

# Oregon Medical Insurance Pool/Federal Medical Insurance Pool

## 2012 OMIP Benefit Summary

|  | Medical & Portability Plan 750 |                             | Medical Plan 1000 | Medical & Portability Plan 1500 |                             |
|--|--------------------------------|-----------------------------|-------------------|---------------------------------|-----------------------------|
| <b>Lifetime Maximum Benefit</b>                              | \$2,000,000                    |                             | \$2,000,000       | \$2,000,000                     |                             |
| <b>OMIP Pre-existing Waiting Period, including Pregnancy</b> | <i>Medical:</i><br>6 months    | <i>Portability:</i><br>None | 6 months          | <i>Medical:</i><br>6 months     | <i>Portability:</i><br>None |

*There is no pre-existing wait period for children under the age of 19.*

|   | In-network you pay | Out-of-network you pay | In-network you pay | Out-of-network you pay | In-network you pay             | Out-of-network you pay |
|---|--------------------|------------------------|--------------------|------------------------|--------------------------------|------------------------|
| <b>Annual Medical Deductible</b>  | \$750              |                        | \$1,000            |                        | \$1,500                        |                        |
| <b>Maximum Annual Medical Out-of-Pocket, excluding medical deductible, per individual<sup>1</sup></b> | \$3,000            | \$6,000                | \$4,000            | \$8,000                | \$6,000                        | \$12,000               |
| <b>Doctor Visits</b>  | 20%                | 40%                    | 20%                | 40%                    | 30%                            | 50%                    |
| <b>Hospital</b>   | 20%                | 40%                    | 20%                | 40%                    | 30%                            | 50%                    |
| <b>Outpatient Surgery</b>   | 20%                | 40%                    | 20%                | 40%                    | 30%                            | 50%                    |
| <b>Skilled Nursing Care – limited to 60 days</b>  | 20%                | 40%                    | 20%                | 40%                    | 30%                            | 50%                    |
| <b>Home Health Care – limited to 130 visits</b>   | 20%                | 40%                    | 20%                | 40%                    | 30%                            | 50%                    |
| <b>Emergency Room<sup>2</sup></b>   | 20%+\$200 co-pay   | 20%+\$200 co-pay       | 20%+\$200 co-pay   | 20%+\$200 co-pay       | 30%+\$200 co-pay               | 30%+\$200 co-pay       |
| <b>Ambulance</b>  | 20%                |                        | 20%                |                        | 30%                            |                        |
| <b>Maternity</b>  | 20%                | 40%                    | 20%                | 40%                    | 30%                            | 50%                    |
| <b>Diagnostic X-ray/Lab</b>   | 20%                | 40%                    | 20%                | 40%                    | 30%                            | 50%                    |
| <b>Transplant<sup>2</sup></b>   | 0%                 | 40%                    | 0%                 | 40%                    | 0%                             | 50%                    |
| <b>Hospice</b>  | 20%                | 40%                    | 20%                | 40%                    | 30%                            | 50%                    |
| <b>Rehabilitation Inpatient/Outpatient – limited to 60 days</b>                                       | 20%                | 40%                    | 20%                | 40%                    | 30%                            | 50%                    |
| <b>Durable Medical Equipment</b>  | 20%                |                        | 20%                |                        | 30%                            |                        |
| <b>Mental Health/Chemical Dependency</b>  | 20%                | 40%                    | 20%                | 40%                    | 30%                            | 50%                    |
| <b>Women’s Health Care Services<sup>3</sup></b>   | 20%                | Not Covered            | 20%                | Not Covered            | 30%                            | Not Covered            |
| <b>Men’s Health Care Services<sup>3</sup></b>   | 20%                | Not Covered            | 20%                | Not Covered            | 30%                            | Not Covered            |
| <b>Immunizations<sup>3</sup></b>  | 20%                | Not Covered            | 20%                | Not Covered            | 30%                            | Not Covered            |
| <b>Well-Baby Care/Well-Child Care<sup>3</sup></b>   | 20%                | Not Covered            | 20%                | Not Covered            | 30%                            | Not Covered            |
| <b>Preventive Care under the PPACA<sup>3</sup></b>  | 0%                 | Not Covered            | 0%                 | Not Covered            | 0%                             | Not Covered            |
| <b>Prescription Drugs: No out-of-pocket maximum on prescription drugs<sup>2</sup></b>                 | \$0 Rx deductible  |                        | \$0 Rx deductible  |                        | \$1,000 Rx deductible (annual) |                        |
| <b>Generic Coinsurance<sup>4</sup></b>  | Up to \$5          |                        | Up to \$5          |                        | Up to \$5                      |                        |
| <b>Preferred Brand Coinsurance<sup>4</sup></b>  | Up to \$40         |                        | Up to \$40         |                        | Up to \$40                     |                        |
| <b>Non-Preferred Brand Coinsurance</b>  | Up to \$70         |                        | Up to \$70         |                        | Up to \$70                     |                        |

<sup>1</sup> This is the maximum amount you will pay for covered medical services per individual, per calendar year, excluding the deductibles, before OMIP will begin paying 100% for covered services.

<sup>2</sup> The emergency room co-pay, out-of-pocket prescription drug payments, transplants performed at non-contracting facilities, and disallowed charges do not apply to the medical deductible or out-of-pocket maximum.

<sup>3</sup> These services do *NOT* accumulate towards the maximum annual out-of-pocket expense. Also, you do not have to meet the annual medical deductible before OMIP pays for these services. Coverage is provided only for those preventative care services designated by: The United States Preventive Services Task Force (USPSTF) for services with an A or B rating in the current recommendations; by the Health Resources and Services Administration (HRSA); or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).

<sup>4</sup> \$0 co-payment for fluoride, regular aspirin, and iron as specified by the *Patient Protection Affordable Care Act* and *specific* diabetic supplies, insulin (excluding pumps), and evidence-based generic maintenance medications as determined by OMIP. A list of these medications can be found on our website at [www.omip.state.or.us](http://www.omip.state.or.us). *This list is subject to change.*

**This Health Benefit Plan Summary is intended only as a brief summary of our benefit plans. Please refer to the contract for specific details. Exact terms, conditions, provisions, exclusions, and limitations are defined in the contract.**

# Oregon Medical Insurance Pool/Federal Medical Insurance Pool

## 2012 FMIP Benefit Summary

|  | Medical Plan 500 | Medical Plan 750 |
|--|------------------|------------------|
| <b>Lifetime Maximum Benefit</b>                              | \$2,000,000      | \$2,000,000      |
| <b>FMIP Pre-existing Waiting Period, including Pregnancy</b> | None             | None             |

|   | In-network<br>you pay             | Out-of-network<br>you pay | In-network<br>you pay             | Out-of-network<br>you pay |
|---|-----------------------------------|---------------------------|-----------------------------------|---------------------------|
| <b>Annual Medical Deductible</b>  | \$500                             |                           | \$750                             |                           |
| <b>Maximum Annual Medical Out-of-Pocket, excluding medical deductible, per individual<sup>①</sup></b> | \$1,500                           | \$3,000                   | \$3,000                           | \$6,000                   |
| <b>Doctor Visits</b>  | 20%                               | 40%                       | 20%                               | 40%                       |
| <b>Hospital</b>   | 20%                               | 40%                       | 20%                               | 40%                       |
| <b>Outpatient Surgery</b>   | 20%                               | 40%                       | 20%                               | 40%                       |
| <b>Skilled Nursing Care – limited to 60 days</b>  | 20%                               | 40%                       | 20%                               | 40%                       |
| <b>Home Health Care – limited to 130 visits</b>   | 20%                               | 40%                       | 20%                               | 40%                       |
| <b>Emergency Room<sup>②</sup></b>   | 20%+\$200 co-pay                  | 20%+\$200 co-pay          | 20%+\$200 co-pay                  | 20%+\$200 co-pay          |
| <b>Ambulance</b>  | 20%                               |                           | 20%                               |                           |
| <b>Maternity</b>  | 20%                               | 40%                       | 20%                               | 40%                       |
| <b>Diagnostic X-ray/Lab</b>   | 20%                               | 40%                       | 20%                               | 40%                       |
| <b>Transplant<sup>②</sup></b>   | 0%                                | 40%                       | 0%                                | 40%                       |
| <b>Hospice</b>  | 20%                               | 40%                       | 20%                               | 40%                       |
| <b>Rehabilitation Inpatient/Outpatient – limited to 60 days</b>                                       | 20%                               | 40%                       | 20%                               | 40%                       |
| <b>Durable Medical Equipment</b>  | 20%                               |                           | 20%                               |                           |
| <b>Mental Health/Chemical Dependency</b>  | 20%                               | 40%                       | 20%                               | 40%                       |
| <b>Women’s Health Care Services<sup>③</sup></b>   | 20%                               | Not Covered               | 20%                               | Not Covered               |
| <b>Men’s Health Care Services<sup>③</sup></b>   | 20%                               | Not Covered               | 20%                               | Not Covered               |
| <b>Immunizations<sup>③</sup></b>  | 20%                               | Not Covered               | 20%                               | Not Covered               |
| <b>Well-Baby Care/Well-Child Care<sup>③</sup></b>   | 20%                               | Not Covered               | 20%                               | Not Covered               |
| <b>Preventive Care under the PPACA<sup>③</sup></b>  | 0%                                | Not Covered               | 0%                                | Not Covered               |
| <b>Prescription Drugs: Deductibles and out-of-pocket maximum on prescription drugs<sup>②</sup></b>    | \$0 Rx deductible                 |                           | \$0 Rx deductible                 |                           |
|   | <b>\$3,950 out-of-pocket max.</b> |                           | <b>\$2,200 out-of-pocket max.</b> |                           |
| <b>Generic Coinsurance<sup>④</sup></b>  | Up to \$5                         |                           | Up to \$5                         |                           |
| <b>Preferred Brand Coinsurance<sup>④</sup></b>  | Up to \$40                        |                           | Up to \$40                        |                           |
| <b>Non-Preferred Brand Coinsurance</b>  | Up to \$70                        |                           | Up to \$70                        |                           |

- ① This is the maximum amount you will pay for covered medical services per individual, per calendar year, excluding the deductibles, before FMIP will begin paying 100% for covered services.
- ② The emergency room co-pay, out-of-pocket prescription drug payments, transplants (\$250,000 max. per transplant on FMIP plans) performed at non-contracting facilities, and disallowed charges do not apply to the medical deductible or out-of-pocket maximum.
- ③ These services do **NOT** accumulate towards the maximum annual out-of-pocket expense. Also, you do not have to meet the annual medical deductible before FMIP pays for these services. Coverage is provided only for those preventative care services designated by: The United States Preventive Services Task Force (USPSTF) for services with an A or B rating in the current recommendations; by the Health Resources and Services Administration (HRSA); or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).
- ④ \$0 co-payment for fluoride, regular aspirin, and iron as specified by the **Patient Protection Affordable Care Act** and **specific** diabetic supplies, insulin (excluding pumps), and evidence-based generic maintenance medications as determined by OMIP. A list of these medications can be found on our website at [www.omip.state.or.us](http://www.omip.state.or.us). **This list is subject to change.**

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## FMIP Benefit Limitations And Exclusions

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FMIP contracts place some exclusions and limitations on the benefits available for the treatment of certain conditions and the use of certain procedures. These exclusions and limitations are explained in the FMIP contract under Benefit Exclusions and Benefit Limitations. You can access a copy of a contract at <http://www.omip.state.or.us/>.

***Under no circumstances will FMIP pay more than \$2 million in lifetime benefits for any enrollee. This amount applies to all contracts and is reduced by benefits paid under any prior FMIP contract.***

Following is a **BRIEF** list of contract exclusions:

- Abortion (***except as defined in the FMIP Contract***)
- Acupuncture
- Appliances or equipment primarily for comfort or convenience
- Charges in excess of reasonable amounts for services and supplies
- Chiropractic care
- Cosmetic or reconstructive surgery
- Custodial care
- Dental examinations and treatment
- Experimental or investigational procedures
- Family planning services and supplies
- Hearing aids (***except as defined in the FMIP Contract***), eyeglasses, and contacts
- Massage or massage therapy
- Naturopathic medicine and treatment
- Off the shelf orthopedic shoes and off the shelf orthopedic inserts
- Orthognathic surgery (***except as defined in the FMIP Contract***)
- Transplant (\$250,000 max. per transplant)
- Treatment for obesity or weight control (***except as defined in the FMIP Contract***)

## OMIP Benefit Limitations And Exclusions

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- Chiropractic care
- Cosmetic or reconstructive surgery
- Custodial care
- Dental examinations and treatment
- Experimental or investigational procedures
- Family planning services and supplies
- Hearing aids (***except as defined in the OMIP Contract***), eyeglasses, and contacts
- Massage or massage therapy
- Naturopathic medicine and treatment
- Off the shelf orthopedic shoes and off the shelf orthopedic inserts
- Orthognathic surgery (***except as defined in the OMIP Contract***)
- Treatment for obesity or weight control (***except as defined in the OMIP Contract***)

This document can be provided upon request in alternative formats for individuals with disabilities. Other formats may include (but are not limited to) large print, Braille, audio recordings, Web-based communications, and other electronic formats. E-mail [omip.mail@state.or.us](mailto:omip.mail@state.or.us) or call **1-800-542-3104** to arrange for the alternative format that will work best for you.

