CIS Benefits Program

Summary of **Plan V Preferred Provider Plan (PPP)** Options
Effective January 1, 2019
(All Plan V PPP Options Terminated December 31, 2017)

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.

Preferred Provider Plans	V-A PPP	V-B PPP	V-C PPP	V-E PPP	V-F PPP
Individual deductible per Calendar Year Maximum family deductible per Calendar Year	$100 $300	$200 $600	$300 $900	$500 $1,500	$1,000 $3,000
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)	$600 Individual $1,300 Family	$700 Individual $1,600 Family	$800 Individual $1,900 Family	$1,000 Individual $2,500 Family	$1,500 Individual $4,000 Family
Category 3 - Non-Preferred Provider (includes deductible and medical copays but does not include prescription copays)	$1,600 Individual $3,300 Family	$1,700 Individual $3,600 Family	$1,800 Individual $3,900 Family	$2,000 Individual $4,500 Family	$2,500 Individual $6,000 Family

Benefit Features	Provider Benefit Category 1 - Preferred	Provider Benefit Category 2 - Participating Category 3 - Non-Preferred
Preventive Care Services	**Deductible Waived – Plan Pays**	
Routine well-baby care, physical examinations, health screenings, and immunizations	100% for Categories 1 & 2 (*deductible waived*) For Category 3 Providers (*after the deductible is met*), Plans V-B, V-C, V-E & V-F pay at 60% and Plan V-A pays at 70%	
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)*	90%	70%
Laboratory, radiology, and diagnostic procedures	90%	70%
Maternity care	90%	70%
Therapeutic injections including allergy shots	90%	70%
Chiropractic care *(12 visits allowance per Calendar Year)*	90%	
Hospital/Facility Services	**After Deductible - Plan Pays**	
Inpatient, outpatient, and ambulatory services	90%	70%
Emergency room care *(including professional charges)*	90% after $100 copay[1] *(copay waived if admitted)*	
Inpatient/outpatient surgery and surgeon fees	90%	70%
Inpatient mental/behavioral health & substance use disorder	90%	70%
Skilled Nursing Facility – *120 inpatient days per Calendar Year*	90%	70%
Other Services	**After Deductible - Plan Pays**	
Ambulance	90%	
Inpatient/outpatient rehabilitation – *77 outpatient visits per Calendar Year*	90%	
Habilitation services- *neurodevelopmental limited to children through age 17*	90%	
Home health care - *180 visits per Calendar Year*	90%	
Hospice – *14 respite days lifetime benefit*	100%	
Durable medical equipment and supplies	90%	70%

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 per person each Calendar Year	$2,500	
Generic drugs	$5 copay	$10 copay
Preferred brand drugs	$25 copay	$50 copay
Non-Preferred brand drugs	$50 copay	$100 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.

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 90% after deductible	$1,000 copay then 70% 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 Plan V PPP Plans for an additional cost. These riders are selected on a group level, not the individual employee level.

Hearing Exam and Hearing Aid Rider (*for participants over the age of 18; state mandated coverage applies to children 18 years and younger*)	
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	
Acupuncture	No deductible, any provider - $20 Copay – Maximum allowance of $500 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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