

CIS Employee Benefits Program

Summary of Copay Plans (Effective 08-01-2011)



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

Benefit Features	Copay Plan				VB Copay Plan 2	
	Plan A	Plan B	Plan C	VB Copay Plan 2 Category 1	Value Tier 1	Value Tier 2
Annual maximum benefit	\$2,000,000			\$2,000,000		
Individual and family deductible per calendar year	\$250 per person	\$500 per person	\$1,000 per person	\$750 per family	\$1,500 per family	\$3,000 per family
				Value Tier 1	\$0 per person	\$0 per family
				Value Tier 2	\$500 per person	\$1,500 per family
				Category 2 & 3	\$500 per person	\$1,500 per family
Provider Network	Preferred Benefit Category 1	Non-Preferred Benefit Category 2 & 3	Preferred Benefit Category 1	Non-Preferred Benefit Category 2 & 3		
Out-of-pocket maximum you pay each calendar year including deductible	Plan A: \$2,250 per person	Plan B: \$2,500 per person	Plan C: \$3,000 per person	Value Tier 1 ²	Value Tier 2 ²	\$4,500
If two family members have met the out-of-pocket maximum, other enrolled family members need only meet any remaining family deductible to have covered charges paid at 100%.					\$2,500	
After this amount is met each calendar year, the plan pays	100%			100%		
Preventive Care Services³ (See below)	Deductible Waived – The Plan Pays			Deductible Waived – The Plan Pays		
Screening for women including Pap and mammogram	100%			100%		
Well-baby care	100%			100%		
Routine physical exams including related lab and X-ray	100%			100%		
Routine immunizations for adults and children	100%			100%		
Chronic Disease Management (See back for list on conditions)	Deductible Waived – The Plan Pays			After Deductible – The Plan Pays		
Outpatient lab & imaging for specific Value Tier 1 benefits	Not Applicable			90%		60%
Professional Services	After Deductible – The Plan Pays			After Deductible – The Plan Pays		
Office visits including mental health/chemical dependency	100% after \$20 copay ¹ deductible waived	60%	100% after \$20 copay ¹ deductible waived	60%		
Diagnostic radiology and lab	\$400 up front allowance then 80% after the deductible	60%	80% (excluding complex imaging)	60%	60%	60%
Therapeutic injections including allergy shots	80%	60%	80%	60%	60%	60%
Maternity care	80%	60%	80%	60%	60%	60%
Surgery	80%	60%	80%	60%	60%	60%
Chiropractic care	Not Covered			Not Covered		
Hospital Services	After Deductible – The Plan Pays			After Deductible – The Plan Pays		
Inpatient stay including maternity, mental health, chemical dependency and rehabilitation	80%	60%	80%	60%	60%	60%
Outpatient surgery	80%	60%	80%	60%	60%	60%
Skilled nursing facility care	80%	60%	80%	60%	60%	60%
Emergency room care (copay applies to the facility charge, whether or not the deductible has been met, copay waived if admitted to hospital or other facility on an inpatient basis)	80% after \$100 copay ¹			80% after \$100 copay ¹		
Outpatient Complex Imaging (See back for list of benefits)	After Deductible – The Plan Pays			After Deductible and \$100 Copay¹ The Plan Pays		
Value Tier 2 benefits	Not Applicable			80%		
Supplemental Services (See back for list of benefits)	After Deductible – The Plan Pays			After Deductible and \$500 Copay¹ The Plan Pays		
Value Tier 2 benefits	Not Applicable			80%		
Other Services	After Deductible – The Plan Pays			After Deductible – The Plan Pays		
Ambulance (to nearest hospital as medically indicated)	80%			80%		
Rehabilitation including occupational, speech, and physical therapy	80%	60%	80%	60%	60%	60%
Home health care	80%	60%	80%	60%	60%	60%
Hospice (as medically indicated by physician's orders, no limit)	100% (deductible waived)			100% (deductible waived)		
Durable medical equipment and supplies	80%	60%	80%	60%	60%	60%
Prescription Medications	You Pay			You Pay		
Deductible per calendar year	No Deductible			No Deductible		
Specified Generic medication (Prescribed for Value Tier 1 medical conditions related to chronic disease)	Not Applicable			\$0 copay		
Generic medication	\$5 copay			\$10 copay		
Preferred medication	\$25 copay			\$20 or 20%, whichever is greater		
Non-preferred medication	\$50 copay			\$40 or 20%, whichever is greater		
Mail order prescriptions (90-day supply)	2 times copay			2 times copay		
Out-of-pocket maximum per person each calendar year	\$2,500			\$2,500		
General Limitations	Inpatient rehabilitation	Unlimited	Inpatient rehabilitation	Unlimited		
	Ambulance	No mile or dollar limit	Ambulance	No mile or dollar limit		
	Outpatient rehabilitation	77 visits per calendar year	Outpatient rehabilitation	77 visits per calendar year		
	Home health care	180 visits per calendar year	Home health care	180 visits per calendar year		
	Pharmacy purchased medication	34-day supply	Pharmacy purchased medication	34-day supply		

Please refer to your plan booklet for a complete list of benefits, limitations, and exclusions that apply.

Provider Network: Preferred Providers are paid under Category 1. Participating Providers are paid under Category 2. Non-Participating Providers are paid under Category 3.

¹Copay amounts do not apply to the out-of-pocket maximum. ²For VB Copay Plan 2, coinsurance for Value Tier 1 is 90%, coinsurance for Value Tier 2 is 80%

³For Preventive Care: In accordance with age limits and frequency guidelines according to and as recommended by the USPSTF, CDC, or HRSA. For a list of services and supplies covered under this benefit, go to www.myregence.com. From there, select "My Navigator", then "Benefits", then "Preventive Care".

This is a brief summary comparison of plans. Any errors or omissions are unintentional. Once enrolled, employees can view the Plan Booklet online at the claims administrator's Web site, www.myregence.com.

Chronic Disease Management List of Conditions (for VB Copay Plan 2)

Benefit Features		
Asthma	Coronary artery disease	Diabetes mellitus
Chronic obstructive pulmonary disease	Depression	Eye exam for treatment of diabetes mellitus
Congestive heart failure		

Outpatient Complex Imaging (for VB Copay Plan 2)

Benefit Features		
Bone density study	Magnetic Resonance Angiogram (MRA)	Positron Emission Tomography (PET)
Computer Tomography (CT) scan	Magnetic Resonance Imaging (MRI)	Single-Proton Emission Computerized Tomography (SPECT)

Supplemental Services (for VB Copay Plan 2)

Benefit Features		
Breast reduction surgery	Lumbar surgery for low back pain	Transurethral resection of the prostate (TURP)
Eye lid surgery	Nasal surgery	Varicose vein surgery
Joint replacement surgery for hips and knees	Podiatric surgery	Vasectomy & tubal ligation

Hearing Examination and Hearing Aids Benefit Rider

Benefit Features	
Hearing Examination	Once every calendar year. Paid according to your medical plan's coinsurance; not subject to the deductible.
Hearing Aids Benefit	Paid 100% up to a maximum of \$3,000 every 48 months. The \$3,000 is an accumulative amount over this period and not a one time benefit.

Alternative Care Rider - VB Copay Plan 2 & Copay Plans A, B, & C

Benefit Features	
Chiropractic, Naturopath and Acupuncture	No deductible - \$20 Copay - Maximum allowance \$1,000 per person per calendar year.

Vision Benefits Rider - offered by VSP (Vision Service Plan)

Benefit Features	VSP Plan	
	Participating Provider	Non-Participating Provider
Eye Exam	100%	100% up to \$71
Lens - Standard		
Single	100%	100% up to \$51
Bifocal	100%	100% up to \$77
Trifocal	100%	100% up to \$100
Lenticular	100%	100% up to \$125
Contacts	100% up to \$166 (in lieu of lenses or frames)	100% up to \$166 (in lieu of lenses or frames)
Frames	100% up to \$120	100% up to \$66

Oregon Dental Service (ODS)

Benefit Features	Plan II	Plan III	Plan IV	Plan V
Maximum benefit per calendar year	\$1,500	\$1,500	\$1,500	\$2,000
Deductible per calendar year	None	None	\$25 per person (maximum 3 per family)	\$25 per person (maximum 3 per family)
Basic Services				
Exams, cleanings, fluoride, fillings, x-rays, simple extractions, root canal therapy, and periodontal treatment	70%/80%/90%/100% ¹	70%/80%/90%/100% ¹	80%	80% ²
Prosthetics				
Dentures, bridges, inlays, crowns	50%	70%/80%/90%/100% ¹	50%	50%
Orthodontia Services - Available with all dental options when selected as a rider.				
Orthodontic treatment	50% up to a lifetime maximum of \$1,000			

¹ Benefits increase 10% each calendar year only if a dentist is seen at least annually for covered services.

² Exams, cleanings, fluoride, and x-rays covered 100% (No deductible).

Willamette Dental

Benefit Features	
Maximum benefit per calendar year	No annual maximum
Deductible per calendar year	None
Basic Services	
Exams, cleanings, fluoride, x-rays, fillings, fluoride treatment, simple extractions, repair or relining of dentures or bridges	\$10 per visit ¹
Prosthetic Services	
Crowns, inlays, and bridges	100% ²
Dentures	100% ²
Periodontal treatment and root planing (per quadrant)	100% ²
Root canal work	100% ²
Surgical Extractions (per tooth)	\$50 ²
Orthodontic Services	
Pre-Orthodontic services	\$150 copay ^{2&3}
Orthodontic treatment	\$1,500 copay ²

¹ Specialty services provided by an Endodontist, Peridontist, or Oral Surgeon require a \$30 copay.

² Plus office visit charge.

³ Fee credited toward orthodontic treatment copay if patient accepts treatment plan.

CIS (Citycounty Insurance Services)

Employee Benefits Program Copay Plan Benefit Options VB Copay Plan 2 and Copay Plans A, B, & C



Effective August 1, 2011