

Oregon Medical Insurance Pool

2009 OMIP HEALTH BENEFIT PLAN SUMMARY

	Medical Plan 500		Medical & Portability Plan 750		Medical Plan 1000		Medical & Portability Plan 1500	
Lifetime Maximum Benefit	\$2,000,000		\$2,000,000		\$2,000,000		\$2,000,000	
Pre-existing Waiting Period, including Pregnancy	6 months		Medical 6 months	Portability None	6 months		Medical 6 months	Portability None
	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	In-network you pay	Out-of-network you pay
Annual Medical Deductible	\$500		\$750		\$1,000		\$1,500	
Maximum Annual Medical Out-of-Pocket, excluding medical deductible, per individual*	\$1,000	\$2,000	\$3,000	\$6,000	\$4,000	\$8,000	\$6,000	\$12,000
Doctor Visits	20%	40%	20%	40%	20%	40%	30%	50%
Hospital	20%	40%	20%	40%	20%	40%	30%	50%
Outpatient Surgery	20%	40%	20%	40%	20%	40%	30%	50%
Skilled Nursing Care – limited to 60 days	20%		20%		20%		30%	
Home Health Care – limited to 60 visits	20%	40%	20%	40%	20%	40%	30%	50%
Emergency Room**	20% + \$100 co-pay	20% + \$100 co-pay	20% + \$100 co-pay	20% + \$100 co-pay	20% + \$100 co-pay	20% + \$100 co-pay	30% + \$100 co-pay	30% + \$100 co-pay
Ambulance	20%		20%		20%		30%	
Maternity	20%	40%	20%	40%	20%	40%	30%	50%
Diagnostic X-Ray/Lab	20%	40%	20%	40%	20%	40%	30%	50%
Transplant**	0%	40%	0%	40%	0%	40%	0%	50%
Hospice	20%	40%	20%	40%	20%	40%	30%	50%
Rehabilitation Inpatient – limited to 60 days	20%	40%	20%	40%	20%	40%	30%	50%
Rehabilitation Outpatient – limited to 60 days	20%	40%	20%	40%	20%	40%	30%	50%
Durable Medical Equipment	20%		20%		20%		30%	
Mental Health	20%	40%	20%	40%	20%	40%	30%	50%
Chemical Dependency	20%	40%	20%	40%	20%	40%	30%	50%
Women's Health Care Services***	20%	Not Covered	20%	Not Covered	20%	Not Covered	30%	Not Covered
Men's Health Care Services***	20%	Not Covered	20%	Not Covered	20%	Not Covered	30%	Not Covered
Immunizations***	20%	Not Covered	20%	Not Covered	20%	Not Covered	30%	Not Covered
Well-Baby Care***	20%	Not Covered	20%	Not Covered	20%	Not Covered	30%	Not Covered
Well-Child Care***	20%	Not Covered	20%	Not Covered	20%	Not Covered	30%	Not Covered
Prescription Drugs: No out-of-pocket maximum on prescription drugs**	\$0 Rx deductible		\$0 Rx deductible		\$0 Rx deductible		\$1,000 Rx deductible (annual)	
Generic Coinsurance	Up to \$5		Up to \$5		Up to \$5		Up to \$5	
Preferred Brand Coinsurance	Up to \$40		Up to \$40		Up to \$40		Up to \$40	
Non-Preferred Brand Coinsurance	Up to \$70		Up to \$70		Up to \$70		Up to \$70	

* 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.

** The emergency room co-pay, out-of-pocket prescription drug payments, transplants performed at noncontracting facilities, and disallowed charges do not apply to the medical deductible or out-of-pocket maximum.

*** 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. Adult (age 19 and above) immunizations are limited to the following: Influenza (flu), Zostavax (shingles), Pneumococcal (pneumonia), Tetanus/Diphtheria Toxoid, and Varicella (chicken pox).

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

BENEFIT LIMITATIONS AND EXCLUSIONS

OMIP 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 OMIP contract under Benefit Exclusions and Benefit Limitations. You can access a copy of a contract at: <http://www.omip.state.or.us/>.

Following is a *BRIEF* list of contract exclusions.

- Acupuncture
- Appliances or equipment primarily for comfort or convenience
- Charges in excess of usual and customary or 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, eyeglasses, and contacts
- Massage or massage therapy
- Naturopathic medicine and treatment
- Off the shelf orthopedic shoes and orthopedic inserts
- Orthognathic surgery
- Treatment for obesity or weight control