

2026

EMPLOYEE BENEFITS GUIDE



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This brochure summarizes the benefit plans that are available to Homes for Good Housing Agency eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. The information provided in this brochure is not a guarantee of benefits.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 41 for more details.

A Message to Our Employees

At Homes for Good we know how important it is to have comprehensive, affordable health benefits. That's why we offer competitive plans that can provide protection, peace of mind, and savings. It's time for you to begin thinking about your 2026 benefits choices.

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

Your Enrollment Responsibilities

Your 2026 Benefits Guide will help you navigate through the process and make the best choices for you and your family.

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

Benefit Resource Center

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

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

Questions

If you have questions in the meantime, contact Rachel Unruh at 541-682-2556, via Teams or via [e-mail at Runruh@homesforgood.org](mailto:Runruh@homesforgood.org).

Benefits for You & Your Family

Homes for Good is pleased to announce our 2026 benefits program, which is designed to help you stay healthy, feel secure, and maintain a work/life balance. Offering a competitive benefits package is just one way we strive to provide our employees with a rewarding workplace.

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

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

Who is Eligible?

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

Dependents are defined as:

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

When and How Do I Enroll?

Open enrollment will be conducted from September 30, 2026 through October 24, 2026 at CIS-Connect.

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

[Click here for written instructions.](#)

[Click here to view an instructional video.](#)

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

When is My Coverage Effective?

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

Changing Coverage During the Year

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

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

Medical / Vision Insurance Highlights

	Kaiser Permanente HMO Copay Plan B	Regence Blue Cross Blue Shield	
Benefit Coverage	Schedule of Benefits	In-Network Benefits	Out-of-Network Benefits
Annual Deductible			
Individual	\$0	\$1,700	
Family	\$0	\$3,400	
Coinsurance	n/a	20%	40%
Maximum Out-of-Pocket*			
Individual	\$1,500	\$3,400	
Family	\$3,000	\$6,800	
Office Visits			
Primary Care	\$5 first 3 visits; then \$20 copay for additional visits in the same year	20% after deductible	40% after deductible
Specialty Care	\$30 copay	20% after deductible	40% after deductible
Urgent Care	\$40 copay	20% after deductible	40% after deductible
Preventive Care			
Adult Periodic Exams	100%	100% deductible waived	40% after deductible
Well-Child Care	100%	100% deductible waived	40% after deductible
Diagnostic Services			
X-ray and Lab Tests	\$20 per dept visit	20% after deductible	40% after deductible
Complex Radiology	\$50 per dept visit	20% after deductible	40% after deductible
Hospital Services			
Emergency Room Facility Charges*	\$200 copay waived if admitted	20% after deductible	
Inpatient Facility Charges	\$200 per day up to \$1,000 per admission	20% after deductible	40% after deductible
Outpatient Facility and Surgical Charges	\$50 copay	20% after deductible	40% after deductible
Mental Health			
Inpatient	\$200 per day up to \$1,000 per admission	20% after deductible	40% after deductible
Outpatient	\$20 copay	20% after deductible	40% after deductible
Substance Abuse			
Inpatient	\$200 per day up to \$1,000 per admission	20% after deductible	40% after deductible
Outpatient	\$20 copay	20% after deductible	40% after deductible
Other Services			
Chiropractic & Acupuncture	\$20 copay \$1,000 Max \$25 copay Massage (12 visit limit)	20% after deductible \$1,000 Max No Massage	40% after deductible Shared \$1,000 Max No Massage

	Kaiser Permanente HMO Copay Plan B	Regence Blue Cross Blue Shield	
Benefit Coverage	Schedule of Benefits	In-Network Benefits	Out-of-Network Benefits
Retail Pharmacy (30 Day Supply)			
Generic (Tier 1)	\$10 copay	20% after deductible	
Preferred (Tier 2)	\$20 copay	20% after deductible	
Non-Preferred (Tier 3)	\$40 copay	20% after deductible	
Preferred Specialty (Tier 4)	\$40 copay	20% after deductible	
Mail Order Pharmacy (90 Day Supply)			
All Tiers	2 x copay	20% after deductible	

Vision Insurance

	Kaiser Permanente HMO Copay Plan B	Regence Blue Cross Blue Shield	
Annual Eye Exam	\$20 copay	\$10 copay	Up to \$50
Lenses	\$150 allowance once every year	\$25 copay basic; \$50 progressive every year	Up to \$35 basic; up to \$105 progressive
Frames	\$150 allowance once every year	\$25 copay \$170 allowance every other year	Up to \$70
Contact Lenses	\$150 allowance once every year	\$166 allowance every year	Up to \$110



Regence Plan Summaries

CIS High Deductible Health Plan 4 w/ HSA

Alternative Care

Benefits Summary

Effective January 1, 2026 – December 31, 2026



cis benefits
www.cisbenefits.org

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

HDHP 4 w/ HSA		
Deductible Per Calendar Year	\$1,700 Individual \$3,400 Family	
Out-of-Pocket Maximum Per Calendar Year <i>includes deductible, medical copays and prescription copays</i>	\$3,400 Individual \$6,800 Family	
<i>Important Note:</i> The Individual Deductible and Out-of-Pocket Maximum apply only if you are enrolled in Employee Only coverage. If you have other family members on the plan, the Family Deductible must be met before the plan begins to pay. Likewise, the Family Out-of-Pocket Maximum must be satisfied before the plan will pay 100% of the allowed amount for any individual on the plan.		
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 <i>(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)</i>	0% <i>(deductible waived)</i>	40% <i>(after deductible)</i>
Professional Services		
	After Deductible – Member Pays	
Office visits for illness or injury, mental/behavioral health or substance use disorder <i>(primary care, specialist, naturopath, urgent/immediate care center or virtual care)</i>	0% for first 3 visits for Primary Care and Behavioral Health combined 20% for additional office visits	40%
Outpatient laboratory, radiology, and diagnostic procedures	20%	40%
Maternity care	20%	40%
Therapeutic injections including allergy shots	20%	40%
Hospital/Facility Services		
	After Deductible – Member Pays	
Ambulatory Surgical Center	10% <i>(20% for all other facilities)</i>	40%
Emergency room care <i>(including professional charges)</i>	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	
Acupuncture – 12 visits per year	20%	40%
Ambulance	20%	
Bariatric surgery to treat obesity – 1 surgery per claimant lifetime <i>Does not accumulate towards the out-of-pocket maximum</i>	\$1,000 copay then 20% Blue Distinction Centers only	
Chiropractic Spinal Manipulations – 20 visits per year	20%	40%
Durable Medical Equipment	20%	40%
Hearing Aids – 1 hearing aid per ear every calendar year up to age 26	20%	40%
Home health care - 180 visits per year	20%	40%
Hospice – 14 respite days per lifetime	20%	40%
Rehabilitation Services - Inpatient: Unlimited / Outpatient: 77 visits per year <i>(visit limit shared with Neurodevelopmental therapy)</i>	20%	40%
Weight management and nutritional counseling - 4 visits per year	0%	40%

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 (855) 902-2777 or sign on to the CIS Health Manager at www.regence.com . Scroll down to Resources and click on Hinge Health.
Lantern— 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 Lantern benefit, you may also save money through reduced financial responsibility.	To learn more, please call (833) 603-0511, go to mysurgery.lanterncare.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 (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 (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 (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 (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 – Provides childbirth to newborn resources.	To learn more, please call (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 (800) 810-BLUE (2583).

Prescription Medication Benefit	At the Pharmacy (30-day supply) Member Pays	At the Pharmacy (90-day supply) or Mail Order thru Amazon (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	
Tier 1 (Preferred Generic)	20% Retail/Mail Order Prescription	
Tier 2 (Non-Preferred Generic)		
Tier 3 (Preferred Brand)		
Tier 4 (Non-Preferred Brand)		
Tier 5 (Generic and Preferred Brand Specialty)	20%	N/A
Tier 6 (Non-Preferred Specialty)	20%	N/A
Compound Medications	20%	N/A
Limitations and Exceptions	Prescription drugs not on the Drug List are not covered, unless an exception is approved. No charge, deductible does not apply for certain preventive medications and immunizations, including those specifically designated as preventive for treatment of chronic diseases that are on the Optimum Value Medication List. Deductible does not apply for insulin. Cost shares for insulin will not exceed \$35 / 30-day supply or \$105 / 90-day supply. Covered drugs limited to: 90-day supply / retail prescription 90-day supply / home delivery prescription 30-day supply / specialty drug prescription 30-day supply / compound medications Specialty medications must be filled through Accredo Specialty Pharmacy. If you fill a brand drug or specialty drug when there is an equivalent generic drug or specialty biosimilar drug available, you pay the difference in cost in addition to the copayment and/or coinsurance, unless your provider specifies "dispense as written." More information about prescription drug coverage is available at https://regence.com/go/2026/OR/6tierLG	

Please note: This benefit summary provides a brief description of your health care plan benefits and is not a guarantee of payment. For a detailed description of your plan benefits, visit www.regence.com on or after January 1, 2026. You must set up an account to review your specific plan booklet.

Make Eye Health a Priority with VSP!

Your health comes first with VSP and CIS TRUST. Take a look at your VSP vision care coverage.



VSP members save an annual average of

\$489*

More Ways to Save

Extra **\$20** to spend on
Featured Frame Brands†

bebe Calvin Klein COLE HAAN
©DRAGON FLEXON LONGCHAMP

and more

Up to **40%** Savings on
lens enhancements‡

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

Create an account today.
Questions?

vsp.com
800.877.7195 (TTY: 711)



Scan QR code or visit vsp.com
to learn more.

Routine eye exams have saved lives.

Did you know an eye exam is the only non-invasive way to view blood vessels in your body? Your VSP® network doctor can detect signs of more than 270 health conditions during your annual eye exam—including diabetes and high blood pressure, as well as eye conditions such as glaucoma and diabetic eye disease.**

Savings you'll love.

See and look your best without breaking the bank. VSP members get exclusive savings on popular frame brands and contact lenses, and they get additional discounts on things like LASIK, and more.

The choice is yours!

With private practice doctors, Visionworks®, and Eyemart Express retail locations to choose from nationwide, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

vsp
PREMIER
edge

Get more at preferred in-network doctor locations

private
practice
doctors

Visionworks

**EYEMART
EXPRESS**
FAMILY OF STORES

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.

*Frame brands and promotion subject to change. Only available to VSP members with applicable plan benefits. Only available at in-network locations. Members who participate in a Medicaid/state-funded plan are not eligible. †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.

‡Based on state and national averages for eye exams and most commonly purchased brands. This represents the average savings for a VSP member with a full-service plan at an in-network provider. Your actual savings will depend on the eyewear you choose, the plan available to you, the eye doctor you visit, your copays, your premium, and whether it is deducted from your paycheck pre-tax. Source: VSP book-of-business paid claims data for Aug-Jan of each prior year. **Full Picture of Eye Health, American Optometric Association, 2020. +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. VSP Premier Edge™ is not available for some members in the state of Texas.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on vsp.com. Visionworks, Eyeconic, and Eyemart Express family of stores are VSP-affiliated companies.

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VSP, Eyeconic, and WellVision Exam are registered trademarks, and VSP LightCare™ and VSP Premier Edge are trademarks of Vision Service Plan. All other brands or marks are the property of their respective owners. 136668 VCCM

Your VSP Vision Benefits Summary

Prioritize your health and your budget with a VSP plan through CIS TRUST.

Provider Network:

VSP Choice

Effective Date:

01/01/2026



BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP DOCTOR			
WELLVISION EXAM	- Focuses on your eyes and overall wellness - Routine retinal screening	\$10 Up to \$39	Every calendar year
ESSENTIAL MEDICAL EYE CARE	- Retinal imaging for members with diabetes covered-in-full - 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 network doctor for details.	\$0 \$20 per exam	Available as needed
PRESCRIPTION GLASSES		\$25	See frame and lenses
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	Standard progressive lenses	\$50	Every calendar year
	Premium progressive lenses	\$50	
	Custom progressive lenses	\$50	
	Anti-glare coating	\$0	
	Tints/Light-reactive lenses	\$0	
	Impact-resistant lenses	\$0	
	Scratch-resistant coating	\$0	
	UV protection	\$0	
	Average savings of 30% on other lens enhancements		
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
ADDITIONAL SAVINGS	Glasses and Sunglasses - Discover all current eyewear offers and savings at vsp.com/offers. 20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam.		
	Laser Vision Correction Average of 15% off the regular price; discounts available at contracted facilities.		
	Exclusive Member Extras for VSP Members - Contact lens rebates, lens satisfaction guarantees, and more offers at vsp.com/offers. - Save up to 60% on digital hearing aids with TruHearing®. Visit vsp.com/offers/special-offers/hearing-aids for details. - Enjoy everyday savings on health, wellness, and more with VSP Simple Values.		
COVERAGE WITH AN OUT-OF-NETWORK DOCTOR			
With so many in-network choices, VSP makes it easy to maximize your benefits. Choose from our large doctor network including private practice and retail locations. Plus, you can shop eyewear online at Eyeconic®. Log in to vsp.com to find an in-network doctor. Your plan provides the following out-of-network reimbursements:			
Exam	up to \$50	Lined Bifocal Lenses	up to \$55
Frame	up to \$70	Lined Trifocal Lenses	up to \$70
Single Vision Lenses	up to \$35	Progressive Lenses	up to \$105
		Contacts	up to \$110
		Tints	up to \$5

Your one-stop shop for managing your health

With the CIS Health Manager on [regence.com](https://www.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.



BeyondWellSM

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



Healthy Benefits

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



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.



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.



MDLIVE

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



VSP: Vision

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



Regence pharmacy services

Sign in to the CIS Health Manager for more information.



Pregnancy program

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



Hinge Health

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

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



Start with your CIS Health Manager!

Download the Regence app or go to [regence.com](https://www.regence.com) to create an account. All you need is your member ID card to get started.



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

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. VSP is a separate company that provides vision services.

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

REG-OR-860116-25/08
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Turn healthy habits into rewards

BeyondWell™

BeyondWell makes wellness simple by bringing all your health activities, goals, and rewards together in one personalized platform designed just for you.

Earn up to
\$150

in e-gift card 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. **Register** your account with your BeyondWell Invitation code (**CIS**) and accept the Terms of Use

Kaiser and Surest members

1. **Visit** www.beyondwellhealth.com
2. Select **Log In** from the top right-hand corner
3. **Register** your account with your BeyondWell Invitation code (**CIS**) and accept the Terms of Use



Take your well-being journey with you anywhere, anytime! Download and log into the BeyondWell app once you've created your account and earn \$5!

Invest in your health, earn rewards at 60+ retailers and restaurants!

Activities with rewards in 2026:

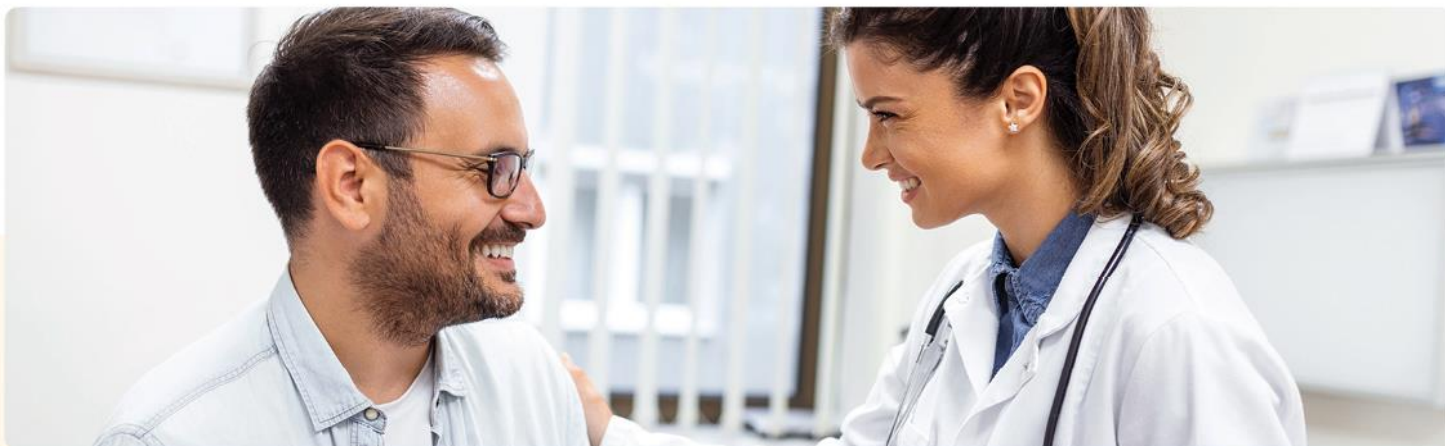
- Connect a device or app
- Verified steps through device
- Personal challenges
- Self-guided programs
- Dental exams
- EAP and BeyondWell Webinars
- Flu shot/ Covid-19 vaccine
- Health assessment
- Preventive Wellness Exam & cancer screenings¹
- Vision exams¹
- Create a Regence.com, KP.org, or Surest.com account
- Cancer Screenings²

¹ Regence and Surest members only

² Kaiser members only

BeyondWell™





This call could change everything — and cost you little to nothing.

How it Works?

1. **Call Lantern before scheduling care.** A dedicated Care Advocate learns about your needs and explains your personalized options.
2. **Choose the right specialist.** We connect you to a board-certified surgeon with extensive experience.
3. **We handle the details.** From scheduling to paperwork to follow-up, you can focus on your health.

Why Call Lantern?

- Little to no out-of-pocket cost to members on surgery
- Access to board-certified surgeons near you
- Personalized support from a Care Advocate every step of the way
- Pre-paid debit card to cover travel, lodging and meals for you and a loved one*
- An exclusive benefit provided by your employer

*Travel benefits vary by employer — Call to confirm your benefits.

**“Call Lantern before you do anything
when you find out you need a surgery.
It’s an incredible benefit.”**

— Tom, Lantern Member

Coverage Highlights

Lantern can help with:

- Joint replacements
- Colonoscopies
- Cardiac procedures
- And more...

Lantern covers thousands of procedures; however, some procedures may be excluded based on your plan. Ask Lantern or your HR team for details.

**One call can
change everything.**

(833) 603-0511

Visit mysurgery.lanterncare.com



No-cost benefit for your back and joint health

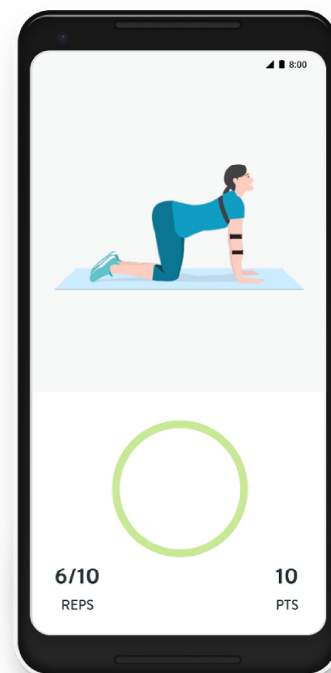
Hinge Health provides all the tools you need to get moving again from the comfort of your home. You'll get exercise therapy tailored to your condition and a personal care team of experts. Best of all, **there's no additional cost to you** – 100% covered by your employer as part of your Regence health plan.

Sign up today for help with any of the following:

- Conquer pain or limited movement
- Recover from a recent or past injury
- Prepare for and recover from surgery
- Keep joints healthy and pain free

Eligibility: Participants must be 18+ and enrolled in a Regence BlueCross BlueShield of Oregon medical plan.

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 digital MSK services for Regence members.



To learn more call (855) 902-2777, or apply at:
HINGEHEALTH.COM/REGENCE-OREGON



Kaiser Plan Summaries



cis benefits
www.cisbenefits.org



KAISER PERMANENTE®

Copay B Plan: Alternative Care & Vision	
January 1, 2026 - December 31, 2026	
Out-of-Pocket Maximum (Note: All Copayment, and Coinsurance amounts count toward the Out-of-Pocket Maximum, unless otherwise noted.)	
For one Member	\$1,500
For an entire Family	\$3,000
Office visits	You pay
Routine preventative physical exam	\$0
Telehealth (phone/video)	\$0*
Primary Care	\$5 for first 3 visits; then \$20 for additional visits in the same Year *
Specialty Care	\$30
Urgent Care	\$40
Tests (outpatient)	You pay
Preventive Tests	\$0
Laboratory	\$20 per department visit
X-ray, imaging, and special diagnostic procedures	\$20 per department visit
CT, MRI, PET scans	\$50 per department visit
Medications (outpatient)	You pay
Prescription drugs (up to a 30 day supply)	Generic \$10, Preferred \$20, Non-preferred \$40, Specialty \$40 (Per prescription)
Mail Order Prescription drugs (up to a 90 day supply)	2 x Copay
Administered medications, including injections (all outpatient settings)	20% Coinsurance
Nurse treatment room visits to receive injections	\$10
Maternity Care	You pay
Scheduled prenatal care visits and postpartum visits	\$0
Laboratory	\$20 per department visit
X-ray, imaging, and special diagnostic procedures	\$20 per department visit
Inpatient Hospital Services	\$200 per day up to \$1,000 per admission
Hospital Services	You pay
Ambulance Services (per transport)	\$75
Emergency services	\$200 (Waived if admitted)
Inpatient Hospital Services	\$200 per day up to \$1,000 per admission
Outpatient Services (other)	You pay
Outpatient surgery visit	\$50
Chemotherapy/radiation therapy visit	\$30
Durable medical equipment	20% Coinsurance
Physical, speech, and occupational therapies (up to 20 visits per therapy per Calendar Year)	\$30
Skilled Nursing Facility Services	You pay
Inpatient skilled nursing Services (up to 100 days per Calendar Year)	\$0
Mental Health and Substance Use Disorder Services	You pay
Outpatient Services (Group visit ½ copay)	\$5 for first 3 visits; then \$20 for additional visits in the same Year *
Inpatient hospital & residential Services	\$200 per day up to \$1,000 per admission
Alternative Care** (self-referred)	You pay

MK-43A

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

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

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

kp.org Resources: Here are some ways to make managing your care easier:

Sign on to our convenient online services and stay on top of your treatment from the comfort of your home.

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

Appointment Alternatives:

-Get Care Now with a Clinician – Talk to a clinician 24/7 over video or phone for quality care when you need it – no appointment needed. Using your Kaiser Permanente App, select Get Care Now on the home screen, and then select Get Care Now with a Clinician to start the process. You can also visit kp.org/getcare to learn more about your care options.

-Advice Nurse Line - If you have a health concern but aren't sure where to go for care, call the Kaiser Permanente advice nurse line at (800) 813-2000. Available 24 hours a day, our advice nurses can give you guidance on getting the care you need, view your medical record, and help schedule an appointment if needed.

-Virtual Care - Virtual care options are available for many health concerns. You can skip a copay and schedule a visit to see a doctor using your computer or mobile device. Call (800) 813-2000 (toll free), (503) 813-2000, or 711 (TTY for the hearing/speech impaired). You can use online scheduling to make an appointment with our Urgent Care providers. We offer both same-day Urgent Care Telephone Appointments and Urgent Care Video Visits.

-Email Your Doctor - You can send a secure email to your doctor and care team for answers to non-urgent health and wellness questions at any time by logging on to kp.org on your computer or mobile device.

Disease Management:

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

Health and Wellness Classes & Resources: kp.org/healthengagement

Find information, tips, and resources you can use to help you take charge of your health. Browse the available classes online or learn more about health coaching.

Wellness Resources: kp.org/health-wellness

As a Kaiser Permanente member, you can enjoy no-cost and discounted online tools, apps, classes, programs, and activities that can help keep you happy and healthy.

Questions? Call Member Services (M-F, 8 am-6 pm) or **visit kp.org** Portland area: 503-813-2000

All other areas: 1-800-813-2000 TTY.711. Language Interpretation Services, all areas 1-800-324-8010

This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on benefit coverage, claims review, and adjudication procedures, please see your Evidence of Coverage (EOC) or call Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail. EOCs are available upon request or you may go to kp.org/plandocuments.



Employee Cost Sharing

2026 Employee Bi-Weekly Cost Share

Employee Bi-Weekly Cost for Medical & Vision Regence HDHP

FTE/Hours	Percent Cost Share	EE Only	EE + Spouse	EE + Family	EE + Child	EE + Children
20	50%	\$180.24	\$335.56	\$458.43	\$383.54	\$528.75
21	45%	\$162.22	\$302.00	\$412.59	\$345.19	\$475.88
22	40%	\$144.19	\$268.44	\$366.74	\$306.83	\$423.00
23	35%	\$126.17	\$234.89	\$320.90	\$268.48	\$370.13
24	30%	\$108.14	\$201.33	\$275.06	\$230.12	\$317.25
25	25%	\$90.12	\$167.78	\$229.22	\$191.77	\$264.38
26	20%	\$72.10	\$134.22	\$183.37	\$153.42	\$211.50
27	15%	\$54.07	\$100.67	\$137.53	\$115.06	\$158.63
28	10%	\$36.05	\$67.11	\$91.69	\$76.71	\$105.75
29	5%	\$18.02	\$33.56	\$45.84	\$38.35	\$52.88
30-40	0%	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Employee Bi-Weekly Cost for Medical & Vision Kaiser HMO

FTE/Hours	Percent Cost Share	EE Only	EE + Spouse	EE + Family	EE + Child	EE + Children
20	50%	\$235.93	\$432.80	\$583.71	\$494.46	\$673.00
21	45%	\$212.34	\$389.52	\$525.34	\$445.01	\$605.70
22	40%	\$188.74	\$346.24	\$466.97	\$395.57	\$538.40
23	35%	\$165.15	\$302.96	\$408.60	\$346.12	\$471.10
24	30%	\$141.56	\$259.68	\$350.23	\$296.68	\$403.80
25	25%	\$117.97	\$216.40	\$291.86	\$247.23	\$336.50
26	20%	\$94.37	\$173.12	\$233.48	\$197.78	\$269.20
27	15%	\$70.78	\$129.84	\$175.11	\$148.34	\$201.90
28	10%	\$47.19	\$86.56	\$116.74	\$98.89	\$134.60
29	5%	\$23.59	\$43.28	\$58.37	\$49.45	\$67.30
30-40	0%	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Employee Bi-Weekly Cost for Medical & Vision Delta Dental

FTE/Hours	Percent Cost Share	EE Only	EE + Spouse	EE + Family	EE + Child	EE + Children
20	50%	\$12.06	\$19.04	\$34.35	\$21.55	\$39.44
21	45%	\$10.85	\$17.13	\$30.91	\$19.39	\$35.50
22	40%	\$9.65	\$15.23	\$27.48	\$17.24	\$31.55
23	35%	\$8.44	\$13.32	\$24.04	\$15.08	\$27.61
24	30%	\$7.24	\$11.42	\$20.61	\$12.93	\$23.66
25	25%	\$6.03	\$9.52	\$17.17	\$10.77	\$19.72
26	20%	\$4.82	\$7.61	\$13.74	\$8.62	\$15.78
27	15%	\$3.62	\$5.71	\$10.30	\$6.46	\$11.83
28	10%	\$2.41	\$3.81	\$6.87	\$4.31	\$7.89
29	5%	\$1.21	\$1.90	\$3.43	\$2.15	\$3.94
30-40	0%	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Employee Bi-Weekly Cost for Medical & Vision Willamette Dental

FTE/Hours	Percent Cost Share	EE Only	EE + Spouse	EE + Family	EE + Child	EE + Children
20	50%	\$14.62	\$22.74	\$38.70	\$25.81	\$44.49
21	45%	\$13.16	\$20.47	\$34.83	\$23.23	\$40.04
22	40%	\$11.70	\$18.19	\$30.96	\$20.65	\$35.59
23	35%	\$10.23	\$15.92	\$27.09	\$18.07	\$31.14
24	30%	\$8.77	\$13.64	\$23.22	\$15.49	\$26.69
25	25%	\$7.31	\$11.37	\$19.35	\$12.91	\$22.25
26	20%	\$5.85	\$9.10	\$15.48	\$10.32	\$17.80
27	15%	\$4.39	\$6.82	\$11.61	\$7.74	\$13.35
28	10%	\$2.92	\$4.55	\$7.74	\$5.16	\$8.90
29	5%	\$1.46	\$2.27	\$3.87	\$2.58	\$4.45
30-40	0%	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00



Tax Favored Accounts

Health Savings Account (HSA)

Deductible Reimbursement (Regence Plan Only)

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

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

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

HSA Employer Monthly Contribution

- Single Enrollment \$1,700 per year; \$141.66 per month
- Family Enrollment \$3,400 per year; \$283.33 per month
- IRS Annual Limit 2026; Single Enrollment \$4,400; Family Enrollment \$8,750

How do I get reimbursed for my eligible expenses?

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

Health Reimbursement Account (HRA)

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

This plan reimburses qualified expenses as outlined in IRS Code 213

Reimbursable expenses may include:

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

HRA Annual Credit Amounts (contributions made monthly)

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

For more information about your deductible reimbursement options, click here to view the **2026 Deductible Reimbursement Guide**.

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

Flexible Spending Account (FSA)

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

How an FSA works:

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

Important rules to keep in mind:

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

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

2026 Projected Maximum Annual Election	
Health Care FSA	\$3,400
Dependent Care FSA	\$7,500

Dental Insurance Options

The chart below is a brief outline of the plans. Please refer to the following benefit summaries for plan details.

Benefit Coverage	Willamette Dental	Delta Dental / Moda
	Schedule of Benefits	
Annual Max Per Person	No Annual Maximum	\$1,500
Preventive	\$20 per office visit	0% - 30% (based on years of active use)
Basic	\$20 office visit plus service copay	0% - 30% (based on years of active use)
Major	\$20 office visit plus service copay	50%
Orthodontia		
Benefit Percentage	Included	Included - 50%
Adult (and Covered Full-Time Students, if Eligible)	\$2,000 copay	\$1,000 Max
Dependent Child(ren)	\$2,000 copay	\$1,000 Max
Lifetime Maximum	n/a	\$1,000



Dental Plan Summaries

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

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

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

¹ Any amount paid by the plan for Preventive services or Orthodontia 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 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 nearly 2,400 licensed Premier providers in Oregon and 154,000 nationwide. More than 1,300 are also PPO providers in Oregon and 116,000 nationwide.
- * **Professional Arrangements:** The Delta Dental Passive PPO plan utilizes a select group of dentists who have contracted with us at a preferred rate. This helps ensure that members who utilize the services of a preferred dentist have lower out-of-pocket costs. While receiving treatment from a Preferred Provider is still the most cost-effective option, your plan allows for services to be rendered by a non-preferred dentist, while still maintaining the same percentage of coverage. Members who utilize Premier and PPO providers will not be balanced billed. Members who utilize non-participating providers will be responsible for charges above the maximum plan allowance.
- * **Pre-determination:** As a service to our customers, your dental office can submit a pre-treatment plan to Delta Dental on your behalf, and we will return it to your dentist, indicating the dollar allowance that will be covered by your plan **before** you go forward with treatment.
- * **Health through Oral Wellness® program:** Your plan includes access to the Health through Oral Wellness program. This patient-centered program provides enhanced benefits designed to help you maintain better oral health through risk assessment, education and additional evidence-based preventive care.



Delta Dental of Oregon & Alaska

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

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

Delta Dental Customer Service 844-721-4939 - Delta Dental's website [DeltaDentalOR.com](https://www.DeltaDentalOR.com)

Key plan features

- **Simple, predictable costs** — No annual maximums,* deductibles, or waiting periods
- **Seamless care access** — Willamette Dental offices provide all benefits and services
- **Hassle-free scheduling** — Call 1.855.433.6825 to book your appointment
- **Convenient office hours** — Open Mon – Fri 7AM – 5:30PM, with rotating Saturday availability
- **Emergency care when you need it** — In-person visits within 48 hrs and 24/7 phone support
- **Language accessibility** — Translation services available from scheduling to chairside
- **Comprehensive specialty services** — Including orthodontics for all ages
- **No ID card needed** — Your information is securely stored for easy access

Your benefits

Effective Date: 1/1/2026

COVERED SERVICE	BENEFIT
Annual Maximum	No Annual Maximum ¹
Deductible	No Deductible
General & Ortho Office Visit	\$20 per Visit ²
Diagnostic & Preventive Services	Covered with Office Visit Copay
Fillings	\$15 Copay
Porcelain-Metal Crown	\$200 Copay ³
Complete Upper or Lower Denture	Covered with Office Visit Copay ³
Bridge (per Tooth)	\$200 Copay ³
Root Canal Therapy – Anterior / Bicuspid / Molar	\$75 Copay
Osseous Surgery (per Quadrant)	Covered with Office Visit Copay
Root Planing (per Quadrant)	Covered with Office Visit Copay
Routine Extraction (Single Tooth)	Covered with Office Visit Copay
Surgical Extraction	\$50 Copay
Comprehensive Orthodontia Treatment	\$2,000 Copay
Dental Implant Surgery	Benefit maximum of \$1,500 per calendar year
Nitrous Oxide	\$10 Copay
Specialty Office Visit	\$30 Copay per Visit
Out of Area Emergency Care Reimbursement	You pay charges in excess of \$100

¹Benefits for implant surgery have a benefit maximum, if covered.

²An office visit copayment applies at each visit, in addition to any copayments for services.

³Dental implant-supported prosthetics (crowns, bridges, and dentures) are not a covered benefit.

Underwritten by Willamette Dental Insurance, Inc. Please refer to your Certificate of Coverage for limitations and exclusions.

Questions?

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

Offices & Specialty Locations

Visit our website at willamettedental.com

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

Oregon Offices

Albany

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

Beaverton

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

Bend

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

Corvallis

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

Eugene

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

Gresham

1107 NE Burnside Road
Gresham, OR 97030
General Dentistry

Hillsboro

5935 SE Alexander Street
Hillsboro, OR 97123
General Dentistry

Lincoln City

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

Medford

773 Golf View Drive
Medford, OR 97504
General Dentistry
Orthodontics

Milwaukie

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

Portland – Jefferson

1933 SW Jefferson Street
Portland, OR 97201
General Dentistry

Portland – Lents

8931 SE Foster Road.,
Portland, OR 97266
General Dentistry
Dentures
Endodontics
Orthodontics
Pediatric Dentistry

Portland – Stark 1

13255 SE Stark Street
Portland, OR 97233
General Dentistry
Dentures

Portland – Stark 2

405 SE 133rd Avenue
Portland, OR 97233
General Dentistry

Salem – Lancaster

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

Salem – Liberty

142 Pembroke Street SE
Salem, OR 97302
General Dentistry

Springfield

2510 Game Farm Road
Springfield, OR 97477
General Dentistry

Springfield Specialty

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

Tigard

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

Tualatin

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

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

For Appointments or Member Services, please call 1.855.433.6825



Employee Assistance Plans

EAP Summary of Services

Helping you get to your happy place

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

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

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

Work/ Life Balance Services

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

Legal

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

Financial Coaching

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

Wellbeing Tools

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

EAP Member Site

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

WholeLife Directions

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





Fertility Health and Family Building

Support for growing families
and their journey

Exclusive access for Canopy members:

- Discounted fertility health check
- \$350 care credit for treatment
- Connection to fertility preservation, care, and donation services
- Counseling support
- Adoption resources, legal and financial guidance



SCAN ME

☎ 800-433-2320
✉ info@canopywell.com
🌐 my.canopywell.com

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





Parenting Support For Those With Furry Kids

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

Access your Pet Parent Benefits:

Go to my.canopywell.com Register as a new user or log in It's **free** and **confidential**



SCAN ME

800-433-2320
@ info@canopywell.com
my.canopywell.com





Here to Help

Get the Most Out of Your Employee Assistance Program.

Congratulations! Your employer has partnered with Cascade Health Counseling & Employee Assistance Program to give you and all members of your household access to free, confidential counseling services.

Counseling can be a good way to combat stress, develop new skills, learn more about yourself and help you make changes to improve your life. Whether your goals are personal, professional or relationship-focused, our counselors can provide guidance, support and action plans to help you live your happiest, healthiest life.

We serve individuals, couples and families ages 6 and up. Give us a call today and get started on your path to self-discovery.

cascadehealth.org | (541) 345-2800

To Schedule

Call (541) 345-2800
Monday - Friday
8:30 a.m. - 5 p.m.

Appointments Available

Monday - Thursday
8 a.m. - 7 p.m.

Friday
8 a.m. - 5 p.m.

If you are having a mental health emergency, call us 24 hours a day for assistance.

Location

2650 Suzanne Way, Ste. 120
Eugene, OR 97408



Other Benefits Summarized

Life and AD&D Insurance

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

Voluntary Life and AD&D Insurance

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

Long-Term Disability Insurance (LTD)

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

Allstate Insurance Options

Accident Insurance

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

Critical Illness Insurance

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

We speak insurance.

**Call the Benefit
Resource Center (BRC).
We're here to help!**

- "Services denied?"
- "Why won't they pay my claim?"
- "How can my claim still be in process? It's been two months!"
- "I called my insurance carrier, but now I'm just more confused."
- "Do I have mail-order prescription benefits?"

Our Benefits Specialists can help you choose the right plan for you and your family, translate confusing jargon, answer questions about which benefits are on your plan, and which aren't, work directly with insurance carriers to resolve tricky issues regarding claims and denials of service — and more!

Benefits Resource Center

**BRCWest@usi.com | Toll Free: 866-468-7272 | Monday – Friday • 8am – 5pm
MST, PST and AST**



MyBenefits2GO



Free Benefits App for iPhone & Android

You and your enrolled dependents can access benefit summaries and other important information about our group plans using MyBenefits2GO. View up-to-date plan information, store photos of ID cards, and easily locate carrier and HR contact information—all in one place.

**SCAN TO
DOWNLOAD!**



**Homes for Good
Housing Agency**

When prompted,
enter code: R89351

**Stay organized,
store ID cards,
and easily
contact carriers!**

Contacts

Have Questions? Need Help?

Homes for Good Housing Agency is excited to offer access to the USI Benefit Resource Center (BRC), which is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals, and their primary responsibility is to assist you.

The Specialists in the Benefit Resource Center are available Monday through Friday 8:00am to 5:00pm Mountain, Pacific and Alaska Standard Time at 866-468-7272 or via e-mail at BRCWest@usi.com. If you need assistance outside of regular business hours, please leave a message and one of the Benefit Specialists will promptly return your call or e-mail message by the end of the following business day.

Please contact Bailey McEuen in human resources to complete any changes to your benefits that are not related to your initial or annual enrollment.

BENEFITS PLAN	CARRIER	PHONE NUMBER	WEBSITE
Medical/Dental/Vision	CIS	800-922-2684	www.cisoregon.org
Medical HMO	Kaiser Permanente	800-813-2000	www.kp.org
Medical PPO	Regence Blue Cross Blue Shield	888-367-2116	www.regence.com
Dental PPO	Delta Dental / Moda Health	877-337-0647	www.modahealth.com
Managed Dental	Willamette Dental	503-475-8132	www.willamettedental.com
Health Savings Account (HSA)	Optum Bank	877-462-5039	www.optumbank.com
Health Reimbursement Arrangement (HRA)	PNC Bank	800-762-2265	https://www.pnc.com/en/customer-service/contact
Life and AD&D	Lincoln Financial Group	800-628-8600	www.lfg.com
Voluntary Life and AD&D	Lincoln Financial Group	800-628-8600	www.lfg.com
Long Term Disability (LTD)	Lincoln Financial Group	800-628-8600	www.lfg.com
Employee Assistance Program (EAP)	Cascade Health	541-345-2800	www.cascadehealth.org
Flexible Spending Account (FSA)	PNC Bank	800-762-2265	https://www.pnc.com/en/customer-service/contact
Accident / Critical Illness	Allstate	541-726-8243 Contact: Bryan Bullock	Email: bryanbullock@allstate.com
Benefit Resource Center (BRC)	USI	866-468-7272	Email: brcwest@usi.com

Homes for Good Housing Agency

Important Legal Notices



IMPORTANT NOTICE: This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.



Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Please see your benefits booklet for additional information.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people, called “fiduciaries” of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan reviewed and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Rachel Unruh
100 W 13th Ave
Eugene, Oregon United States 97401
runruh@homesforgood.or

Your Information. Your Rights. Our Responsibilities.

*This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.***

Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases, we never share your information unless you give us written permission:
Marketing purposes
Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls

- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

10/01/2025

Questions regarding any of this information can be directed to:

Rachel Unruh

100 W 13th Ave

Eugene, Oregon United States 97401

runruh@homesforgood.org

Important Notice from Homes For Good Housing Agency 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 Homes for Good Housing Agency 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. Homes for Good Housing Agency has determined that the prescription drug coverage offered by the Regence BlueCross BlueShield (BCBS) and Kaiser for the plan year 2026 is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered **Creditable Coverage**. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. 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, the following options may apply:

- You may stay in the Regence BlueCross BlueShield (BCBS) and Kaiser plans and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
 - During the Medicare prescription drug annual enrollment period, or
 - If you lose Regence BlueCross BlueShield (BCBS) and Kaiser creditable coverage.
- You may stay in the Regence BlueCross BlueShield (BCBS) and Kaiser plans and also enroll in a Medicare prescription drug plan. The Regence BlueCross BlueShield (BCBS) and Kaiser plans will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.

- You may decline coverage in the Regence BlueCross BlueShield (BCBS) and Kaiser plans and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the Regence BlueCross BlueShield (BCBS) and Kaiser plans, you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Homes for Good Housing Agency 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 person 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 Homes for Good Housing Agency 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: 10/01/2025

Name/Entity of Sender: CIS Benefit

Address: 15875 Boones Ferry Rd., #1469 Lake Osego, 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, 2025. Contact your State for more information on eligibility –

OREGON – Medicaid and CHIP

Website: <http://healthcare.oregon.gov/Pages/index.aspx>
Phone: 1-800-699-9075

To see if any other states have added a premium assistance program since July 31, 2025, 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)



Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%¹ of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.²

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution – as well as your employee contribution to employment-based coverage – is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset

¹ Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

² An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023, and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023, and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact:

Date:	10/01/2025
Name/Entity of Sender:	Rachel Unruh
Contact Position/Office:	HR Specialist
Address:	100 W 13 th Ave, Eugene, OR 97401
Phone Number:	541-682-2556

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name Homes for Good Housing Agency		4. Employer Identification Number (EIN) 93-6002480	
5. Employer address 100 W 13 th Ave		6. Employer phone number 541-682-3755	
7. City Eugene		8. State OR	9. ZIP code 97401
10. Who can we contact about employee health coverage at this job? Rachel Unruh			
11. Phone number (if different from above) 541-682-2556		12. Email address runruh@homesforgood.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
 - ☒ All employees. Eligible employees are:
 - Full-time employees working 20 hours per week or more
 - Begins first day of the month following 1 month of employment

- ☐ Some employees. Eligible employees are:

- With respect to dependents:
 - ☒ We do offer coverage. Eligible dependents are:
 - Dependent children up to age 26, spouses and domestic partners

- ☐ We do not offer coverage.

- ☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

- ** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly



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



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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	No charge for upfront office visits; 20% <u>coinsurance</u> for additional office visits; 20% <u>coinsurance</u> for other services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	First 3 upfront office visits / year. Limit is for primary care and behavioral health visits combined.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge, <u>deductible</u> does not apply	No charge, <u>deductible</u> does not apply	40% <u>coinsurance</u>	<u>Coinurance</u> and <u>deductible</u> waived for childhood immunizations from <u>non-participating providers</u> . You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Imaging</u> (CT/PET scans, MRIs)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://regence.com/go/2026/OR/6tierLGStd	Tier 1 (Typically, generic drugs with highest overall value)	Not applicable, refer to <u>participating provider</u> and <u>non-participating provider</u> columns.	20% <u>coinsurance</u> / retail prescription; 20% <u>coinsurance</u> / home delivery prescription	20% <u>coinsurance</u> / retail prescription; 20% <u>coinsurance</u> / home delivery prescription	<u>Prescription drugs</u> not on the Drug List are not covered, unless an exception is approved. <u>Deductible</u> does not apply for insulin. No charge, <u>deductible</u> does not apply for drugs specifically designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medication List. 90-day supply / retail prescription (your <u>cost share</u> is per 30-day supply) 90-day supply / home delivery prescription 30-day supply / <u>specialty drug</u> prescription 30-day supply / compound medications <u>Specialty drugs</u> are not available through home
	Tier 2 (Typically, generic drugs with moderate overall value)	Not applicable, refer to <u>participating provider</u> and <u>non-participating provider</u> columns.	20% <u>coinsurance</u> / retail prescription; 20% <u>coinsurance</u> / home delivery prescription	20% <u>coinsurance</u> / retail prescription; 20% <u>coinsurance</u> / home delivery prescription	
	Tier 3 (Typically, brand drugs with	Not applicable, refer to <u>participating provider</u> and <u>non-</u>	20% <u>coinsurance</u> / retail prescription; 20% <u>coinsurance</u> /	20% <u>coinsurance</u> / retail prescription; 20% <u>coinsurance</u> /	

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)	
	moderate overall value)	<u>participating provider</u> columns.	home delivery prescription	home delivery prescription	delivery. Coverage includes compound medications at 20% <u>coinsurance</u> . <u>Cost shares</u> for insulin will not exceed \$35 / 30-day supply or \$105 / 90-day supply. No charge, <u>deductible</u> does not apply for certain preventive drugs, contraceptives and immunizations at a participating pharmacy. If you fill a brand drug or <u>specialty drug</u> when there is an equivalent generic drug or specialty biosimilar drug available, you pay the difference in cost in addition to the <u>copayment</u> and/or <u>coinsurance</u> , unless your <u>provider</u> specifies "dispense as written." The first fill of <u>specialty drugs</u> may be provided by a retail pharmacy; additional refills must be provided by a specialty pharmacy.
	Tier 4 (Typically, brand drugs with lower overall value)	Not applicable, refer to <u>participating provider</u> and <u>non-participating provider</u> columns.	20% <u>coinsurance</u> / retail prescription; 20% <u>coinsurance</u> / home delivery prescription	20% <u>coinsurance</u> / retail prescription; 20% <u>coinsurance</u> / home delivery prescription	
	Tier 5 (Typically, <u>specialty drugs</u> with moderate overall value)	Not applicable, refer to <u>participating provider</u> and <u>non-participating provider</u> columns.	20% <u>coinsurance</u> / <u>specialty drug</u>	20% <u>coinsurance</u> / <u>specialty drug</u>	
	Tier 6 (Typically, <u>specialty drugs</u> with lower overall value)	Not applicable, refer to <u>participating provider</u> and <u>non-participating provider</u> columns.	20% <u>coinsurance</u> / <u>specialty drug</u>	20% <u>coinsurance</u> / <u>specialty drug</u>	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u> for ambulatory surgery centers; 20% <u>coinsurance</u> for all other facilities	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u> for ambulatory surgery center physicians; 20% <u>coinsurance</u> for all other physicians	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	<u>Urgent care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

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 have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge for upfront office or psychotherapy visits; 20% <u>coinsurance</u> for additional office or psychotherapy visits; 20% <u>coinsurance</u> for other services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	First 3 upfront visits / year. Limit is for primary care and behavioral health visits combined.
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you are pregnant	Office visits	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Cost sharing does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	130 visits / year
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	77 visits / year for all <u>habilitation</u> and outpatient <u>rehabilitation</u> services
	<u>Habilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Includes physical therapy, occupational therapy, speech therapy and neurodevelopmental therapy services.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	120 inpatient days / year
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Hospice services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	14 respite inpatient or outpatient days / lifetime

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 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 | • Long-term care | • Routine foot care, except for diabetic patients |
| • Dental care | • Private-duty nursing | • Weight loss programs |
| • Infertility treatment | • Routine eye care | |

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

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

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 preferred provider pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,700
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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
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In this example, Peg would pay:

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

Managing Joe's Type 2 Diabetes

(a year of routine preferred provider care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,700
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,700
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$500
What isn't covered	
Limits or exclusions	\$200
The total Joe would pay is	\$2,400

Mia's Simple Fracture

(preferred provider emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,700
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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
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In this example, Mia would pay:

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

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

NONDISCRIMINATION NOTICE

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

Regence:

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

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

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

- Qualified interpreters
- Information written in other languages.

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

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

Customer Service

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

Medicare Customer Service

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

VSP Customer Service

Phone: 1-844-299-3041
TTY: 1-800-428-4833

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

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

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

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



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage see <https://kp.org/plandocuments> or call 1-800-813-2000 (TTY: 711). 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 www.healthcare.gov/sbc-glossary/ or call 1-800-813-2000 (TTY: 711) to request a copy.

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

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

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

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

Common Medical Event	Services You May Need	What You Will Pay Participating Provider (You will pay the least)	What You Will Pay Non-Participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	130 visit limit / year. Prior authorization required.
	Rehabilitation services	Outpatient: \$30 / visit Inpatient: \$200 / day up to \$1,000 / admission.	Not covered	Outpatient: 20 visit limit / year. Prior authorization required. Inpatient: Prior authorization required.
	Habilitation services	\$30 / visit	Not covered	20 visit limit / year. Prior authorization required.
	Skilled nursing care	No charge	Not covered	100 day limit / year. Prior authorization required.
	Durable medical equipment	20% coinsurance	Not covered	Subject to formulary guidelines. Prior authorization required.
	Hospice service	No charge	Not covered	Prior authorization required.
If your child needs dental or eye care	Children's eye exam	No charge for refractive exam	Not covered	None
	Children's glasses	No charge	Not covered	Limited to one pair of select frames and lenses or contact lenses / 1 year.
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
• Cosmetic surgery • Dental care (Adult & Child) • Long-term care	• Non-emergency care when traveling outside the U.S. • Private-duty nursing	• Routine foot care • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (12 visit limit / year) • Bariatric surgery	• Chiropractic care (20 visit limit/year) • Hearing aids (Under age 26: 1 aid / ear / 36 months)	• Infertility treatment • Routine eye care (Adult)

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

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

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

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

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

TRADITIONAL CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-813-2000 (TTY: 711)

PENNSYLVANIA DUTCH (Deutsch): Fer Hilf griege in Deutsch, ruf 1-800-813-2000 (TTY: 711) uff

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

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

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

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

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

About these Coverage Examples:



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

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

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

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$360

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

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

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$600
Coinsurance	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$610

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

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

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$600
Coinsurance	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$650

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

Nondiscrimination Notice

Kaiser Foundation Health Plan of the Northwest (Kaiser Health Plan) complies with applicable federal and state civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin (including limited English proficiency), age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Kaiser Health Plan:

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

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

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator, by mail, phone, or fax. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You may contact our Civil Rights Coordinator at:

Member Relations Department
Attention: Kaiser Civil Rights Coordinator
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: **1-855-347-7239**

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

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
Phone: **1-800-368-1019**
TDD: **1-800-537-7697**

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

For Washington Members:

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

This notice is available at <https://healthy.kaiserpermanente.org/oregon-washington/language-assistance/nondiscrimination-notice>

