

# CIS Employee Benefits Program

Summary of PPP Options (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	Plan I				Plan V			
	\$2,000,000				\$2,000,000			
Annual maximum benefit								
Individual and family deductible per calendar year	Plan I-A <sup>1</sup>	\$100 per person	\$300 per family	Plan V-A <sup>1</sup>	\$100 per person	\$300 per family		
	Plan I-B	\$200 per person	\$600 per family	Plan V-B	\$200 per person	\$600 per family		
	Plan I-C	\$300 per person	\$900 per family	Plan V-C	\$300 per person	\$900 per family		
	Plan I-E	\$500 per person	\$1,500 per family	Plan V-E	\$500 per person	\$1,500 per family		
	Plan I-F	\$1,000 per person	\$3,000 per family	Plan V-F	\$1,000 per person	\$3,000 per family		
Provider Network	Preferred Provider Plan Network				Preferred Provider Plan Network			
	Preferred Benefit Category 1		Non-Preferred Benefit Category 2 & 3		Preferred Benefit Category 1		Non-Preferred Benefit Category 2 & 3	
We pay a percentage of covered expenses up to this amount	\$10,000		\$10,000		\$5,000		\$5,000	
Out-of-pocket maximum you pay each calendar year including deductible	Plan I-A	\$2,100 per person	\$4,100 per person	Plan V-A	\$600 per person	\$1,600 per person		
	Plan I-B	\$2,200 per person	\$4,200 per person	Plan V-B	\$700 per person	\$1,700 per person		
	Plan I-C	\$2,300 per person	\$4,300 per person	Plan V-C	\$800 per person	\$1,800 per person		
	Plan I-E	\$2,500 per person	\$4,500 per person	Plan V-E	\$1,000 per person	\$2,000 per person		
	Plan I-F	\$3,000 per person	\$5,000 per person	Plan V-F	\$1,500 per person	\$2,500 per person		
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%.	100%		100%		100%		100%	
After this amount is met each calendar year, the plan pays	100%		100%		100%		100%	
<b>Preventive Care Services</b> (See schedule on back)	<b>Deductible Waived – The Plan Pays</b>				<b>Deductible Waived – The Plan Pays</b>			
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%			
<b>Professional Services</b>	<b>After Deductible – The Plan Pays</b>				<b>After Deductible – The Plan Pays</b>			
Office visits including mental health/chemical dependency	80%		60%		90%		70%	
Diagnostic radiology and lab	80%		60%		90%		70%	
Therapeutic injections including allergy shots	80%		60%		90%		70%	
Maternity care	80%		60%		90%		70%	
Surgery	80%		60%		90%		70%	
Chiropractic care (12 visit allowance per calendar year)	80%				90%			
<b>Hospital Services</b>	<b>After Deductible – The Plan Pays</b>				<b>After Deductible – The Plan Pays</b>			
Inpatient stay including maternity, mental health, chemical dependency and rehabilitation	80%		60%		90%		70%	
Outpatient surgery	80%		60%		90%		70%	
Skilled nursing facility care	80%		60%		90%		70%	
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 <sup>2</sup>				90% after \$100 copay <sup>2</sup>			
<b>Other Services</b>	<b>After Deductible – The Plan Pays</b>				<b>After Deductible – The Plan Pays</b>			
Ambulance (to nearest hospital as medically indicated)	80%				90%			
Rehabilitation including occupational, speech, and physical therapy	80%				90%			
Home health care	80%				90%			
Hospice (as medically indicated by physician's orders, no limit)	100% (deductible waived)				100% (deductible waived)			
Durable medical equipment and supplies	80%		60%		90%		70%	
Additional accident (deductible waived for 90 days from injury date)	80%		60%		90%		70%	
<b>Prescription Medications</b>	<b>Rx1 - You Pay</b>		<b>Rx2 - You Pay</b>		<b>Rx3 - You Pay</b>		<b>Rx4 - You Pay</b>	
Deductible per calendar year	\$100		No Deductible		Deductible combined with medical		No Deductible	
Generic medication	\$5 copay		\$10 copay		10%		\$5 copay	
Preferred medication	30%		\$20 or 20% (whichever greater)		10%		\$25 copay	
Non-preferred medication	40%		\$40 or 20% (whichever greater)		10%		\$50 copay	
Mail order prescriptions (90-day supply)	\$10 copay or percentage (whichever applies)		2 times copay or 20% (whichever greater)		\$20 copay		2 times copay	
Out-of-pocket maximum per person each calendar year	\$2,500		\$2,500		Out-of-pocket maximum combined with medical <sup>2</sup>		\$2,500	
<b>General Limitations</b>								
<i>Please refer to your plan booklet for a complete list of benefits, limitations, and exclusions that apply.</i>	<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 180 visits per calendar year 34-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 180 visits per calendar year 90-day supply for Rx3 34-day supply for Rx4	

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

<sup>1</sup>Plans I-A and V-A: Not open to new enrollment. <sup>2</sup>Copay amounts do not apply to the out-of-pocket maximum.

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".	

### 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 - Plans I and V

Benefit Features	
Naturopath and Acupuncture	No deductible - \$20 Copay - Maximum allowance \$500 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)
<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 - Available with all dental options when selected as a rider.</b>				
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, Perodontist, 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

PPP Benefit Options

Plan I and Plan V



Effective August 1, 2011