CIS - Plan V E PPP RX4 with Alternative Care

Coverage Period: 01/01/2015 - 12/31/2015

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.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** claimant / **$1,500** family per calendar year. Doesn't apply to certain preventive care. **Copayments** or amounts in excess of the **allowed amount** do not count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **Preferred** & Participating: **$1,000** claimant / **$2,500** family per calendar year. Non-Participating: **$2,000** claimant / **$4,500** family per calendar year.	The **out–of–pocket limit** 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 out–of–pocket limit?	**Coinsurance** and **copayments** for alternative care, **premiums**, prescription drugs **out-of-pocket limit**, balance–billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Does this plan use a network of providers?	Yes. See www.Regence.com or call 1 (888) 370-6159 for lists of **preferred** or participating **providers**.	If you use an in–network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in–network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** 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 **excluded services**.

Questions: Call 1 (888) 370-6159 or visit us at www.Regence.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.cciio.cms.gov or call 1 (888) 370-6159 to request a copy.

Claims Administrator: Regence BlueCross BlueShield of Oregon
M-91

- **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	10% coinsurance	30% coinsurance	30% coinsurance	——————none——————
	Specialist visit	10% coinsurance	30% coinsurance	30% coinsurance	
	Other practitioner office visit	10% coinsurance for spinal manipulations, $20 copay / visit for alternative care - acupuncture	10% coinsurance for spinal manipulations, $20 copay / visit for alternative care - acupuncture	10% coinsurance for spinal manipulations, $20 copay / visit for alternative care - acupuncture	**Coinsurance** applies to spinal manipulations only, after **deductible**. All other services are covered at the **copayment** and limit specified, **deductible** waived. Coverage is limited to 12 spinal manipulations / year. Coverage for alternative care is limited to $500 maximum / year.
	Preventive care/ screening/immunization	No charge	No charge	30% coinsurance	No charge for childhood immunizations from non–participating **providers**.
If you have a test	Diagnostic test (x–ray, blood work)	10% coinsurance	30% coinsurance	30% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	30% 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 self-
	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			injectable medications or 90-day supply for specialty drugs retail or mail order. No charge for generic or preferred brand drugs specifically 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)	10% coinsurance	30% coinsurance	30% coinsurance	——none——
	Physician/surgeon fees	10% coinsurance	30% coinsurance	30% coinsurance	——none——
If you need immediate medical attention	Emergency room services	10% coinsurance after $100 copay / visit	10% coinsurance after $100 copay / visit	10% 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	10% coinsurance	10% coinsurance	10% 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——
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	30% coinsurance	——none——
	Physician/surgeon fee	10% coinsurance	30% coinsurance	30% coinsurance	——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 mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	10% coinsurance	30% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	10% coinsurance	10% coinsurance	30% coinsurance	
	Substance use disorder outpatient services	10% coinsurance	10% coinsurance	30% coinsurance	
	Substance use disorder inpatient services	10% coinsurance	10% coinsurance	30% coinsurance	
If you are pregnant	Prenatal and postnatal care	10% coinsurance	30% coinsurance	30% coinsurance	——————none——————
	Delivery and all inpatient services	10% coinsurance	30% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	10% coinsurance	10% coinsurance	Coverage is limited to 180 visits / year.
	Rehabilitation services	10% coinsurance	10% coinsurance for outpatient 30% coinsurance for inpatient	10% coinsurance for outpatient 30% coinsurance for inpatient	Coverage is limited to 77 outpatient visits for all rehabilitation and habilitation services, including neurodevelopmental services / year.
	Habilitation services	10% coinsurance	10% coinsurance for outpatient 30% coinsurance for inpatient	10% coinsurance for outpatient 30% coinsurance for inpatient	Coverage for neurodevelopmental therapy is limited to services for claimants through age 17.
	Skilled nursing care	10% coinsurance	30% coinsurance	30% coinsurance	Coverage is limited to 120 inpatient days / year.
	Durable medical equipment	10% coinsurance	30% coinsurance	30% 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.)

- 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care, including spinal manipulations
- 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:** $6,200
- **Patient pays:** $1,340

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	$500
Copays	$10
Coinsurance	$680
Limits or exclusions	$150
Total	**$1,340**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,840
- **Patient pays:** $1,560

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	$500
Copays	$960
Coinsurance	$60
Limits or exclusions	$40
Total	**$1,560**

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.

PLAN V – ALTERNATIVE CARE, PRESCRIPTIONS & VALUE ADDED SERVICES

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 need an alternative care provider	Acupuncture	$20 Copay	$20 Copay	$20 Copay	**Deductible waived.** **Not applied to annual out-of-pocket limit.** Limited to $500 per calendar year per person.
	Chiropractor	10% coinsurance	10% coinsurance	10% coinsurance	**Applied to annual deductible & out-of-pocket limit.** Maximum 12 visits per calendar year per person.
If your child needs a hearing specialist	Hearing Aid	10% coinsurance	30% coinsurance	30% coinsurance	**Applied to deductible & out-of-pocket limit.** For claimants 18 years of age and younger, or enrolled children 19 years of age or older and enrolled in a secondary school or an accredited educational institution.
If you have nutritional needs	Counseling	0%	0%	0%	Limited to 4 visits per calendar year. **(Diabetic education and counseling is not subject to the 4 visit limitation per calendar year.**)
If you need assistance losing weight	Weight management & obesity treatment	0%	0%	0%	Includes integrated care coordination, nutritional counseling (up to 4 visits per calendar year), physician visit (up to 4 visits per calendar year) and coordination of care.
	Bariatric surgery to treat morbid obesity	$1,000 copay, then 10% coinsurance	$1,000 copay, then 30% coinsurance	$1,000 copay, then 30% coinsurance	**Deductible applied.** **Not applied to out-of-pocket limit.** This may be a covered service if you have participated, successfully, in at least six consecutive months of Turning Point. To learn more about our Bariatric Program call **(888) 370-6159.** Surgery must be authorized to be covered.

Additional Prescription Benefits	
Brand-Name Prescription Medication Instead of Generic	If an equivalent generic medication is available and a brand-name medication is chosen, the member is responsible for paying the applicable brand-name co-payment plus the difference in price between the equivalent generic medication and the brand-name medication, not to exceed total retail cost. The exception is when the prescribing provider specifies that the brand-name medication must be dispensed, in which case the member will not be responsible for payment of the difference in cost.
Value-Based Medications	You do not need to pay the copay when you fill prescriptions for those generic medications or formulary brand-name medications that we specifically designate as preventative for asthma, diabetes, high blood pressure, high cholesterol or tobacco addiction. You can find a list of such medications at the Claims Administrator's website, www.regence.com. (From there click on Regence Rx Pharmacy Benefit)
Value Added Services Offered by Regence BCBS of Oregon and CIS	
Case Management	Receive one-on-one help and support in the event you have a serious or sudden illness or injury. An experienced, compassionate case manager will serve as your personal advocate during a time when you need it most. Your case manager is a licensed healthcare professional who will help you understand your treatment options, show you how to get the most of our available Plan benefits and work with your physician to support your treatment plan. To learn more or to make a referral to case management, please call **(866) 543-5765.**
Disease Management	Regence Disease Management is a support and education program for people with chronic conditions such as diabetes, heart disease, asthma and/or depression. The Claim's Administrator's nurses and behavioral health care coordinators provide tailored educational materials, tools and other services to help you get on track with your care and stay there. They can help you understand the care plan you developed with your physician, and make smarter choices for better health. To learn more, please call **(866) 543-5765.**
Special Beginnings Program	Pregnancy is a time of planning and excitement, but it can also be a time of confusion and questions. Special Beginnings can provide answers and assistance so that you can relax and enjoy those nine life-changing months. This program offers expectant mothers access to a nurse 24 hours a day, 7 days a week, an informative maternity book or DVD and educational materials tailored to their needs. To learn more call **(888) JOY-BABY (569-2229).**
Regence Advice 24 (Nurse Advice Line)	Registered nurses are available 24/7 to answer your health-related questions and help you make informed decisions about when, where, and if you should seek care. If you're not sure whether to visit the emergency room, see your doctor or treat your condition at home, the nurses are there, day or night. Call the Nurse Advice Line any time 24 hours a day seven days a week, at **(800) 267-6729.**
BlueCard® Program (Out of Area Service)	The BlueCard Program is a unique program that enables you to access hospitals and physicians when outside the four-state area Regence services (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world. Find a provider near you at www.bcbs.com or call **(800) 810-BLUE (2583).**
Quit for Life® Tobacco Cessation Program	A tobacco cessation program offered through CIS for all eligible Regence covered members. For program eligibility and details go to www.cisbenefits.org >>**Healthy Benefits & Wellness** or call 24-hours a day, 7 days a week at **(866) 784-8454.**

CIS - Plan I C PPP RX2 with Alternative Care

Coverage Period: 01/01/2015 - 12/31/2015

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.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$300** claimant / **$900** family per calendar year. Doesn't apply to certain preventive care. **Copayments** or amounts in excess of the **allowed amount** do not count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **Preferred** & Participating: **$2,300** claimant / **$4,900** family per calendar year. Non-Participating: **$4,300** claimant / **$8,900** family per calendar year.	The **out–of–pocket limit** 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 out–of–pocket limit?	**Coinsurance** and **copayments** for alternative care, **premiums**, prescription drugs **out-of-pocket limit**, balance–billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Does this plan use a network of providers?	Yes. See www.Regence.com or call 1 (888) 370-6159 for lists of **preferred** or participating **providers**.	If you use an in–network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in–network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** 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 **excluded services**.

Questions: Call 1 (888) 370-6159 or visit us at www.Regence.com.
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- **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% coinsurance	40% coinsurance	40% coinsurance	——————none——————
	Specialist visit	20% coinsurance	40% coinsurance	40% coinsurance	
	Other practitioner office visit	20% coinsurance for spinal manipulations, $20 copay / visit for alternative care - acupuncture	20% coinsurance for spinal manipulations, $20 copay / visit for alternative care - acupuncture	20% coinsurance for spinal manipulations, $20 copay / visit for alternative care - acupuncture	**Coinsurance** applies to spinal manipulations only, after **deductible**. All other services are covered at the **copayment** and limit specified, **deductible** waived. Coverage is limited to 12 spinal manipulations / year. Coverage for alternative care is limited to $500 maximum / year.
	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)	20% coinsurance	40% coinsurance	40% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	40% coinsurance	

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Regence.com.	Generic drugs	$10 copay / retail prescription $20 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 self-injectable medications or 90-day supply for specialty drugs retail or mail order. 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.
	Preferred brand drugs	$20 copay or 20% coinsurance (whichever is greater) / retail prescription $40 copay or 20% coinsurance (whichever is greater) / mail order prescription			
	Non-preferred brand drugs	$40 copay or 20% coinsurance (whichever is greater) / retail prescription $80 copay or 20% coinsurance (whichever is greater) / mail order prescription			
	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——————
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——————

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 mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	20% coinsurance	40% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	
	Substance use disorder outpatient services	20% coinsurance	20% coinsurance	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	20% coinsurance	20% coinsurance	Coverage is limited to 180 visits / year.
	Rehabilitation services	20% coinsurance	20% coinsurance for outpatient 40% coinsurance for inpatient	20% coinsurance for outpatient 40% coinsurance for inpatient	Coverage is limited to 77 outpatient visits for all rehabilitation and habilitation services, including neurodevelopmental services / year.
	Habilitation services	20% coinsurance	20% coinsurance for outpatient 40% coinsurance for inpatient	20% coinsurance for outpatient 40% coinsurance for inpatient	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.)

- 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care, including spinal manipulations
- 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:** $5,680
- **Patient pays:** $1,860

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	$300
Copays	$20
Coinsurance	$1,390
Limits or exclusions	$150
Total	**$1,860**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,910
- **Patient pays:** $1,490

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	$300
Copays	$980
Coinsurance	$170
Limits or exclusions	$40
Total	**$1,490**

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.

PLAN I – ALTERNATIVE CARE, PRESCRIPTIONS & VALUE ADDED SERVICES

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 need an alternative care provider	Acupuncture	$20 Copay	$20 Copay	$20 Copay	**Deductible waived.** **Not applied to annual out-of-pocket limit.** Limited to $500 per calendar year per person.
	Chiropractor	20% coinsurance	20% coinsurance	20% coinsurance	**Applied to annual deductible & out-of-pocket limit.** Maximum 12 visits per calendar year per person.
If your child needs a hearing specialist	Hearing Aid	20% coinsurance	40% coinsurance	40% c5oinsurance	**Applied to deductible & out-of-pocket limit.** For claimants 18 years of age and younger, or enrolled children 19 years of age or older and enrolled in a secondary school or an accredited educational institution.
If you have nutritional needs	Counseling	0%	0%	0%	Limited to 4 visits per calendar year. **(Diabetic education and counseling is not subject to the 4 visit limitation per calendar year.**)
If you need assistance losing weight	Weight management & obesity treatment	0%	0%	0%	Includes integrated care coordination, nutritional counseling (up to 4 visits per calendar year), physician visit (up to 4 visits per calendar year) and coordination of care.
	Bariatric surgery to treat morbid obesity	$1,000 copay, then 20% coinsurance	$1,000 copay, then 40% coinsurance	$1,000 copay, then 40% coinsurance	**Deductible applied.** **Not applied to out-of-pocket limit.** This may be a covered service if you have participated, successfully, in at least six consecutive months of Turning Point. To learn more about our Bariatric Program call **(888) 370-6159.** Surgery must be authorized to be covered.

Additional Prescription Benefits	
Brand-Name Prescription Medication Instead of Generic	If an equivalent generic medication is available and a brand-name medication is chosen, the member is responsible for paying the applicable brand-name co-payment plus the difference in price between the equivalent generic medication and the brand-name medication, not to exceed total retail cost. The exception is when the prescribing provider specifies that the brand-name medication must be dispensed, in which case the member will not be responsible for payment of the difference in cost.
Value-Based Medications	You do not need to pay the copay when you fill prescriptions for those generic medications or formulary brand-name medications that we specifically designate as preventative for asthma, diabetes, high blood pressure, high cholesterol or tobacco addiction. You can find a list of such medications at the Claims Administrator's website, www.regence.com. (From there click on Regence Rx Pharmacy Benefit)
Value Added Services Offered by Regence BCBS of Oregon and CIS	
Case Management	Receive one-on-one help and support in the event you have a serious or sudden illness or injury. An experienced, compassionate case manager will serve as your personal advocate during a time when you need it most. Your case manager is a licensed healthcare professional who will help you understand your treatment options, show you how to get the most of our available Plan benefits and work with your physician to support your treatment plan. To learn more or to make a referral to case management, please call **(866) 543-5765.**
Disease Management	Regence Disease Management is a support and education program for people with chronic conditions such as diabetes, heart disease, asthma and/or depression. The Claim's Administrator's nurses and behavioral health care coordinators provide tailored educational materials, tools and other services to help you get on track with your care and stay there. They can help you understand the care plan you developed with your physician, and make smarter choices for better health. To learn more, please call **(866) 543-5765.**
Special Beginnings Program	Pregnancy is a time of planning and excitement, but it can also be a time of confusion and questions. Special Beginnings can provide answers and assistance so that you can relax and enjoy those nine life-changing months. This program offers expectant mothers access to a nurse 24 hours a day, 7 days a week, an informative maternity book or DVD and educational materials tailored to their needs. To learn more call **(888) JOY-BABY (569-2229).**
Regence Advice 24 (Nurse Advice Line)	Registered nurses are available 24/7 to answer your health-related questions and help you make informed decisions about when, where, and if you should seek care. If you're not sure whether to visit the emergency room, see your doctor or treat your condition at home, the nurses are there, day or night. Call the Nurse Advice Line any time 24 hours a day seven days a week, at **(800) 267-6729.**
BlueCard® Program (Out of Area Service)	The BlueCard Program is a unique program that enables you to access hospitals and physicians when outside the four-state area Regence services (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world. Find a provider near you at www.bcbs.com or call **(800) 810-BLUE (2583).**
Quit for Life® Tobacco Cessation Program	A tobacco cessation program offered through CIS for all eligible Regence covered members. For program eligibility and details go to www.cisbenefits.org >>**Healthy Benefits & Wellness** or call 24-hours a day, 7 days a week at **(866) 784-8454.**

KAISER PERMANENTE®: CIS – HMO Copay Plan with Vision and Alternative Care

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest

Coverage Period: 01/01/2015-12/31/2015

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

Coverage for: Individual/Family | **Plan Type:** TRAD

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.kp.org** or by calling **503-813-2000** or **1-800-813-2000**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$600** Individual / **$1,200** Family.	The **out-of-pocket limit** 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 out–of–pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.kp.org** or call **503-813-2000 or 1-800-813-2000** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes. Written approval is required to see most specialists.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **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 **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	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	$10 per visit	Not covered	If you receive services in addition to an office visit, additional copayments or coinsurance may apply.
	Specialist visit	$10 per visit	Not covered	If you receive services in addition to an office visit, additional copayments or coinsurance may apply.
	Other practitioner office visit	$10 per visit for physician-referred alternative care	Not covered	Prior authorization required. If you receive services in addition to an office visit, additional copayments or coinsurance may apply.
	Preventive care/screening/immunization	No charge	Not covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Some services may require prior authorization.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.kp.org/formulary**	Generic drugs	$10 per prescription at KP pharmacy/ $20 per prescription mail order	Not covered	Up to 30-day supply (retail); 31-90-day supply (mail order). No charge for contraceptives (subject to formulary guidelines).
	Preferred brand drugs	$10 per prescription at KP pharmacy/ $20 per prescription mail order	Not covered	
	Non-preferred brand drugs	$10 per prescription at KP pharmacy/ $20 per prescription mail order	Not covered	Covered only when you meet formulary exception criteria.
	Specialty drugs	$10 per prescription at KP pharmacy/ $20 per prescription mail order	Not covered	KP Formulary applies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$10 per visit	Not covered	——————none——————
	Physician/surgeon fees	Included in facility fee	Not covered	——————none——————
If you need immediate medical attention	Emergency room services	$75 per visit		This cost sharing does not apply if admitted directly to the hospital as an inpatient for covered services (see "If you have a hospital stay" for inpatient cost sharing).
	Emergency medical transportation	$75 per trip		——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Urgent care	$30 per visit		Non-participating provider urgent care covered only if you are temporarily outside of our service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Prior authorization required.
	Physician/surgeon fee	Included in facility fee	Not covered	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Individual: $10 per visit/ Group: $5 per visit	Not covered	If you receive services in addition to an office visit, additional copayments or coinsurance may apply.
	Mental/Behavioral health inpatient services	No charge	Not covered	Prior authorization required.
	Substance use disorder outpatient services	Individual: $10 per visit/ Group: $5 per visit	Not covered	If you receive services in addition to an office visit, additional copayments or coinsurance may apply.
	Substance use disorder inpatient services	No charge	Not covered	Prior authorization required.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits. If you receive services in addition to an office visit, additional copayments or coinsurance may apply.
	Delivery and all inpatient services	No charge	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Coverage is limited to 130 visits per year. Prior authorization required.
	Rehabilitation services	Outpatient: $10 per visit/ Inpatient: No charge	Not covered	Coverage is limited to 20 visits per therapy per year. Prior authorization required.
	Habilitation services			Coverage is limited to neurodevelopmental disorders of early childhood. Rehabilitation limits apply. Prior authorization required.
	Skilled nursing care	No charge	Not covered	Coverage is limited to 100 days per year. Prior authorization required.
	Durable medical equipment	20% coinsurance	Not covered	Coverage is limited to items on our DME formulary. Prior authorization required.
	Hospice service	No charge	Not covered	Prior authorization required.
If your child needs dental or eye care	Eye exam	$10 per visit	Not covered	For members age 18 and younger.
	Glasses	No charge for one pair standard frames and lenses or 6-month supply contact lenses every 24 months.	Not covered	For members age 18 and younger.
	Dental check-up	Not covered	Not covered	No coverage for dental checkup.

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.)			
• Dental care • Long-term care • Weight loss programs	• Non-emergency care when traveling outside the U.S.	• Hearing aids (Age 19 and older) • Private-duty nursing	• Cosmetic surgery • Routine foot care
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your cost for these services.)			
• Acupuncture (self-referred)	• Bariatric surgery • Hearing aids (Age 18 and younger)	• Chiropractic care (self-referred) • Infertility treatment	• Glasses (Age 19 or older) • Routine eye care (Age 19 and older)

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 503-813-2000 or 1-800-813-2000. 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: Kaiser Permanente at 503-813-2000 or 1-800-813-2000, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally a consumer assistance program can help you file your appeal. Contact the Oregon Insurance Division, P.O. Box 14480, Salem, OR 97309-0405, 503-947-7984, http://www.cbs.state.or.us/ins/index.html, or cp.ins@state.or.us.

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?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **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 1-800-324-8010.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-324-8010.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码): 1-800-324-8010.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-324-8010.

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 $7320**
- **Patient pays $220**

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	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$200
Total	**$220**

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,590**
- **Patient pays $810**

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	$0
Copays	$700
Coinsurance	$30
Limits or exclusions	$80
Total	**$810**

Total amounts above are based on subscriber only coverage.

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.

Dental Plan II
CIS
Effective January 1, 2015

How To Use this Dental Plan

When you visit your dental provider, tell him or her that you are a member of an ODS dental program.

Calendar year maximum, per member*	**$1,500**
Calendar year deductible, per member	**$0**

Service	Benefit Amount
CLASS I - PREVENTIVE [1] - Examination/X-rays - Prophylaxis - Fissure Sealants	**** 1st year - 70%** **2nd year - 80%** **3rd year - 90%** **4th year - 100%**
CLASS II - BASIC - Restorative Dentistry (treatment of tooth decay with amalgam or composite) - Oral Surgery (surgical extractions & certain minor surgical procedures) - Endodontic (pulp therapy & root canal filling) - Periodontics (treatment of tissues supporting the teeth) - Space Maintainers - Repair or reline of dentures and bridges	**** 1st year - 70%** **2nd year - 80%** **3rd year - 90%** **4th year - 100%**
CLASS III - MAJOR[2] - Crowns - Implants - Denture and Bridge Work (construction of fixed bridges, partials and complete dentures)	**50%**

* Annual dental maximum does not apply to members under age 16.

** Under this plan, benefits start at 70% your first calendar year of coverage. Thereafter, payments increase by 10% each calendar year (up to a maximum benefit of 100%) provided the individual has visited the dentist at least once during the previous calendar year. If in any calendar year the individual fails to receive covered dental services, the percentage for Class I and II services will decrease by 10% the next calendar year, but it will never be reduced below 70%.

[1] Any amount paid by the plan for Preventive services does not apply towards the calendar year maximum.

[2] There is a 12 month waiting period for Late Enrollees. A Late Enrollee is anyone not enrolled when initially eligible.

MEMBER SERVICES

Through our online service, **myModa**, you can download your member handbook, view claims status and payment information, search for participating providers, order ID cards, view personal information, and email dental customer service. You can access myModa at **www.modahealth.com,** or the CIS website at **www.cisbenefits.org**.

Dental Optimizer™ is a free resource on myModa that enables you to assess your risk level for oral health concerns and use that assessment to learn about reducing your risks and treatment costs. Dental Optimizer is comprised of a cavities risk assessment, dental health suggestions, and a Savings Optimizer based on a personal survey.

ODS provides dental claims payment services only and does not assume financial risk or obligation with respect to payment of claims

This is a benefit summary only. Any errors or omissions are unintentional.
For a more detailed description of benefits, refer to your member handbook, which can be accessed through myModa, or by calling Customer Service for a copy.

ODS Customer Service 888-217-2365 - ODS' website www.modahealth.com

See back for additional information

ADVANTAGES

DELTA DENTAL

* **Freedom to choose your dentist:** ODS is unique in that we have contracts with more than 1,800 licensed dentists in Oregon.
* **Professional Arrangements:** ODS has specific fee arrangements with our participating dentists in Oregon to ensure that actual charges made by the dentist do not exceed his or her accepted fees on file with ODS. We believe that the unique feature in all ODS programs is that every participating dentist becomes a party to cost control as well as the quality of care. Participating dentists will update your records with your new information and will submit claims to ODS for you.
* **Pre-determination:** As a service to our customers, your dental office can submit a pre-treatment plan to ODS on your behalf, and we will return it to your dentist, indicating the dollar allowance that will be covered by your plan **before** you go forward with treatment.

LIMITATIONS

If an eligible person selects a more expensive plan of treatment than is functionally adequate, ODS will pay the applicable percentage of the maximum plan allowance for the least costly treatment. The patient will then be responsible for the remainder of the dental providers' fees.

Class I - Preventive

* **Diagnostic:** Supplementary bitewing x-rays are covered once in any 12-month period. Complete series x-rays or a panoramic film are covered once in any 5-year period.

Class II - Basic

* **Restorative:** A separate charge for general anesthesia and/or IV sedation is not covered when used for non-surgical procedures. A separate charge for anesthesia may be covered when, in our judgment, it is necessary for complex oral surgery or due to the existence of a concurrent medical condition.

Class III - Major

* **Restorative:** If a tooth can be restored with a material such as amalgam, but another type of restoration is selected by the patient and dentist, the covered expense will be limited to the cost of amalgam. Crowns and other cast restorations (including onlays and replacement inlays) are covered once in a seven (7) year period on any tooth.

* **Prosthodontic:** A prosthetic device will be covered once in a seven (7) year period provided the tooth has not been crowned within the past seven (7) years. Specialized or personalized prosthetics are limited to the cost of standard devices.

EXCLUSIONS

* Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
* Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing teeth.
* Services started prior to the date the individual became eligible for services under the program.
* Hypnosis, prescribed drugs, premedications or analgesia (e.g. nitrous oxide) or any other euphoric drugs.
* Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
* General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office.
* Plaque control and oral hygiene or dietary instructions.
* Experimental procedures.
* Missed or broken appointments.
* Orthodontic services.
* Services for cosmetic reasons.
* Claims submitted more than 12 months after the date of rendition of the services.
* All other services or supplies, not specifically covered.

ODS Customer Service 888-217-2365 - ODS' website www.modahealth.com

ODS provides dental claims payment services only and does not assume financial risk or obligation with respect to payment of claims.

Summary of Benefits

Group Number: OR27
Effective Date: January 1, 2015

Willamette Dental Group

CIS

	COPAYS
Annual Maximum	No Annual Maximum
Deductible	No Deductible
General Office Visit	You pay $10 per Visit
DIAGNOSTIC AND PREVENTIVE SERVICES	
Routine and Emergency Exams	Covered with the Office Visit Copay
X-rays	Covered with the Office Visit Copay
Teeth Cleaning	Covered with the Office Visit Copay
Fluoride Treatment	Covered with the Office Visit Copay
Sealants (per Tooth)	Covered with the Office Visit Copay
Head and Neck Cancer Screening	Covered with the Office Visit Copay
Oral Hygiene Instruction	Covered with the Office Visit Copay
Periodontal Charting	Covered with the Office Visit Copay
Periodontal Evaluation	Covered with the Office Visit Copay
RESTORATIVE DENTISTRY	
Fillings (Amalgam)	Covered with the Office Visit Copay
Porcelain-Metal Crown	Covered with the Office Visit Copay
PROSTHODONTICS	
Complete Upper or Lower Denture	Covered with the Office Visit Copay
Bridge (per Tooth)	Covered with the Office Visit Copay
ENDODONTICS AND PERIODONTICS	
Root Canal Therapy – Anterior	Covered with the Office Visit Copay
Root Canal Therapy – Bicuspid	Covered with the Office Visit Copay
Root Canal Therapy – Molar	Covered with the Office Visit Copay
Osseous Surgery (per Quadrant)	Covered with the Office Visit Copay
Root Planing (per Quadrant)	Covered with the Office Visit Copay
ORAL SURGERY	
Routine Extraction (Single Tooth)	Covered with the Office Visit Copay
Surgical Extraction	You pay a $50 Copay
ORTHODONTIA TREATMENT	
Pre-Orthodontia Treatment	You pay a $150 Copay*
Comprehensive Orthodontia Treatment	You pay a $1,500 Copay
MISCELLANEOUS	
Local Anesthesia	Covered with the Office Visit Copay
Dental Lab Fees	Covered with the Office Visit Copay
Nitrous Oxide	You pay a $10 Copay
Specialty Office Visit	You pay a $30 Copay per visit
Out of Area Emergency Care Reimbursement	You pay charges in excess of $100

*Copayment credited towards the Comprehensive Orthodontic Service copayment if patient accepts treatment plan.

Underwritten by Willamette Dental Insurance, Inc.
This plan provides extensive coverage of services and supplies to prevent, diagnose, and treat diseases or conditions of the teeth and supporting tissues. Presented are just some of the most common procedures covered in your plan. Please see the Certificate of Coverage for a complete plan description, limitations, and exclusions.

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Form No. 028-OR(6/13)
Contract No. 001-OR (1/10R), 001-OR(2/14)

Exclusions and Limitations

Willamette Dental Group

Exclusions

Bridges, crowns, dentures or any prosthetic devices requiring multiple treatment dates or fittings if the prosthetic item is installed or delivered more than 60 days after termination of coverage.
The completion or delivery of treatments, services, or supplies initiated prior to the effective date of coverage
Dental implants, including attachment devices and their maintenance.
Endodontic services, prosthetic services, and implants that were provided prior to the effective date of coverage.
Endodontic therapy completed more than 60 days after termination of coverage.
Exams or consultations needed solely in connection with a service or supply not listed as covered.
Experimental or investigational services or supplies and related exams or consultations.
Full mouth reconstruction, including the extensive restoration of the mouth with crowns, bridges, or implants; and occlusal rehabilitation, including crowns, bridges, or implants used for the purpose of splinting, altering vertical dimension, restoring occlusions or correcting attrition, abrasion, or erosion.
General anesthesia, moderate sedation and deep sedation.
Hospital care or other care outside of a dental office for dental procedures, physician services, or facility fees.
Nightguards.
Orthognathic surgery.
Personalized restorations.
Plastic, reconstructive, or cosmetic surgery and other services or supplies, which are primarily intended to improve, alter, or enhance appearance.
Prescription and over-the-counter drugs and pre-medications.
Provider charges for a missed appointment or appointment cancelled without 24 hours prior notice.
Replacement of lost, missing, or stolen dental appliances; replacement of dental appliances that are damaged due to abuse, misuse, or neglect.
Replacement of sound restorations.
Services or supplies and related exams or consultations that are not within the prescribed treatment plan and/or are not recommended and approved by a Willamette Dental Group dentist.
Services or supplies and related exams or consultations to the extent they are not necessary for the diagnosis, care, or treatment of the condition involved.
Services or supplies by any person other than a licensed dentist, denturist, hygienist, or dental assistant.
Services or supplies for the diagnosis or treatment of temporomandibular joint disorders.
Services or supplies for the treatment of an occupational injury or disease, including an injury or disease arising out of self-employment or for which benefits are available under workers' compensation or similar law.
Services or supplies for treatment of injuries sustained while practicing for or competing in a professional athletic contest.
Services or supplies for treatment of intentionally self-inflicted injuries.
Services or supplies for which coverage is available under any federal, state, or other governmental program, unless required by law.
Services or supplies not listed as covered in the contract.
Services or supplies provided to correct congenital or developmental malformations of the teeth and supporting structure if primarily for cosmetic reasons.
Services or supplies where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

Limitations

If alternative services can be used to treat a condition, the service recommended by the Willamette Dental Group dentist is covered.
Services or supplies listed in the contract, which are provided to correct congenital or developmental malformations which impair functions of the teeth and supporting structures will be covered for dependent children if primarily for the purpose of controlling or eliminating infection, controlling or eliminating pain, or restoring function.
Crowns, casts, or other indirect fabricated restorations are covered only if dentally necessary and if recommended by the Willamette Dental Group dentist.
When initial root canal therapy was performed by a Willamette Dental Group dentist, the retreatment of such root canal therapy will be covered as part of the initial treatment for the first 24 months. When the initial root canal therapy was performed by a non-participating provider, the retreatment of such root canal therapy by a Willamette Dental Group dentist will be subject to the applicable copayments.
The services provided by a dentist in a hospital setting are covered if medically necessary; pre-authorized by a Willamette Dental Group dentist; the services provided are the same services that would be provided in a dental office; and applicable copayments are paid.
The replacement of an existing denture, crown, inlay, onlay, or other prosthetic appliance or restoration denture is covered if the appliance is more than 5 years old and replacement is dentally necessary.

cis benefits
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KAISER PERMANENTE®

Effective January 1, 2015

Dental	
Annual Deductible	None
Annual Benefit Maximum	Unlimited
Dental Office Visit Charge – applies to all visits	$10
Preventive and Diagnostic Care – includes oral examinations and x-rays, teeth cleaning (prophylaxis), fluoride treatments, instruction in the care of your teeth and gums, and prescribed space maintainers	No additional charge
Restorative Services – includes routine fillings, plastic and stainless steel crowns	No additional charge
Simple Extractions	No additional charge
Oral Surgery	No additional charge
Periodontic Procedures – includes diagnosis, evaluation, and treatment of disease of the gums, including scaling and root planning	No additional charge
Endodontic Procedures – includes root canal and related therapy, including diagnosis and evaluation	No additional charge
Major Restorative Services – includes gold or porcelain crowns, inlays, bridge abutments and pontics	$45 for each
Removable Prosthetics – Full and partial dentures Relines Rebasis	 $95 for each partial denture, $65 for each full denture $25 $25
Orthodontics	Not covered

PLEASE NOTE:

- You will be charged a $25 fee when you miss a dental appointment without calling in advance to cancel.
- You pay $15 for nitrous oxide for adults and children 13 and older.
- You pay 10% of charges for night-guards.

EXCLUSIONS

The following are not covered:

- Service not approved by a Kaiser Permanente dentist. Kaiser Permanente does not pay for unauthorized services from dentists or facilities not affiliated with Kaiser Permanente, except as indicated under "Emergency Treatment."
- Conditions covered by workers' compensation or that are the employer's responsibility.
- Procedures not generally and customarily available in the service area.
- Surgery to correct malocclusion or temporomandibular joint disorders; treatment for problems of the jaw joint, including temporomandibular joint syndrome and craniomadibular disorders; and treatment of conditions of the joint linking the jaw bone and skull and of the complex of muscles, nerves, and other tissues related to that joint.
- Restorative or reconstructive treatment for specific congenital or developmental malformations.
- Full-mouth reconstruction and occlusal rehabilitation including appliances, restorations, and procedures needed to alter vertical dimension or occlusion or to splint or correct attrition or abrasion.
- Cosmetic services.
- Prescription Drugs.
- Experimental or investigational services.
- Orthodontic services.
- More than two visits for routine teeth cleaning (oral prophylaxis) in any twelve consecutive month period.
- Conditions covered by government agencies or programs other than Medicaid.
- Genetic testing.
- Dental implants, including bone augmentation and fixed or removable prosthetic devices attached to or covering the implants; all related services, including diagnostic consultations, impressions, oral surgery, placement, removal, and cleaning; and services associated with postoperative conditions and complications arising from implants.
- Removal and replacement, with alternative materials, of clinically acceptable material or restorations for any reason except the pathological condition of the tooth or teeth.
- General anesthesia and intravenous sedation.
- Medical, hospital, and certain dental services.
- Work in progress before your coverage is effective.
- Replacement of prefabricated, non-cast crowns, including stainless steel crowns, that were not placed by a Kaiser Permanente dentist.
- Repair or replacement of fixed prosthetics or removable prosthetic appliances that are less than five years old.

This summary provides a brief description of your dental plan benefits. Any errors or omissions are unintentional. Please refer to your Evidence of Coverage brochure for detailed information, including limitations and exclusions that may apply to the benefits above. In the case of conflict between this summary and the EOC, the EOC will prevail. If you have questions or to request an EOC, please contact Kaiser Membership Services at 1-800-813-2000; Portland area 503-813-2000; or Salem 503-361-5400.

Your VSP Vision Benefits Summary

Welcome to VSP® Vision Care. Your VSP vision benefit offers you the best in eyecare and eyewear.

Personalized Care. A VSP doctor provides personalized care that focuses on keeping you and your eyes healthy year after year. Plus, when you see a VSP doctor, you'll get the most out of your benefit, have lower out-of-pocket costs, and your satisfaction is guaranteed.

Eyewear. Choose the eyewear that's right for you and your budget. From classic styles to the latest designer frames, you'll find the eyewear that's right for you and your family.

Choice of Providers. With open access to see any eyecare provider, you can see the one who's right for you. Choose a VSP doctor or any other provider.

Using your VSP benefit is easy.

- **Find the right eyecare provider for you.** To find a VSP doctor, visit **vsp.com** or call **800.877.7195**.
- **Review your benefit information.** Visit **vsp.com** to review your plan coverage before your appointment.
- **At your appointment, tell them you have VSP.** There's no ID card required.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP doctor.

For your complete benefit description, visit **vsp.com** or call **800.877.7195**.

VSP provides vision claims payment services only and does not assume financial risk or obligation with respect to payment of claims.

VSP Vision care for life

CAT#00611 JOB#3755CM 6/10

CIS
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www.cisbenefits.org

CIS Benefits and VSP provide you an affordable eyecare plan
Effective 1/1/15 – 12/31/15

Doctor Network……VSP Signature

Your Coverage with a VSP Doctor

WellVision Exam® focuses on your eye health and overall wellness
Exam.....*every other calendar year – Adults*
Exam..... *every calendar year – Children*

Prescription Glasses
Lenses.....*every other calendar year – Adults*
Lenses..... *every calendar year – Children*
Single vision, lined bifocal, and lined trifocal lenses. Progressive lenses covered after $50 copay. Polycarbonate lenses for dependent children.

Frame.....***every other calendar year***
- *$120.00 allowance for a wide selection of frames*
- *20% off the amount over your allowance.*

~OR~

Contact Lens Care.....*every other calendar year*
Contact Lens Care. *every calendar year – Children*
$166.00 allowance for contacts and the contact lens exam (fitting and evaluation).

Extra Discounts and Savings

Glasses and Sunglasses
- *Average 35 - 40% savings on all non-covered lens options*
- *30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last WellVision Exam*

Contacts
- *15% off cost of contact lens exam (fitting and evaluation)*

Laser Vision Correction
- *Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.*
- *After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor*

Your Coverage with Other Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP doctor.
Out-of-network claims must be submitted to VSP within one year. Send an itemized receipt with employee name, DOB, last 4 digits of ss#, patient name and DOB to: VSP, PO Box 997105, Sacramento, CA 95899-7105. Keep a copy for your records.

Exam .....*Up to $71.00*
Single vision lenses.....*Up to $51.00*
Lined bifocal lenses.....*Up to $77.00*
Lined trifocal lenses.....*Up to $100.00*
Frame .....*Up to $66.00*
Contacts .....*Up to $166.00*

VSP guarantees service from VSP doctors only. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.