

CIS - Copay Plan A RX4 with Hearing Aids

Coverage Period: 01/01/2016 - 12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual & Eligible Family | Plan Type: PPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.regence.com or by calling 1 (888) 370-6159. **Please Note:** Your health coverage is insured by CIS, but administered by Regence BlueCross BlueShield of Oregon. This means that CIS, not Regence BlueCross BlueShield of Oregon, pays for your covered medical services and supplies.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$250 claimant / \$750 family per calendar year. Doesn't apply to the following in-network services: preventive care, diagnostic x-ray / laboratory / imaging or outpatient mental health and substance abuse. <u>Copayments</u> or amounts in excess of the <u>allowed amount</u> do not count toward the <u>deductible</u> .	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. <u>Preferred</u> & Participating: \$2,250 claimant / \$4,750 family per calendar year. Non-Participating: \$4,250 claimant / \$8,750 family per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , prescription drugs <u>out-of-pocket limit</u> , balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Does this plan use a <u>network of providers</u> ?	Yes. See www.regence.com or call 1 (888) 370-6159 for lists of <u>preferred</u> or participating <u>providers</u> .	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a <u>specialist</u> .	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .

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If you aren't clear about any of the underlined terms used in this form, see the Glossary.

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Claims Administrator: Regence BlueCross BlueShield of Oregon



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **preferred** and participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay / visit	40% coinsurance	40% coinsurance	Copayment applies to each preferred office visit only, deductible waived. All other services are covered at the coinsurance specified, after deductible .
	Specialist visit	\$20 copay / visit	40% coinsurance	40% coinsurance	
	Other practitioner office visit	20% coinsurance	40% coinsurance	40% coinsurance	—————none—————
	Preventive care/ screening/immunization	No charge	No charge	40% coinsurance	No charge for childhood immunizations from non-participating providers .
If you have a test	Diagnostic test (x-ray, blood work)	No charge for the first \$400 / year, then 20% coinsurance	40% coinsurance	40% coinsurance	No charge for the first \$400 per year for upfront outpatient diagnostic tests for preferred providers , deductible waived. Once the limit has been met and for all inpatient services, services are covered at the coinsurance specified, after deductible .
	Imaging (CT/PET scans, MRIs)	No charge for the first \$400 / year, then 20% coinsurance	40% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition	Generic drugs	\$5 copay / retail prescription \$10 copay / mail order prescription			Out-of-pocket limit \$2,500 / claimant / year Coverage is limited to a 34-day supply retail or 90-day supply mail order. Coverage is limited to a 34-day supply for
	Preferred brand drugs	\$25 copay / retail prescription \$50 copay / mail order prescription			

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
More information about prescription drug coverage is available at www.regence.com .	Non-preferred brand drugs	\$50 copay / retail prescription \$100 copay / mail order prescription			specialty drugs (includes specialty self-injectable medications) and 34-day supply retail or 90-day supply mail order for self-injectable medications. No charge for certain preventive drugs, women’s contraceptives and immunizations at a participating pharmacy. No charge for generic and preferred brand drugs designated as preventive for treatment of chronic diseases that are on the Optimum Value Medication List. You are responsible for the difference in cost between a dispensed brand-name drug and the equivalent generic drug, in addition to the copayment and/or coinsurance , unless your provider specifies “dispense as written.” The first fill for specialty drugs may be provided at a retail pharmacy. Additional fills and any fills for self-administrable cancer chemotherapy drugs must be provided at a specialty pharmacy.
	Specialty drugs	Refer to generic, preferred brand and non-preferred brand drugs above, for specialty medication or self-administrable cancer chemotherapy drug coverage.			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	40% coinsurance	_____none_____
	Physician/surgeon fees	20% coinsurance	40% coinsurance	40% coinsurance	_____none_____
If you need immediate medical attention	Emergency room services	20% coinsurance after \$100 copay / visit	20% coinsurance after \$100 copay / visit	20% coinsurance after \$100 copay / visit	Copayment applies to the facility charge for each visit (waived if admitted), whether or not the deductible has been met.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	_____none_____
	Urgent care	Covered the same as the If you visit a health care provider’s office or clinic or If you have a test Common Medical Events.			_____none_____

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	40% coinsurance	_____none_____
	Physician/surgeon fee	20% coinsurance	40% coinsurance	40% coinsurance	_____none_____
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20 copay / visit	\$20 copay / visit	40% coinsurance	Deductible waived for outpatient services for preferred and participating providers .
	Mental/Behavioral health inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	
	Substance use disorder outpatient services	\$20 copay / visit	\$20 copay / visit	40% coinsurance	
	Substance use disorder inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	40% coinsurance	_____none_____
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	40% coinsurance	Coverage is limited to 180 visits / year.
	Rehabilitation services	20% coinsurance	40% coinsurance	40% coinsurance	Coverage is limited to 77 outpatient visits for all rehabilitation and habilitation services, including neurodevelopmental services / year.
	Habilitation services	20% coinsurance	40% coinsurance	40% coinsurance	Coverage for neurodevelopmental therapy is limited to services for claimants through age 17.
	Skilled nursing care	20% coinsurance	40% coinsurance	40% coinsurance	Coverage is limited to 120 inpatient days / year.
	Durable medical equipment	20% coinsurance	40% coinsurance	40% coinsurance	_____none_____
	Hospice service	No charge	No charge	No charge	Coverage is limited to 14 respite days / lifetime.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered	_____none_____
	Glasses	Not covered	Not covered	Not covered	_____none_____
	Dental check-up	Not covered	Not covered	Not covered	_____none_____

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Chiropractic care, including spinal manipulations
- Cosmetic surgery, except congenital anomalies
- Dental care (Adult or child)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Vision hardware
- Weight loss programs, except for nutritional counseling

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Hearing aids (Adult)
- Hearing aids for claimants 18 or younger or for enrolled children 19 years of age or older and enrolled in a secondary school or an accredited educational institution
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1 (888) 370-6159. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1 (877) 267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan at 1 (888) 370-6159 or visit www.regence.com. You may also contact the Oregon Insurance Division by calling (503) 947-7984 or the toll free message line at 1 (888) 877-4894; by writing to the Oregon Insurance Division, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx; or by E-mail at: cp.ins@state.or.us or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the “minimum value standard.” **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1 (888) 370-6159.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays: \$5,730
- Patient pays: \$1,810

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$250
Copays	\$10
Coinsurance	\$1,400
Limits or exclusions	\$150
Total	\$1,810

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays: \$4,000
- Patient pays: \$1,400

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$250
Copays	\$1,080
Coinsurance	\$30
Limits or exclusions	\$40
Total	\$1,400

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ No. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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