

oregon – small group

basic plan \$15 / 50% / \$3,000

This is a summary of benefits only. Please consult your Member Handbook for detailed information on plan use and benefit coverage. Benefits are provided for medically necessary services when provided by a participating physician or provider. **The annual (calendar year) out-of-pocket maximum payable by you for covered services is \$3,000 per person/\$9,000 per family. Some services do not apply to the maximum. The lifetime maximum coverage for benefits is \$2,000,000.**

benefits

you pay:

Preventive Health Services (from a Personal Physician/Provider only)

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|--|------------|
| • Periodic health exams, well-baby care | \$15/visit |
| • Vision & hearing screening, including necessary vision exams, for children under 18* | \$15/visit |

Women's Health Care Services

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|--|------------|
| • Annual (calendar year) gynecological exams & Pap tests | \$15/visit |
| • Follow-up visits after annual gynecological exam | 50% |
| • Mammograms | \$15 |

Physician / Provider Services

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|--|------------|
| • Office visits to a Personal Physician/Provider | \$15/visit |
| • Office visits to all other participating providers | 50% |
| • Inpatient hospital visits | 50% |
| • Surgery & anesthesia | 50% |
| • Allergy shots & serums, injectable medications | 50% |
| • Routine immunizations/shots | \$15/visit |
| • Other office procedures | 50% |

Hospital Services

- | | |
|--|-----|
| • Acute care | 50% |
| • Rehabilitative care (30 days per condition; 60 days for head/spinal) | 50% |
| • Skilled nursing facility (20 days per condition) | 50% |

Maternity

- | | |
|---|-----|
| • Pre-natal visits, delivery, & post-natal visits | 50% |
| • Hospital services | 50% |
| • Routine newborn nursery care | 50% |

Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic Devices (Orthotics covered up to \$200 per calendar year)

50%

Emergent/Urgent & Ambulance Services (your Emergent/Urgent copayment is waived if admitted to hospital within 24 hours)

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|---|-------|
| • Emergency services (for the treatment of emergency medical conditions only) | \$125 |
| • Urgent care services (for non-life threatening illness/minor injury) | 50% |
| • Ambulance services (for emergency transportation only) | 50% |

Other Covered Services

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|--|--|
| • X-ray & lab services | 50% |
| • Outpatient rehabilitation (30 visits per condition within 60 days) | 50% |
| • Outpatient surgery, dialysis, chemotherapy & radiation therapy | 50% |
| • Temporomandibular joint (TMJ) services | 50% |
| • Home health care (60 consecutive days per condition) | 50% |
| • Hospice care | 50% |
| • Hearing aids; children under age 18 (who lost hearing before age 3) | 50% |
| • Dental care; children ages 3-12 (exam/cleaning/flouride once per year; bitewing x-rays once in 18 months; sealants as appropriate) | \$15/visit; \$50 for sealants
(from Willamette Dental Group only) |

*Children 2-6 years are limited to one exam every 12 months; children 7-17 are limited to one exam every 24 months.

benefits

you pay:

Mental Health / Chemical Dependency

(To initiate services, call 1-800-711-4577. All inpatient, residential and day or partial hospitalization treatment services must be prior authorized.)

• Inpatient/residential services	
- Facility	50%
- Provider visits	50%
• Day treatment services	
- Facility	50%
• Outpatient services	
- Provider visits	50%

general limitations and exclusions

Following are the most common limitations and exclusions. Please refer to your Member Handbook for a complete listing. Your employer may have purchased a supplemental benefit offering some of the services listed below. Please call your Customer Service team if you have questions.

- **Alternative care**, including acupuncture, chiropractic and naturopathic care.
- Some services do not apply to the **annual out-of-pocket maximums**. Please see your Member Handbook for a complete listing.
- **Cochlear implants**.
- **Cosmetic surgery**.
- **Custodial care** and private nursing services.
- **Dental care**, including orthognathic surgery, except as otherwise stated in this Summary.
- **Experimental/investigational procedures**.
- **Eye surgery** which alters the refractive character of the eye, including laser eye and radial keratotomy.
- Services and supplies for **family planning** (including birth control devices such as IUD's and diaphragms), **fertility/infertility** treatment, including in vitro fertilization.
- Routine **foot care**, except for diabetes.
- **Genetic testing**, except as otherwise stated in your Member Handbook.
- **Hearing aids**, hearing therapies and hearing devices used in association with hearing therapies or training, except as otherwise stated in this Summary.
- **Home births** and all related services.
- **Massage therapy**.
- Certain **mental health services**, such as treatment of developmental or learning disabilities and self-help programs, including family, marriage, sex and career counseling in the absence of illness.
- **Non-participating provider** services unless prior authorized by us or in an emergency.
- **Physical exams** primarily for camps, sports, insurance, licensing, employment, or other third-party purposes.
- Services, supplies and prescription drugs for **sexual dysfunction or sexual transformation**.
- Voluntary **sterilization** or **termination of pregnancy**.
- **TMJ** services are limited to \$1,000 per calendar year, \$5,000 per lifetime.
- Organ **transplants**, except as otherwise stated in your Member Handbook. No benefits will be provided during the first 24 months of coverage unless you meet the circumstances outlined in your Member Handbook. Approved transplants are limited to \$250,000 per lifetime.
- Amounts in excess of **usual, customary and reasonable (UCR) charges**. These amounts do not apply to out-of-pocket maximums.
- Routine **vision exams and eyeglasses**.
- **Weight loss programs** and other services and supplies for the treatment of **obesity**.
- Services for injury/illness sustained as a result of any **work for wage or profit**. Services covered by **motor vehicle insurance** or other liability insurance.

Other Important Information

- If you have an enrolled out-of-area dependent, please refer to the **Basic Plan Out-of-area Dependent Summary of Benefits**.

customer service:	• Portland Metro Area: 503-574-7500	• All Other Areas: 1-800-878-4445	• TTY (For the Hearing Impaired): 503-574-8702 or 1-888-244-6642
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