

# CIS Employee Benefits Program



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

Regence BlueCross BlueShield of Oregon

## Summary of High Deductible Health Plan (HDHP) with HSA Options (Effective 08-01-2011)

Benefit Features	HDHP-1 w/HSA		HDHP-2 w/HSA	
Annual maximum benefit	\$2,000,000		\$2,000,000	
Single and family deductible per calendar year	Single Deductible	\$1,500	Single Deductible	\$2,500
The single coverage deductible applies when an individual is enrolled without dependents. The family coverage deductible applies when an individual and one or more dependents are enrolled. Prior to benefits being paid, the entire family deductible must be met.	Family Deductible	\$3,000	Family Deductible	\$4,000
<b>Provider Network</b>	Participating Network		Participating Network	
Out-of-pocket maximum you pay each calendar year <b>including deductible</b>	Single Coverage	\$2,300	Single Coverage	\$3,300
The single coverage maximum applies when an individual is enrolled without dependents. The family coverage maximum applies when an individual and one or more dependents are enrolled.	Family Coverage	\$5,050	Family Coverage	\$6,050
After this amount is met each calendar year, the plan pays	100%		100%	
	<b>In-Network Benefit Category 1 &amp; 2</b>	<b>Out-of-Network Benefit Category 3</b>	<b>In-Network Benefit Category 1 &amp; 2</b>	<b>Out-of-Network Benefit Category 3</b>
<b>Preventive Care Services</b> (See schedule on back)	Deductible Waived – The Plan Pays		Deductible Waived – The Plan Pays	
Screening for women including Pap and mammogram	100%	60%	100%	60%
Well-baby care	100%	60%	100%	60%
Routine physical exams including related lab and X-ray	100%	60%	100%	60%
Routine immunizations through age 17	100%	100%	100%	100%
Routine immunizations age 18+	100%	60%	100%	60%
<b>Professional Services</b>	After Deductible – The Plan Pays		After Deductible – The Plan Pays	
Office visits including mental health/chemical dependency	80%	60%	80%	60%
Diagnostic radiology and lab	80%	60%	80%	60%
Therapeutic injections including allergy shots	80%	60%	80%	60%
Maternity care	80%	60%	80%	60%
Surgery	80%	60%	80%	60%
Chiropractic care	Not Covered		Not Covered	
<b>Hospital Services</b>	After Deductible – The Plan Pays		After Deductible – The Plan Pays	
Inpatient stay including maternity, mental health, chemical dependency and rehabilitation	80%	60%	80%	60%
Outpatient surgery	80%	60%	80%	60%
Skilled nursing facility care	80%	60%	80%	60%
Emergency room care	80%		80%	
<b>Other Services</b>	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%
Home health care	80%	60%	80%	60%
Hospice (as medically indicated by physician's orders, no limit)	80%	60%	80%	60%
Durable medical equipment and supplies	80%	60%	80%	60%
<b>Prescription Medications</b>	You Pay		You Pay	
Deductible per calendar year	Deductible combined with medical		Deductible combined with medical	
Generic medication	20%		20%	
Preferred medication	20%		20%	
Non-preferred medication	20%		20%	
Mail order prescriptions (90-day supply)	20%		20%	
Out-of-pocket maximum per person each calendar year	Out-of-pocket maximum combined with medical		Out-of-pocket maximum combined with medical	
<b>General Limitations</b>	<ul style="list-style-type: none"> <li>➢ Inpatient rehabilitation</li> <li>➢ Ambulance</li> <li>➢ Outpatient rehabilitation</li> <li>➢ Home health care</li> <li>➢ Pharmacy purchased medication</li> </ul>	Unlimited No mile or dollar limit 77 visits per calendar year 130 visits per calendar year 90-day supply	<ul style="list-style-type: none"> <li>➢ Inpatient rehabilitation</li> <li>➢ Ambulance</li> <li>➢ Outpatient rehabilitation</li> <li>➢ Home health care</li> <li>➢ Pharmacy purchased medication</li> </ul>	Unlimited No mile or dollar limit 77 visits per calendar year 130 visits per calendar year 90-day supply

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

**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](http://www.myregence.com).**

### Preventive Care Benefits\*

Benefit Features	
<b>Immunizations</b>	
Children and Adults	As recommended by the CDC
<b>Well-Baby Care</b>	
Routine visits	
<b>Routine Physical Exam (including related lab and X-ray)</b>	
Includes colonoscopies	
Includes prostate screening	
<b>Women's Exam</b>	
Routine examinations	
Mammograms	
*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 <a href="http://www.myregence.com">www.myregence.com</a> . From there, select "My Navigator", then "Benefits", then "Preventive Care".	

### Alternative Care Rider

Benefit Features	In-Network Provider Benefit Category 1 & 2	Out-Of-Network Provider Benefit Category 3
Chiropractic, Naturopath, and Acupuncture	80% after deductible Maximum allowance \$1,000 per person per calendar year	60% after deductible Maximum allowance \$1,000 per person per calendar year
<b>Provider Network:</b> Preferred Providers are paid under Category 1. Participating Providers are paid under Category 2. Non-Participating Providers are paid under Category 3.		

### 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)
<b>Basic Services</b>				
Exams, cleanings, fluoride, fillings, x-rays, simple extractions, root canal therapy, and periodontal treatment	70%/80%/90%/100% <sup>1</sup>	70%/80%/90%/100% <sup>1</sup>	80%	80% <sup>2</sup>
<b>Prosthetics</b>				
Dentures, bridges, inlays, crowns	50%	70%/80%/90%/100% <sup>1</sup>	50%	50%
<b>Orthodontia Services</b> - Available with all dental options when selected as a rider.				
Orthodontic treatment	50% up to a lifetime maximum of \$1,000			

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

<sup>2</sup> 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
<b>Basic Services</b>	
Exams, cleanings, fluoride, x-rays, fillings, fluoride treatment, simple extractions, repair or relining of dentures or bridges	\$10 per visit <sup>1</sup>
<b>Prosthetic Services</b>	
Crowns, inlays, and bridges	100% <sup>2</sup>
Dentures	100% <sup>2</sup>
Periodontal treatment and root planing (per quadrant)	100% <sup>2</sup>
Root canal work	100% <sup>2</sup>
Surgical Extractions (per tooth)	\$50 <sup>2</sup>
<b>Orthodontic Services</b>	
Pre-Orthodontic services	\$150 copay <sup>2&amp;3</sup>
Orthodontic treatment	\$1,500 copay <sup>2</sup>

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

<sup>2</sup> Plus office visit charge.

<sup>3</sup> Fee credited toward orthodontic treatment copay if patient accepts treatment plan.

# CIS (Citycounty Insurance Services)

## Employee Benefits Program High Deductible Health Plan (HDHP) with HSA Options



Effective August 1, 2011