These medical plans are self-insured by CIS — covered medical services and supplies are paid by CIS. Regence BlueCross BlueShield of Oregon (BCBSO) administers these plans on behalf of CIS. This is a summary only and is subject to change. Any errors or omissions are unintentional. Plan Handbooks are available by request.

High Deductible Health Plan (HDHP)Options

DEDUCTIBLES AND CO-INSURANCE MAXIMUMS	HDHP-4	HDHP-5
Deductible per Calendar Year	$1,700 Single $3,400 Family	$2,500 Single $5,000 Family
Maximum Out-of-Pocket per Calendar Year	$3,400 Single/$6,800 Family	$5,000 Single/$10,000 Family*
Categories 1 & 2 - *Preferred and Participating Provider (includes deductible and medical copays; excludes prescription copays)*		
Category 3 - *Non-Preferred Provider (includes deductible and medical copays; excludes prescription copays)*		

BENEFIT FEATURES	THE BELOW BENEFITS APPLIES TO HDHP-4 & 5	
	Categories 1 & 2	Category 3
Preventive Care Services: Routine well-baby care, physical examinations, health screenings, and immunizations*	100% *(deductible waived)*	60% *(after deductible)*
	After Deductible – Plan Pays	
	Categories 1 & 2	Category 3
Office visits for illness or injury, mental/behavioral health or substance use disorder *(primary care, specialist, naturopath or urgent/immediate care center)***	80%	60%
PROFESSIONAL SERVICES	Categories 1 & 2	Category 3
Outpatient laboratory, radiology, and diagnostic procedures	80%	60%
Maternity care	80%	60%
Therapeutic injections including allergy shots	80%	60%
Chiropractic and acupuncture care	*Available as a rider*	
HOSPITAL/FACILITY SERVICES	Categories 1 & 2	Category 3
Ambulatory Surgical Center	90% (80% for all other facilities)	60%
Emergency room care *(including professional charges)*	80%	
Inpatient/outpatient surgery services and surgeon fees	80%	60%
Inpatient mental/behavioral health & substance use disorder	80%	60%
Skilled Nursing Facility – *120 inpatient days/Calendar Year*	80%	60%
OTHER SERVICES	Categories 1 & 2	Category 3
Ambulance	80%	
Rehabilitation Services – Inpatient: *Unlimited visits* / Outpatient: *77 visits/year*	80%	60%
Home health care – *180 visits/Calendar Year*	80%	60%
Hospice – *14 respite days/lifetime*	80%	60%
Durable medical equipment and supplies	80%	60%

**Embedded $5,000 out-of-pocket maximum/individual*
***Co-insurance and copay amounts are subject to change based on Oregon legislation and rule making.*

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Copay Plan Options

COPAY E	COPAY F	COPAY G	COPAY H
$250 Single $750 Family	$500 Single $1,500 Family	$1,000 Single $3,000 Family	$1,500 Single $4,500 Family
Maximum Out-of-Pocket per Calendar Year			
$2,250 Single/$4,750 Family	$2,500 Single/$5,000 Family	$3,000 Single/$7,000 Family	$3,500 Single/$8,500 Family
$4,250 Single/$8,750 Family	$4,500 Single/$9,500 Family	$5,000 Single/$11,000 Family	$5,500 Single/$12,500 Family

THE BELOW BENEFITS APPLIES TO COPAY PLANS E, F, G & H	
Categories 1 & 2	Category 3
100% *(deductible waived)*	60% *(after deductible)*
After Deductible – Plan Pays	
$5/visit for first three visits, then $20 copay	
Categories 1 & 2	Category 3
100% up to first $400 *(deductible waived)*; then 80% after deductible	60%
80%	60%
80%	60%
Available as a rider	
Categories 1 & 2	Category 3
90% (80% for all other facilities)	60%
80% after $100 copay *(copay waived if admitted)*	
80%	60%
80%	80% - Category 2 / 60% - Category 3
80%	60%
Categories 1 & 2	Category 3
80%	
80%	60%
80%	60%
100% *(deductible waived)*	
80%	60%

PRESCRIPTION MEDICATION BENEFIT – PROVIDED BY EXPRESS SCRIPTS (ESI)*

DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS	COPAY PLANS E, F, G & H		HDHP-4 & 5
Individual deductible per Calendar Year	No deductible		Combined with medical deductible
Out-of-pocket maximum each Calendar Year	$2,500 per person/$7,500 per family		Combined with medical out-of-pocket maximum
Rx Tier Levels and Copays	Retail Pharmacy (30-day supply)	Mail Order (90-day supply)	Pharmacy or Mail Order program (limited to 90-day supply) After Deductible – Plan Pays
Generic drugs	$10 Copay	$20 Copay	80% *(Generic, preferred and non-preferred drugs) Refer to generic, preferred brand and non-preferred brand drugs above, for specialty drugs or self-administrable cancer chemotherapy drug coverage.* *Exception: Specific value-based generic drugs are covered at 100%, and specific preferred drugs are covered at 80% with the deductible waived. These value-based medications are designated as preventive for: asthma, diabetes, high blood pressure, high cholesterol or tobacco cessation. For a current list visit www.express-scripts.com*
Preferred brand drugs	$40 Copay	$80 Copay	
Non-Preferred brand drugs	$100 Copay	$200 Copay	
Specialty Generic	$50 Copay	$100 Copay	
Specialty Preferred brand drugs	$100 Copay	$200 Copay	
Specialty Non-Preferred brand drugs	$200 Copay	$400 Copay	

OTHER SERVICES INCLUDED WITH CIS COPAY PLANS AND HDHPs

PROVIDED BY REGENCE	PREFERRED PROVIDER BENEFIT Category 1 Plan Pays	PARTICIPATING AND NON-PREFERRED PROVIDER Categories 2 & 3 Plan Pays
Weight Management/Nutritional Counseling (*Up to four visits per calendar year*)	100% (deductible waived)	60%
Bariatric Surgery (*Must meet participation requirements*)	$1,000 copay then 80% after deductible	$1,000 copay then 60% after deductible
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.		
Case Management — Supports and educates members with serious illnesses or injuries.	Regence Pregnancy Program — Childbirth to Newborn resources	
MDLIVE (Telehealth) — 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. No cost for copay plans. Deductible applies on HDHPs.		
BeyondWell (Offered to Regence and Kaiser members) — A comprehensive well-being solution for members that integrates wellness activities, goals, rewards, and challenges into a single location for a holistic wellness offering.		
Chronic Condition Counseling (Provided through BeyondWell for Regence BCBSO members only) — Supports and educates members with chronic conditions including hypertension, diabetes, COPD, CAD, CHF, asthma, and obesity.		
Hinge Health — Virtual physical therapy program at $0 cost to the participant.		
SurgeryPlus — Select network of providers & facilities for non-emergent surgical procedures reducing participant's out-of-pocket cost. No cost for eligible surgeries through SurgeryPlus on copay plans. IRS minimum deductible must be met on HDHPs.		

**CIS is currently in the RFP process for pharmacy benefit management for the 2024 Plan Year.*

Additional Plan Riders

The following benefits can be added to all Copay and HDHP Plans administered through Regence for an additional cost, unless otherwise noted. These riders are only available when combined with a medical plan. These riders are selected on the group level, not at the individual employee level. This is a summary only. Any errors or omissions are unintentional. Plan Handbooks are available by request.

CIS TRUST VISION SERVICE PLAN - ADMINISTERED BY VSP

Benefits reset annually on Jan. 1	VSP CHOICE PROVIDER VSP-A 12/12/24	NON-VSP PROVIDER VSP-A 12/12/24
Eye Exam	$10 copay – covered *every* Calendar Year	Up to $50 *every* Calendar Year
Single Lenses	$25 copay – covered *every* Calendar Year *The $25 copay only applies once if purchasing both lenses and frames at the same time*	Up to $50 *every* Calendar Year
Lined Bifocal Lenses		Up to $55 *every* Calendar Year
Lined Trifocal Lenses		Up to $70 *every* Calendar Year
Lenticular Lenses		Up to $105 *every* Calendar Year
Progressive Lenses	$50 copay – covered every Calendar Year	Up to $105 *every* Calendar Year
Lens Enhancements *(UV, scratch, blue-light, etc)*	$0 copay – covered *every* Calendar Year	Tints up to $5 every Calendar Year. Other enhancements Not Covered
Elective Contacts *(instead of glasses)*	$166 allowance for contacts lenses (includes the fitting exam and evaluation); subject to same benefit frequency as lenses. Covered *every* Calendar Year	**Elective** - Up to $110 **Necessary** - Up to $215 *every* Calendar Year
Frames *The $25 copay only applies once if purchasing both lenses and frames at the same time*	Covered *every other* Calendar Year: • $25 copay • $170 allowance • $95 allowance at Costco/Walmart/ Sam's Club • 20% savings on amount over the allowance	Up to $70 *every other* Calendar Year

ALTERNATIVE CARE RIDER

Acupuncture and Chiropractic Spinal Manipulations	No deductible, any provider - $20 Copay *Maximum allowance of 12 visits per calendar year for Acupuncture and 20 visits per calendar year for Chiropractic Spinal Manipulations.*

HEARING AID RIDER

Note: The Hearing Aid Rider can only be added to Copay Plans.

Hearing Examination	One every Calendar Year. Covered at 80% using a Category 1 provider, 60% using a Category 2 or 3 provider: not subject to the deductible. *Does not accumulate toward the out-of-pocket maximum.*
Hearing Aids Benefit	Paid at 100% up to a maximum of $3,000 every 4 calendar years. The $3,000 is an accumulative amount over the 4 calendar years and not a one-time benefit. ***State mandated coverage applies to children 18 years and younger or children 19 to 25 enrolled in an accredited education institution.***