cis benefits
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2025

FIND THE PLAN THAT'S RIGHT FOR YOUR EMPLOYEES

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 OUT-OF-POCKET 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 *(Includes deductible and coinsurance)*		
Categories 1 & 2 - *Preferred and Participating Provider*	$3,400 Single/$6,800 Family	$5,000 Single/$10,000 Family *Embedded $5,000 out-of-pocket maximum/individual*
Category 3 - *Non-Preferred Provider*		

BENEFIT FEATURES	THE BELOW BENEFITS APPLY TO HDHP-4 & 5	
	Categories 1 & 2	Category 3
Preventive Care Services: Routine well-baby care, physical examinations, health screenings, and immunizations*	$0 *(deductible waived)*	40% *(after deductible)*
	After Deductible – Covered Person 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)*	0% after deductible 1st 3 visits, then 20% after deductible	40%
PROFESSIONAL SERVICES	Categories 1 & 2	Category 3
Outpatient laboratory, radiology, and diagnostic procedures	20%	40%
Maternity care	20%	40%
Therapeutic injections including allergy shots	20%	40%
Chiropractic and acupuncture care	*Available as a rider*	
HOSPITAL/FACILITY SERVICES	Categories 1 & 2	Category 3
Ambulatory Surgical Center	10%	40%
Emergency room care *(including professional charges)*	20%	
Inpatient/outpatient surgery services and surgeon fees	20%	40%
Inpatient mental/behavioral health & substance use disorder	20%	40%
Skilled Nursing Facility – *120 inpatient days/Calendar Year*	20%	40%
OTHER SERVICES	Categories 1 & 2	Category 3
Ambulance	20%	
Rehabilitation Services – Inpatient: *Unlimited visits* / Outpatient: *77 visits/year*	20%	40%
Home health care – *180 visits/Calendar Year*	20%	40%
Hospice – *14 respite days/lifetime*	20%	40%
Durable medical equipment and supplies	20%	40%

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
$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*

**Excludes prescription copays*

THE BELOW BENEFITS APPLY TO COPAY PLANS E, F, G & H	
Categories 1 & 2, $0 *(deductible waived)* Category 3, 40% (*after deductible)*	
After Deductible – Covered Person Pays	
Category 1	Categories 2 & 3
$5/visit for 1st three visits, then $20 copay *(deductible waived)*	40%
Category 1	Categories 2 & 3
0% up to first $400 *(deductible waived)*; then 20% after deductible	40%
20%	40%
20%	40%
Available as a rider	
Category 1	Categories 2 & 3
10%	40%
20% after $100 copay *(copay waived if admitted)*	
20%	40%
20%	20% - Category 2, 40% - Category 3
20%	40%
Category 1	Categories 2 & 3
20%	
20%	40%
20%	40%
No charge	No charge - Category 2, 40% - Category 3
20%	40%

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) Covered Person Pays
Preventive	$0	$0	$0
Generic	$10	$20	20% after deductible *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	$40	$80	
Non-Preferred Brand	$100	$200	
Speciality Generic	$50	N/A	
Specialty Preferred Brand	$100	N/A	
Specialty Non-Preferred brand	$200	N/A	

OTHER VALUE-ADDED SERVICES INCLUDED WITH CIS COPAY PLANS AND HDHPs

Weight Management/Nutritional Counseling — Up to four visits per calendar year for nutritional counseling.
Bariatric Surgery *(must meet participation requirements)* — Bariatric surgery to treat obesity is covered through Blue Distinction Centers.
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.
Hinge Health — Virtual physical therapy program at $0 cost to the participant.
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 — A comprehensive well-being solution for members that integrates wellness activities, goals, rewards, and challenges into a single location for a holistic wellness offering.
Regence Pregnancy Program — Childbirth to Newborn resources
Chronic Condition Counseling (Provided through BeyondWell) — Supports and educates members with chronic conditions including hypertension, diabetes, COPD, CAD, CHF, asthma, and obesity.
Case Management — Supports and educates members with serious illnesses or injuries.
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.

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 VISION SERVICE PLANS - ADMINISTERED BY VSP

Benefits reset annually on Jan. 1	**VSP-A**		**VSP INDEMNITY**
	VSP CHOICE PROVIDER	**NON-VSP PROVIDER**	
Eye Exam	$10 copay per year	Up to $50 *per year*	20% discount w/VSP Provider, up to $200 per year*
Single Lenses	$25 copay per year *The $25 copay only applies once if purchasing both lenses and frames at the same time*	Up to $50 *per year*	20% discount w/VSP Provider, up to $300 per year**
Lined Bifocal Lenses		Up to $55 *per year*	
Lined Trifocal Lenses		Up to $70 *per year*	
Lenticular Lenses		Up to $105 *per year*	
Progressive Lenses	$50 copay per year	Up to $105 *per year*	
Lens Enhancements *(UV, scratch, blue-light, etc.)*	$0 copay per year	Tints up to $5 *per year*. Other enhancements not covered.	
Elective Contacts *(instead of glasses)*	$166/year allowance for contact lenses (includes the fitting exam and evaluation);	**Elective** - Up to $110 **Necessary** - Up to $215/*year*	15% off fitting and evaluation w/VSP provider, up to $300 per year**
Frames	Covered *every other* 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	20% discount w/VSP Provider, up to $300 per year**

**Eye exam allowance is $200 per year. Not combined with frames, glasses, and contacts allowance.*
*** Frames, glasses, and contacts have a combined $300 allowance per year.*

ALTERNATIVE CARE RIDER

Benefits reset annually on Jan. 1	**HDHP-4 & 5**	**COPAY PLANS**
Acupuncture *12 visits per calendar year*	20% after deductible (40% out-of-network, after deductible)	$20 Copay
Chiropractic Spinal Manipulations *20 visits per calendar year*		

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.***