying, selling, and refinancing. Resource retrieval for housing assistance.

Coaching

Three (3) phone or video sessions with a Coach to support goal setting, healthy habits, and personal development.

Pet Parent Resources

Free pet information and support, including pet insurance discounts, new pet parent resources, and bereavement support.

Wellbeing Tools

- **Fertility health support**
- **Online legal tools**
- **Will kit questionnaire**
- **Wellness and gym membership discounts**

Member Site

Innovative educational tools, chat for support, take self-assessments, view videos and webinars, access courses, download documents and more. Access at **my.canopywell.com**, and register as a new user or log-in. Enter **CIS** for company name when you register.

WholeLife Directions

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

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Crisis Counselors are available by phone **24/7/365**

call: 800-433-2320 **text:** 503-850-7721 **email:** info@canopywell.com

Canopy is committed to creating a safe, inclusive, and equitable society for all.