

## oregon – large group

## personal option \$10 / 10% / \$1,200

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 \$1,200 per person / \$3,600 per family.** Some services do not apply to the maximum.

**The lifetime maximum coverage for benefits is \$2,000,000.**

### benefits

### you pay:

#### Women’s Health Care Services

• Annual (calendar year) gynecological exams, Pap tests	\$10/visit
• Follow-up visits after annual gynecological exam	\$10/visit
• Mammograms	\$10

#### Physician / Provider Services

• Office visits	\$10/visit
• Periodic health exams, well-baby care (from a Personal Physician/Provider only)	\$10/visit
• Inpatient hospital visits	10%
• Surgery & anesthesia	10%
• Allergy shots & serums, injectable medications	10%
• Routine immunizations/shots	\$10/visit
• Other office procedures	10%

#### Hospital Services

• Acute care	10%
• Rehabilitative care (30 days per calendar year)	10%
• Skilled nursing facility (60 days per calendar year)	10%

#### Maternity

• Pre-natal visits, delivery, & post-natal visits	\$100
• Hospital services	10%
• Routine newborn nursery care	10%

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

10%

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

• Emergency services (for the treatment of emergency medical conditions only)	\$125
• Urgent care services (for non-life threatening illness/minor injury)	\$25
• Ambulance services (for emergency transportation only)	10%

#### Other Covered Services

• X-ray & lab services	10%
• Outpatient rehabilitative services (30 visits per calendar year)	10%
• Outpatient surgery, dialysis, chemotherapy & radiation therapy	10%
• Temporomandibular joint (TMJ) services	50%
• Home health care	10%
• Hospice care	Covered in full

## 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	10%
- Provider visits	10%
• Day treatment services	
- Facility	10%
• Outpatient services	
- Provider visits	\$10/visit

## 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.
- **Cosmetic surgery**.
- **Custodial care** and private nursing services.
- **Dental care**, including orthognathic surgery, except as otherwise stated in your Member Handbook.
- **Experimental/investigational procedures**.
- **Eye surgery** which alters the refractive character of the eye, including laser eye and radial keratotomy.
- Services and supplies for **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.
- **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 **Out-of-area Dependent Summary of Benefits**.

<b>customer service:</b>	• 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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