CIS Benefits Program

Summary of **Copay Plan** Options
Effective January 1, 2019

cis benefits
www.cisbenefits.org

These medical plans are insured by CIS, but administered by Regence BlueCross BlueShield (BCBSO) of Oregon. This means that CIS, not Regence BCBSO, pays for your covered medical services and supplies.

Copay Plans	**Copay A**	**Copay B**	**Copay C**	**Copay D**
Individual deductible per Calendar Year Maximum family deductible per Calendar Year	$250 $750	$500 $1,500	$1,000 $3,000	$1,500 $4,500
Maximum out-of-pocket per Calendar Year: **Categories 1 & 2** - Preferred and Participating Provider (includes deductible and medical copays but does not include prescription copays)	$2,250 Individual $4,750 Family	$2,500 Individual $5,500 Family	$3,000 Individual $7,000 Family	$3,500 Individual $8,500 Family
Category 3 - Non-Preferred Provider (includes deductible and medical copays but does not include prescription copays)	$4,250 Individual $8,750 Family	$4,500 Individual $9,500 Family	$5,000 Individual $11,000 Family	$5,500 Individual $12,500 Family

Benefit Features	**Provider Benefit** **Category 1 - Preferred**	**Provider Benefit** **Category 2 - Participating** **Category 3 - Non-Preferred**
Preventive Care Services		
Routine well-baby care, physical examinations, health screenings, and immunizations	100% for Categories 1 & 2 (*deductible waived*) 60% for Category 3 (*after deductible*)	
Professional Services	**After Deductible - Plan Pays**	
Office visits for illness or injury, mental/behavioral health or substance use disorder *(primary care, specialist, naturopath or urgent/immediate care center)*	100% after $20 copay Deductible Waived	60%
Laboratory, radiology, and diagnostic procedures	$400 up front allowance; then 80% after the deductible	60%
Maternity care	80%	60%
Therapeutic injections including allergy shots	80%	60%
Chiropractic and Acupuncture care	*Available as a rider (see back)*	
Hospital/Facility Services	**After Deductible - Plan Pays**	
Inpatient, outpatient, and ambulatory services	80%	60%
Emergency room care *(including professional charges)*	80% after $100 copay *(copay waived if admitted)*	
Inpatient/outpatient surgery and surgeon fees	80%	60%
Inpatient mental/behavioral health & substance use disorder	80%	60%
Skilled Nursing Facility – *120 inpatient days per Calendar Year*	80%	60%
Other Services	**After Deductible - Plan Pays**	
Ambulance	80%	
Inpatient/outpatient rehabilitation – *77 outpatient visits per Calendar Year*	80%	60%
Habilitation services- *neurodevelopmental limited to children through age 17*	80%	60%
Home health care - *180 visits per Calendar Year*	80%	60%
Hospice – *14 respite days lifetime benefit*	100%	
Durable medical equipment and supplies	80%	60%

Prescription Medication Benefit	**At the Pharmacy (34-day supply)** **Covered Person Pays**	**Mail Order Program (90-day supply)** **Covered Person Pays**
Individual deductible per Calendar Year	No deductible	
Out-of-pocket maximum each Calendar Year	Copay A & B - $2,500 per person/$7,500 per family Copay C – $2,500 per person/$6,200 per family Copay D - $2,500 per person/$4,700 per family	
Generic drugs	$5 copay	$10 copay
Preferred brand drugs	$25 copay	$50 copay
Non-Preferred brand drugs	$50 copay	$100 copay

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7/2018

Other services provided by Regence BlueCross BlueShield	Preferred Provider Benefit Category 1 Plan Pays	Participating and Non-Preferred Provider Benefit Categories 2 & 3 Plan Pays
Weight Management/Nutritional Counseling and Bariatric Surgery: - *Weight management and nutritional counseling visits* (up to four (4) visits per Calendar Year per covered person)	100% (deductible waived)	100% (deductible waived)
- *Bariatric surgery may be covered to treat morbid obesity* (participant must meet specified medical criteria)	$1,000 copay then 80% after deductible	$1,000 copay then 60% after deductible
Case and Disease Management	Provided by Regence BCBSO as part of the medical plan	
Baby Wise (*Childbirth to Newborn resources*)	Provided by Regence BCBSO as part of the medical plan	
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.	Provided by Regence BCBSO as part of the medical plan	

Additional Plan Riders

The following benefits can be added to all Copay Plans for an additional cost. These riders are selected on a group level, not the individual employee level.

Hearing Exam and Hearing Aid Rider	
Hearing Examination	One every Calendar Year. Covered at 80% using a Category 1 provider, 60% using a Category 2 or 3 provider; not subject to the deductible.
Hearing Aids Benefit	Paid 100% up to a maximum of $3,000 every 48 months. The $3,000 is an accumulative amount over the 48 months and not a one-time benefit. ***State mandated coverage applies to children 18 years and younger or children 19 to 25 enrolled in an accredited education institution.***

Alternative Care Rider	
Chiropractic and Acupuncture	No deductible, any provider - $20 Copay – Maximum allowance of $1000 per covered person per Calendar Year.

Vision Service Plan (VSP)			
	VSP Provider 12/12/24	VSP Provider 24/24/24	Non-VSP Provider
Benefit Frequency for Exam and Lenses Benefits reset annually on January 1st	***Covered every Calendar Year***	***Covered every other Calendar Year[1]***	***Matches VSP plan selected***
Eye Exam	Covered at 100%	Covered at 100%	Up to $45
Single Lenses	Covered at 100%	Covered at 100%	Up to $30
Bifocal Lenses	Covered at 100%	Covered at 100%	Up to $50
Trifocal Lenses	Covered at 100%	Covered at 100%	Up to $65
Lenticular Lenses	Covered at 100%	Covered at 100%	Up to $100
Contacts	Allowance for contacts lenses and exam, fitting and evaluation (in lieu of lenses); subject to same benefit frequency as lenses.		Elective - Up to $105 Necessary – Up to $210
Frames	Allowance **every other year**; 20% off the amount over allowance		100% up to $70

[1] Children 18 and under are eligible for annual exams and lenses replacement.

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