CIS Benefits Program

Summary of **Copay Plan** Options
Effective January 1, 2020
(All Copay Plans Terminate December 31, 2020, new plan options will be available January 1, 2021).

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.

cis benefits
www.cisbenefits.org

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; excludes 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; excludes 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%
Outpatient 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**	
Ambulatory Surgical Center	90% (80% for all other facilities)	60%
Emergency room care *(including professional charges)*	80% after $100 copay *(copay waived if admitted)*	
Inpatient/outpatient surgery services and surgeon fees	80%	60%
Inpatient mental/behavioral health & substance use disorder	80%	60%
Skilled Nursing Facility – *120 inpatient days/Calendar Year*	80%	60%
Other Services	**After Deductible - Plan Pays**	
Ambulance	80%	
Rehabilitation Services – Inpatient: Unlimited / Outpatient: *77 visits/year*	80%	60%
Home health care - *180 visits/Calendar Year*	80%	60%
Hospice – *14 respite days/lifetime*	100%	
Durable medical equipment and supplies	80%	60%

Prescription Medication Benefit – Provided by Express Scripts	At the Pharmacy (30-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, C & D - $2,500 per person/$7,500 per family			
Calendar Year	**2020**	**2021**	**2020**	**2021**
Generic drugs	$5 copay	$10 copay	$10 copay	$20 copay
Preferred brand drugs	$25 copay	$40 copay	$50 copay	$80 copay
Non-Preferred brand drugs	$50 copay	$100 copay	$100 copay	$200 copay
Specialty Generic	$5 copay	$50 copay	$10 copay	$100 copay
Specialty Preferred brand drugs	$25 copay	$100 copay	$50 copay	$200 copay
Specialty Non-Preferred brand drugs	$50 copay	$200 copay	$100 copay	$400 copay

This is a summary only. Any errors or omissions are unintentional. Once enrolled, employees can view their Plan Booklets online at www.regence.com.

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 participation requirements)	$1,000 copay then 80% after deductible	$1,000 copay then 60% after deductible
Chronic Condition Counseling	Provided by Regence BCBSO as part of the medical plan	
BlueCard Program (Out of Area Services)		
Beyond Well – A lifestyle and wellness program offered to Regence and Kaiser members		

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 four calendar years. ***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-1* 12/12/24 *(plan ends 12/31/2020)*	VSP-A 12/12/24	Non-VSP Provider VSP-1* *(plan ends 12/31/2020)*	Non-VSP Provider VSP-A
Exam and Lenses - *Benefits reset annually on January 1st*	***Covered every Calendar Year***	***Covered every Calendar Year***	***Matches VSP plan selected***	***Covered every Calendar Year***
Eye Exam	Covered at 100%	$10 copay	Up to $45	Up to $50
Single Lenses	Covered at 100%	$25 copay[2]	Up to $30	Up to $35
Lined Bifocal Lenses	Covered at 100%		Up to $50	Up to $55
Lined Trifocal Lenses	Covered at 100%		Up to $65	Up to $70
Lenticular Lenses	Covered at 100%		Up to $100	Up to $105
Progressive Lenses	$50 copay	$50 copay	$50 allowance	Up to $105
Lens Enhancement *(UV, scratch, blue-light, etc)*	Not Covered	$0 copay	Not Covered	Not Covered
Elective Contacts (instead of glasses)	$166 allowance for contacts lenses (includes the fitting exam and evaluation); subject to same benefit frequency as lenses.		**Elective** - *Up to* $105 **Necessary** - *Up to* $210	**Elective** - *Up to* $110 **Necessary** - *Up to* $215
Frames	Allowance **every other calendar year:** • $120 allowance • $65 allowance at Costco, Walmart & Sam's Club • 20% savings on amount over the allowance	Allowance **every other calendar year:** • $25 copay[2] • $170 allowance • $95 allowance at Costco, Walmart & Sam's Club • 20% savings on amount over the allowance	100% up to $70	Up to $70

[1] *Children 18 and under are eligible for annual exams and lenses replacement.*
[2] *The $25 copay only applies once if buying both lenses and frames.*
* VSP-1 terminates December 31, 2020