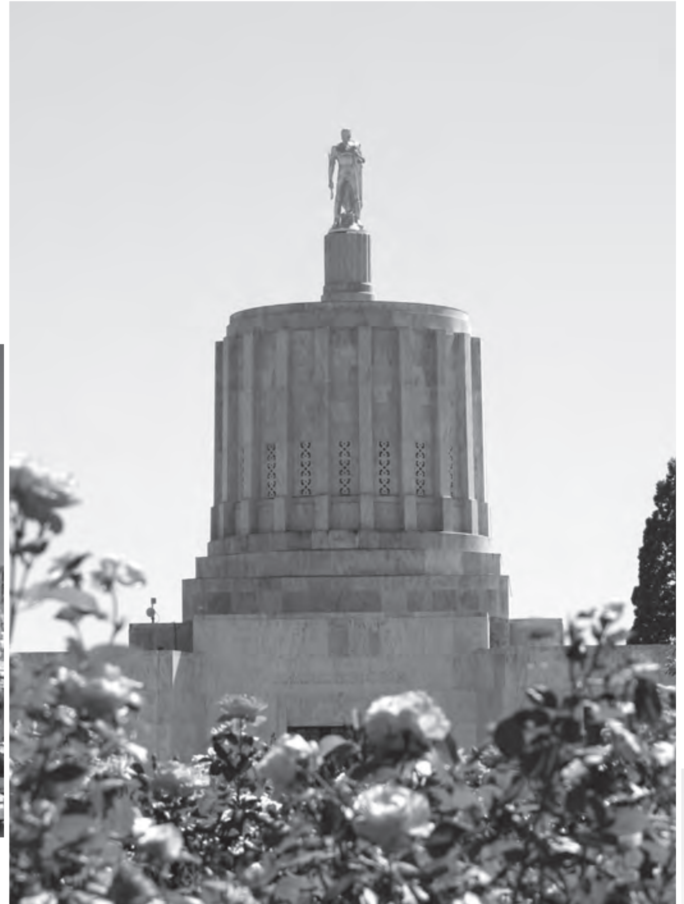
Oregon Medical Insurance Pool/Federal Medical Insurance Pool

OMIP-FMIP
We're here for you!



Member Handbook 2011

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 or call **1-800-542-3104** to arrange for the alternative format that will work best for you.

Oregon Medical Insurance Pool (**OMIP**) and the Federal Medical Insurance Pool (**FMIP**) both offer health insurance benefits for those who qualify.

To determine which high risk pool you are eligible for, please review the following questions:

1. **Are you an Oregon resident?** Oregon residency means you must be a permanent resident of Oregon to be eligible for OMIP/FMIP. A resident is a person who maintains a residence in Oregon, lives there at least 180 days ***per benefit enrollment year***.
   a. If yes, then please continue onto question number 2.
   b. ***If no, STOP you are not eligible for benefits through either high risk pool.***
2. **Have you been uninsured for the past six months and are you a U.S. citizen or non-citizen U.S. national, or a non-citizen who is lawfully present in the U.S.? (See page 4 of the *Member Handbook*.)**
   a. If yes, you are eligible for health care benefits through FMIP. Please read the eligibility requirements for FMIP to see if you qualify on page 3.
   b. If no, then you are ***not*** eligible for health care benefits through FMIP. Please read the eligibility requirements for OMIP to see if you qualify on page 7.

If you are Health Care Tax Credit (HCTC) eligible you only qualify for OMIP. Please read the eligibility requirements for OMIP on page 7.

Please return this completed application to:

Oregon Medical Insurance Pool
PO Box 1271
Mail Station 5K
Portland, OR 97207-1271

Customer Service: 1-800-848-7280
Fax: 503-225-5474

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FMIP Eligibility

Who Is Eligible For FMIP?

If you are an Oregon resident, you may be eligible to enroll under a Federal Medical Insurance Pool (FMIP) contract. ***You must be a U.S. citizen or non-citizen U.S. national, or a non-citizen who is lawfully present in the U.S. and have been uninsured for the past six months to qualify for FMIP.***

Once you enroll, your FMIP health insurance contract will provide additional information pertinent to your specific plan.

In addition, you may contact Regence BlueCross BlueShield of Oregon's Customer Service Department at **1-800-848-7280** for information.

What Are The Requirements To Enroll In FMIP?

Residency Requirement

To apply for FMIP coverage you must be a resident of Oregon. A resident is someone who is legally domiciled in Oregon. Once enrolled in FMIP you must maintain a principal place of residence in Oregon and physically reside in this state, at least 180 days each benefit enrollment year.

If FMIP discovers you have made any fraudulent misrepresentation, FMIP may terminate your policy back to the effective date of FMIP coverage. In addition, FMIP may retain your premiums as liquidated damages and reserve the right to recover from you the benefits paid.

If FMIP discovers you have made any material misrepresentations or omissions, FMIP may terminate your policy back to the effective date of FMIP coverage. In addition, FMIP may retain your premiums to cover any claims and administration costs FMIP paid retroactive to the date FMIP terminates your policy and recover from you any amounts FMIP paid in excess of your premiums.

Eligibility Requirements

To apply for FMIP coverage you must meet the **medical** eligibility requirements.

The availability and unavailability of membership in FMIP and any benefits through the plan are at all times subject to federal law, regulation, and the agreement between the Oregon Health Authority and the U.S. Department of Health and Human Services, and is dependent on continued availability of federal funding.

Medical Eligibility

If any of the following statements fit your situation, you are eligible to apply for FMIP coverage under a FMIP medical plan.

- Within the last five years you have had professional medical treatment and or were diagnosed by a professional medical provider for any of the medical conditions listed in ***Section C of the FMIP application.***
- Within the last six months, you were issued a declination letter from an insurance carrier refusing to sell you an individual comprehensive medical insurance policy, due to your health status.
- Within the last six months, you were offered an individual health insurance policy that excluded coverage for a specific medical condition that you currently have or had in the past.
- Within the last six months, you were offered an individual health insurance policy but were limited by the choice of particular plans the carrier was willing to offer you due to a specific medical condition that you currently have or had in the past.

If any of these medical situations apply to you, please refer to *Rate Schedule B, FMIP Eligibility.*

Persons Not Eligible

Note that the following circumstances will make you ineligible for FMIP coverage regardless of whether or not you meet residency or medical requirements:

- Are **NOT** a U.S. citizen or non-citizen U.S. national or a non-citizen who is lawfully present in the U.S.
- Are enrolled in Medicare.
- Are eligible and enrolled in health care benefits under Medicaid/Oregon Health Plan (OHP)/ Healthy KidsConnect (HKC).
- Are or become an inmate of a correctional institution or a patient at a mental institution as defined by ORS 179.321.
- Have terminated FMIP coverage within the last 6 months for any reason. This includes non-payment of FMIP premiums.
- FMIP has paid up to $2 million in health care benefits for you.
- Have been enrolled in creditable health insurance coverage at any time in the last six months.
- Have FMIP premiums paid or reimbursed by a public entity, employer, or a health care provider for the purpose of reducing the payer's financial loss or obligation.
- Are employed by a business with two or more employees and you have applied to FMIP at the direction of an insurance agent, insurance company, or an employer to separate yourself from the group health care benefit coverage offered or provided to the rest of the employees at your place of employment.
- Fail to pay your premium payments in the time-frame required.
- Dependents are not allowed to be added onto policies, except for newborns, where specified in the FMIP contract.
- If you obtain other creditable coverage you are no longer eligible for FMIP.

Creditable Coverage Defined. For purposes of FMIP, the term "***creditable coverage***" means, with respect to an individual, coverage of the individual under any of the following:

A group health plan; health insurance coverage; Medicare; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a public health plan; or Tri-care.

*The following is **NOT** considered creditable coverage and should not affect your eligibility for FMIP:* Coverage only for accident or disability income insurance; coverage issued as a supplement to liability insurance; liability insurance including general liability insurance and automobile liability insurance; workers' compensation insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; coverage only for a specified disease or illness; and hospital indemnity or other fixed indemnity insurance.

Acceptable proof of lawful presence in the U.S.

I-327 (Reentry Permit), I-551 (Permanent Resident Card), I-571 (Refugee Travel Document), I-766 (Employment Authorization Card) accompanied by either the I-94 and an Unexpired Foreign Passport or an I-797 (Notice of Action), Machine Readable Immigrant Visa (with Temporary I-551 Language) affixed to Unexpired Foreign Passport, Temporary I-551 Stamp (on passport or I-94) affixed to I-94 or Unexpired Foreign Passport, I-94 (Arrival/Departure Record) with Unexpired Foreign Passport, Unexpired Foreign Passport, I-20 (Certificate of Eligibility for Nonimmigrant (F-1) Student Status) accompanied by I-94 and an Unexpired Foreign Passport, DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status) accompanied by I-94 and an Unexpired Foreign Passport, Other Document with an I-94 or Alien Number.

How To Apply

To apply for FMIP coverage, you must complete and sign an ***OMIP/FMIP application*** *(included in the back of this Handbook)* and attach all the required documentation. Examples of possible documentation include proof of your Oregon residency; a declination letter for individual health insurance dated within six months of your application or a physician's statement for the medical condition listed in *Section C of the application*; or your permanent resident card. Submit your completed application to:

Oregon Medical Insurance Pool
c/o Regence BCBSO MS 5K
PO Box 1271
Portland, OR 97207-1271

We will not process any applications that do not include the required documentation. This will result in a later effective date of coverage.

When Coverage Begins

Coverage begins on the first day of the month, after we have received your ***completed*** application.

Premium Payments

Do not send money with your application.

After accepting your application, we will notify you in writing and mail you a bill. You will then receive a contract endorsement document, which you receive with your insurance contract, displaying the premiums that you must pay.

Premium payments are due in advance for all payment methods. As an example we will bill you in January for February's premium. We will allow you a 31-day grace period after the premium due date. **If you do not make your payment within the grace period, your policy will end without notice.**

Medical Deductibles

Each FMIP plan has an annual medical deductible you must satisfy before FMIP will begin paying for covered medical services. As an example, if you choose a plan that has a $500 annual medical deductible, then you will be responsible for paying for the first $500 in covered medical expenses before FMIP begins paying.

The medical deductible accrues on a calendar year basis beginning with January 1 of each year.

The following out-of-pocket payments do not accrue toward the medical deductible: prescription medications, emergency room co-pays, certain preventive care and services, transplants performed at non-contracting facilities, and non-covered medical expenses.

There are certain services for which FMIP will pay benefits before you satisfy your deductible. Those services include all preventive benefits.

Annual Maximum Out-Of-Pocket Expense

The maximum out-of-pocket expense is the most an individual will incur in a calendar year, beginning January 1 of each year. Once you have reached your out-of-pocket maximum for eligible medical expenses, the plan begins paying at 100% for eligible medical expenses.

There is a separate prescription maximum out-of-pocket expense *as defined in the contract*.

If you are using both in-network and out-of-network providers, we will ***NOT*** combine your out-of-pocket expenses for both in-network and out-of-network services. You will need to satisfy an out-of-pocket maximum for your **in-network services *AND*** a separate out-of-pocket maximum for your **out-of-network services**. The in-network maximum is not the same amount as the out-of-network maximum.

Prescription medications do not accumulate toward the medical maximum out-of-pocket expense. Other services which do not accumulate toward the medical maximum out-of-pocket expense ***(as defined in the contract)*** include:

- Preventive care benefits ***(as defined in PPACA)***
- Women's preventive services
- Men's preventive services
- Routine physical examinations
- Colorectal cancer screenings and exams
- Immunizations for children up through age 18
- Immunizations for adults age 19 and older
- PKU testing for a child
- Well-baby/well-child care
- Outpatient diabetic instruction

Please read your contract carefully for any additional services which may not accumulate towards the medical maximum out-of-pocket expense.

Benefit Limitations And Exclusions

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
- Coverage of medical services provided to individuals other than to the named insured covered by the plan
- 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 Eligibility

Who Is Eligible For OMIP?

If you are an Oregon resident, you and your dependents (legal spouse, domestic partner, or *child) may be eligible to enroll under an Oregon Medical Insurance Pool (OMIP) contract.

Once you enroll, your OMIP health insurance contract will provide additional information regarding eligibility and other information pertinent to your specific contract.

In addition, you may contact Regence BlueCross BlueShield of Oregon's Customer Service Department at **1-800-848-7280** for information.

Child/children means your children up to 26 years of age who are Oregon residents.

What Are The Requirements To Enroll In OMIP?

Residency Requirements

To apply for OMIP coverage you must be a resident of Oregon. A resident is someone who is legally domiciled in Oregon. Once you enroll in OMIP you must maintain a principal place of residence in Oregon and physically reside in this state for at least 180 days each benefit enrollment year and file personal resident income taxes in Oregon.

If OMIP discovers you have made any fraudulent misrepresentation, OMIP may terminate your policy back to the effective date of OMIP coverage. In addition, OMIP may retain your premiums as liquidated damages and reserve the right to recover from you or your enrolled dependent the benefits paid.

If OMIP discovers you have made any material misrepresentations or omissions, OMIP may terminate your policy back to the effective date of OMIP coverage. In addition, OMIP may retain your premiums to cover any claims and administration costs OMIP paid retroactive to the date OMIP terminates your policy and recover from you any amounts OMIP paid in excess of your premiums.

Eligibility Requirements

To apply for OMIP coverage you must meet the **medical** eligibility requirements, **portability** (loss of group health benefit coverage) requirements or be eligible for a **Federal Health Coverage Tax Credit** (HCTC) under the Federal Trade Adjustment Assistance Program or under the Pension Benefit Guarantee Corporation. The following information will help you decide the category for which you may be eligible:

Medical Eligibility

If any of the following statements fit your situation, you are eligible to apply for OMIP coverage under a OMIP medical plan.

- Within the last five years you have had professional medical treatment or were diagnosed by a professional medical provider for any of the medical conditions listed in ***Section C of the OMIP application.***
- Within the last six months, you were issued a declination letter from an insurance carrier refusing to sell you an individual comprehensive medical insurance policy, due to your health status.
- Within the last six months, you were offered an individual health insurance policy that excluded coverage for a specific medical condition that you currently have or had in the past.
- Within the last six months, you were offered an individual health insurance policy but were limited by the choice of particular plans the carrier was willing to offer you due to a specific medical condition that you currently have or had in the past.
- You have permanently moved to Oregon and are transferring your coverage from another state's high risk pool.

If any of these medical situations apply to you, please refer to *Rate Schedule A, Medical Eligibility.*

Portability Eligibility

You may be eligible for OMIP portability coverage under certain circumstances when you lose group health benefit coverage as outlined below.

- You had at least 180 consecutive days of group coverage or at least 18 months of creditable coverage without a gap in coverage greater than 63 days, with the most recent coverage ending in group insurance and no COBRA or Oregon portability benefits are available through your health plan.
- You had at least 180 consecutive days of group coverage or at least 18 months of creditable coverage without a gap in coverage greater than 63 days, with the most recent coverage ending in group insurance and you have exhausted your COBRA benefits and there are no Oregon portability benefits available through your health plan.
- You were currently enrolled or eligible for Oregon portability coverage through your previous health plan but you have moved out of the service area or the carrier no longer services the area where you live.

If you are eligible for portability coverage your application must be received by OMIP within 63 days from your previous employer's health coverage's termination date.

If you are applying for portability coverage please refer to the *OMIP Rate Schedule C, Portability Eligibility.*

Note: Your OMIP coverage starts the date your former coverage ends meaning you will owe premiums from that date which may include more than one month of premium.

Federal Health Coverage Tax Credit Eligibility

If you are eligible to receive a Federal Health Coverage Tax Credit (HCTC) under Section 35 of the Internal Revenue Code, then you are automatically eligible to receive ***health coverage through one of the four OMIP medical plan options***. There is ***not*** a six-month waiting period for qualified Federal HCTC enrollees.

Persons Not Eligible

Note that the following circumstances will make you or your dependent(s) ineligible for OMIP coverage regardless of whether or not you meet residency, medical, portability, or Federal Health Coverage Tax Credit Eligibility requirements:

- Are eligible for, entitled to, or enrolled in Medicare.
- Are eligible and enrolled in health care benefits under Medicaid/Oregon Health Plan (OHP)/ Healthy KidsConnect (HKC).
- Are or become an inmate of a correctional institution or a patient at a mental institution as defined by ORS 179.321.
- Have terminated OMIP coverage within the last 12 months for a reason other than becoming eligible for Medicaid/OHP health care benefits. This includes non-payment of OMIP premiums.
- OMIP has paid up to $2 million in health care benefits for you.
- Are actively enrolled in a substantially equivalent health insurance policy on the date your OMIP policy goes into effect.
- Have OMIP premiums paid or reimbursed by a public entity, employer, or a health care provider for the purpose of reducing the payer's financial loss or obligation.
- Are employed by a business with two or more employees and you have applied to OMIP at the direction of an insurance agent, insurance company, or an employer to separate yourself from the group health care benefit coverage offered or provided to the rest of the group.
- Fail to pay your premium payments in the time-frame required.

Pre-existing Conditions

Pre-existing Condition — Six-Month Waiting Period

The OMIP contracts have a six-month waiting period for coverage for pre-existing conditions, including pregnancy, unless you are under the age of 19 or you are eligible for OMIP portability or are HCTC eligible.

We will not pay benefits during the first six months of enrollment for coverage of expenses incurred for a pre-existing condition unless we grant you credit for prior health coverage.

A pre-existing condition is one for which professional medical advice, diagnosis, care, or treatment was recommended or received or a treatment plan was prescribed in the six-months prior to your OMIP effective date.

For purposes of the six-month waiting period, the term "pregnancy" includes, pre and postnatal care, miscarriage, abortion, delivery (vaginal or surgical), and complication of pregnancy, including, but not limited to:

- Intra-abdominal surgical procedures;
- Placenta abruptio and placenta previa;
- Acute exacerbations or heart conditions and/or diabetes;
- Toxemias.

Ectopic pregnancy is not considered a pre-existing medical condition and is not subject to this six-month waiting period for pregnancy.

Credit For Prior Coverage

We will grant credits toward the six-month pre-existing condition waiting period for each month of prior health coverage, if you or your enrolled dependents had prior continuous creditable coverage, and your application was received within 63 days of your prior health coverage's termination date.

Each month of prior creditable coverage will reduce the six-month waiting period under the contract by one month.

Creditable coverage means prior substantially equivalent health insurance coverage that reimburses for medical and hospital expenses without regards to a specific medical condition or disease and has comparable, similar benefits and payout amounts to OMIP's health benefit plan.

How To Apply

To apply for OMIP coverage, you must complete and sign an ***OMIP application*** *(included in the back of this Handbook)* and attach all the required documentation. Examples of possible documentation include proof of your Oregon residency; a declination letter for individual health insurance because of health reasons, dated within six months of your application; *a certificate of creditable coverage* from your prior health plan. Submit your completed application to:

Oregon Medical Insurance Pool
c/o Regence BCBSO MS 5K
PO Box 1271
Portland, OR 97207-1271

We will not process any applications that do not include all the required documentation. This will result in a later effective date of coverage.

Proof of continuous health coverage can be obtained from your prior carrier. It is called a "Certificate of Creditable Coverage."

You may apply for OMIP coverage up to 90 days before the date that you want OMIP coverage to begin.

When Coverage Begins

Unless you are eligible for a portability plan, your coverage begins on the first of the month after we have received the ***completed*** application for you and your eligible dependents listed on your application.

Portability coverage begins on the day after your employer-sponsored group health plan ends. You must have applied for OMIP portability coverage and your completed application must be received by OMIP within 63 days of losing your employer-sponsored group health plan coverage.

Premium Payments

Do not send money with your application.

After accepting your application, we will notify you in writing and mail you a bill. You will then receive a contract endorsement document, which you receive with your insurance contract, displaying the premiums that you must pay.

Premium payments are due in advance for all payment methods. As an example we will bill you in January for February's premium. We will allow you a 31-day grace period after the premium due date. **If you do not make your payment within the grace period, your policy will end without notice.**

Medical Deductibles

The OMIP Plans each have an annual medical deductible you must satisfy before OMIP will begin paying for covered medical services. As an example, if you choose a plan that has a $500 annual medical deductible, then you will be responsible for paying for the first $500 in covered medical expenses before OMIP begins paying. If you have a family plan, the maximum family deductible will be three times the individual medical deductible (in this example $1,500).

The medical deductible accrues on a calendar year basis beginning with January 1 of each year. **The following out-of-pocket payments do not accrue toward the medical deductible: prescription medications, emergency room co-pays, certain preventive care benefits and services, transplants performed at non-contracting facilities, and non-covered medical expenses.**

There are certain services for which OMIP will pay benefits before you satisfy your deductible. Those services include preventive care benefits.

Prescription Deductible Applies Only To The 1500 Plan

If you enroll in Plan 1500, **you will have a separate annual prescription deductible in the amount of $1,000 that you must satisfy before OMIP will begin paying for covered prescriptions. The prescription deductible accrues on a calendar year basis beginning with January 1 each year.**

This means that you will be responsible for paying for the first $1,000 in prescription expenses before OMIP begins paying, except for medications that are included in the Preventive Prescription Medications – Federally Mandated.

Annual Maximum Out-Of-Pocket Expense

The maximum out-of-pocket expense is the most an individual will incur in a calendar year, beginning January 1 of each year. Once you have reached your out-of-pocket maximum for eligible medical expenses the plan begins paying at 100% for eligible medical expenses.

If you are using both in-network and out-of-network providers, we will ***NOT*** combine your out-of-pocket expenses for both in-network and out-of-network services. You will need to satisfy an out-of-pocket maximum for your **in-network services** ***AND*** a separate **out-of-pocket maximum** for your out-of-network services. The in-network maximum is not the same amount as the out-of-network maximum.

Prescription medications do not accumulate toward the maximum out-of-pocket expense. Other services which do not accumulate toward the maximum out-of-pocket expense ***(as defined in the contract)*** include:

- Preventive care benefits ***(as defined in PPACA)***
- Women's preventive services
- Men's preventive services
- Routine physical examinations
- Colorectal cancer screenings and exams
- Immunizations for children up through age 18
- Immunizations for adults age 19 and older
- PKU testing for a dependent child
- Well-baby/well-child care
- Outpatient diabetic instruction

Please read your contract carefully for any additional services which may not accumulate towards the maximum out-of-pocket expense.

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/.

Under no circumstances will OMIP 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 OMIP contract.

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

- 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 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)***

2011 OMIP Benefit 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	
OMIP Pre-existing Waiting Period, including Pregnancy	6 months		***Medical:*** 6 months	***Portability:*** None	6 months		***Medical:*** 6 months	***Portability:*** 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	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]	$1,500	$3,000	$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%	40%	20%	40%	20%	40%	30%	50%
Home Health Care – limited to 130 visits	20%	40%	20%	40%	20%	40%	30%	50%
Emergency Room[2]	20%+$200 co-pay	20%+$200 co-pay	20%+$200 co-pay	20%+$200 co-pay	20%+$200 co-pay	20%+$200 co-pay	30%+$200 co-pay	30%+$200 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[2]	0%	40%	0%	40%	0%	40%	0%	50%
Hospice	20%	40%	20%	40%	20%	40%	30%	50%
Rehabilitation Inpatient/Outpatient – limited to 60 days	20%	40%	20%	40%	20%	40%	30%	50%
Durable Medical Equipment	20%		20%		20%		30%	
Mental Health/Chemical Dependency	20%	40%	20%	40%	20%	40%	30%	50%
Women's Health Care Services[3]	20%	Not Covered	20%	Not Covered	20%	Not Covered	30%	Not Covered
Men's Health Care Services[3]	20%	Not Covered	20%	Not Covered	20%	Not Covered	30%	Not Covered
Immunizations[3]	20%	Not Covered	20%	Not Covered	20%	Not Covered	30%	Not Covered
Well-Baby Care/Well-Child Care[3]	20%	Not Covered	20%	Not Covered	20%	Not Covered	30%	Not Covered
Preventive Care under the PPACA[3]	0%	Not Covered	0%	Not Covered	0%	Not Covered	0%	Not Covered
Prescription Drugs: **No out-of-pocket maximum on prescription drugs**[2]	$0 Rx deductible		$0 Rx deductible		$0 Rx deductible		$1,000 Rx deductible (annual)	
Generic Coinsurance[4]	Up to $5		Up to $5		Up to $5		Up to $5	
Preferred Brand Coinsurance[4]	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	

[1] 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.

[2] 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.

[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 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).

[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. ***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.

2011 FMIP Benefit Summary

	Medical Plan 500	Medical Plan 750
Lifetime Maximum Benefit	$2,000,000	$2,000,000
FMIP Pre-existing Waiting Period, including Pregnancy	None	None

	In-network you pay	Out-of-network you pay	In-network you pay	Out-of-network you pay
Annual Medical Deductible	$500		$750	
Maximum Annual Medical Out-of-Pocket, excluding medical deductible, per individual❶	$1,500	$3,000	$3,000	$6,000
Doctor Visits	20%	40%	20%	40%
Hospital	20%	40%	20%	40%
Outpatient Surgery	20%	40%	20%	40%
Skilled Nursing Care – limited to 60 days	20%	40%	20%	40%
Home Health Care – limited to 130 visits	20%	40%	20%	40%
Emergency Room❷	20%+$200 co-pay	20%+$200 co-pay	20%+$200 co-pay	20%+$200 co-pay
Ambulance	20%		20%	
Maternity	20%	40%	20%	40%
Diagnostic X-ray/Lab	20%	40%	20%	40%
Transplant❷	0%	40%	0%	40%
Hospice	20%	40%	20%	40%
Rehabilitation Inpatient/Outpatient – limited to 60 days	20%	40%	20%	40%
Durable Medical Equipment	20%		20%	
Mental Health/Chemical Dependency	20%	40%	20%	40%
Women's Health Care Services❸	20%	Not Covered	20%	Not Covered
Men's Health Care Services❸	20%	Not Covered	20%	Not Covered
Immunizations❸	20%	Not Covered	20%	Not Covered
Well-Baby Care/Well-Child Care❸	20%	Not Covered	20%	Not Covered
Preventive Care under the PPACA❸	0%	Not Covered	0%	Not Covered
***Prescription Drugs:* Deductibles and out-of-pocket maximum on prescription drugs❷**	$0 Rx deductible		$0 Rx deductible	
	$3,950 out-of-pocket max.		**$2,200 out-of-pocket max.**	
Generic Coinsurance❹	Up to $5		Up to $5	
Preferred Brand Coinsurance❹	Up to $40		Up to $40	
Non-Preferred Brand Coinsurance	Up to $70		Up to $70	

❶ 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.

❷ The emergency room co-pay, out-of-pocket prescription drug payments, transplants ($250,000 max. per transplant on FMIP plans) performed at noncontracting facilities, and disallowed charges do not apply to the medical deductible or out-of-pocket maximum.

❸ 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).

❹ $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. ***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.

Types Of Provider Networks Available To You

The OMIP/FMIP contracts include benefits for ***in-network*** and ***out-of-network*** providers. The benefits for using in-network providers are greater than those benefits for using out-of-network providers. It is extremely important to use in-network providers in order to receive the maximum benefit available under your contract.

In-network providers will not charge more than your co-insurance amount. Some services may be subject to deductibles that are explained in each plan contract. Out-of-network providers or hospitals may bill you the full amount of services or a fee in excess of the negotiated fee that has been arranged with in-network providers. ***See example below.***

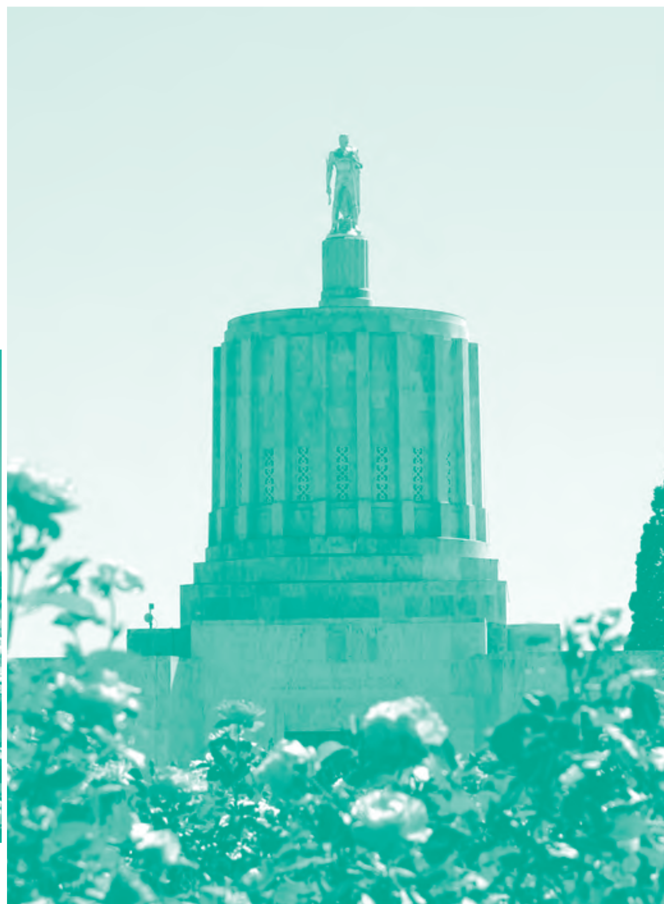
Regence BlueCross BlueShield of Oregon administers all of the OMIP/FMIP plans. You may obtain a list of in-network providers from them at their internet address, www.regence.com, or by calling their **Customer Service Department** at **1-800-848-7280**. They can also mail you a provider directory if you prefer.

Example of how we pay benefits when you use an *in- and out-of-network provider*

	In-Network	Out-of-Network	
	Preferred provider	**Participating provider**	**Non-participating provider**
Provider charge	$1,000	$1,000	$1,000
OMIP/FMIP ***maximum allowed amount***	$500	$500	$500
OMIP/FMIP pays	$400 (80%)	$300 (60%)	$300 (60%)
You pay	$100 (20%)	$200 (40%)	$200 (40%)
+ *Amount above OMIP/FMIP allowed amount*	**+** $0	**+** $0	**+** $500
Your total cost	**$100**	**$200**	**$700**

Examples of plans 500, 750, and 1,000 only. The examples in the table above assume that you have met any applicable deductible, but have not met the annual maximum out-of-pocket limit. The actual benefits of the contract you choose will vary. You will need to read your contract to determine how your benefits under the contract will be paid.

OMIP-FMIP
We're here for you!



Health Rates
Valid January 2011

Instructions:

- You and your dependents must be Oregon residents to be eligible for OMIP/FMIP.
- FMIP does not allow dependents.
- Determine your rates:

  A. If you are unable to obtain individual health insurance due to health conditions use ***Monthly Rate Schedule A for OMIP, Schedule B for FMIP or,***

  B. If you have exhausted COBRA benefits and are not being offered a portability plan, or if you have a portability plan but are moving out of the portability service area, use ***Monthly Rate Schedule C.***

  C. If you receive a federal Health Coverage Tax Credit (HCTC), use ***Monthly Rate Schedule A.***

- Using the ***Health Benefit Plan Summary***, determine which plan will best suit your needs.
- Determine the number of persons to be covered by the plan.
  Individual insures one person.
  Two-party insures an adult and one dependent ***(OMIP only)***.
  Family insures an adult and two or more dependents ***(OMIP only)***.
- Find the age of the oldest family member to be covered by the plan ***(OMIP only)***.
- Your billing options are monthly, quarterly (every three months), or monthly by checking account deduction. Indicate your selection on the ***OMIP/FMIP Application Form.***
- To determine the amount you would pay under the three billing options, multiply the monthly rate by the number of months in the billing cycle. If you choose monthly payments, your rate will be the rate given in the schedule. If you choose quarterly payments, your rate will be three times the rate given in the schedule.
- Please note: Monthly payments are available through automatic bank withdrawal or by direct bill. If you prefer to pay using automatic bank withdrawal, complete the ***Authorization Agreement*** portion of the ***OMIP/FMIP Application***. Be sure to include a voided check or deposit slip to verify account information.
- Do not send money with the application. You will be sent a bill for the first premium payment after your completed application is processed.
- If you have any questions, please call Customer Service at **1-800-848-7280.**

OMIP Medical Eligibility • 2011 Monthly Rate Schedule A

PLAN 500

	Individual	Two-party	Family
Age 0-17	$272	$544	$816
Age 18-19	$306	$612	$884
Age 20-24	$344	$688	$960
Age 25-29	$369	$738	$1,010
Age 30-34	$411	$822	$1,094
Age 35-39	$428	$856	$1,128
Age 40-44	$510	$1,020	$1,292
Age 45-49	$586	$1,172	$1,444
Age 50-54	$671	$1,342	$1,614
Age 55-59	$771	$1,542	$1,814
Age 60-64	$771	$1,542	$1,814
Age 65+	$810	$1,620	$1,892

PLAN 750

	Individual	Two-party	Family
Age 0-17	$255	$510	$765
Age 18-19	$286	$572	$827
Age 20-24	$322	$644	$899
Age 25-29	$345	$690	$945
Age 30-34	$385	$770	$1,025
Age 35-39	$400	$800	$1,055
Age 40-44	$477	$954	$1,209
Age 45-49	$548	$1,096	$1,351
Age 50-54	$628	$1,256	$1,511
Age 55-59	$721	$1,442	$1,697
Age 60-64	$721	$1,442	$1,697
Age 65+	$758	$1,516	$1,771

PLAN 1000

	Individual	Two-party	Family
Age 0-17	$243	$486	$729
Age 18-19	$273	$546	$789
Age 20-24	$307	$614	$857
Age 25-29	$329	$658	$901
Age 30-34	$367	$734	$977
Age 35-39	$382	$764	$1,007
Age 40-44	$455	$910	$1,153
Age 45-49	$523	$1,046	$1,289
Age 50-54	$599	$1,198	$1,441
Age 55-59	$688	$1,376	$1,619
Age 60-64	$688	$1,376	$1,619
Age 65+	$723	$1,446	$1,689

PLAN 1500

	Individual	Two-party	Family
Age 0-17	$197	$394	$591
Age 18-19	$221	$442	$639
Age 20-24	$249	$498	$695
Age 25-29	$266	$532	$729
Age 30-34	$297	$594	$791
Age 35-39	$309	$618	$815
Age 40-44	$369	$738	$935
Age 45-49	$424	$848	$1,045
Age 50-54	$485	$970	$1,167
Age 55-59	$557	$1,114	$1,311
Age 60-64	$557	$1,114	$1,311
Age 65+	$586	$1,172	$1,369

FMIP Eligibility • 2011 Monthly Rate Schedule B

PLAN 500	
	Individual
Age 0-17	$263
Age 18-19	$295
Age 20-24	$332
Age 25-29	$356
Age 30-34	$398
Age 35-39	$414
Age 40-44	$493
Age 45-49	$566
Age 50-54	$649
Age 55-59	$745
Age 60-64	$745
Age 65+	$783

PLAN 750	
	Individual
Age 0-17	$247
Age 18-19	$278
Age 20-24	$312
Age 25-29	$335
Age 30-34	$374
Age 35-39	$390
Age 40-44	$463
Age 45-49	$533
Age 50-54	$611
Age 55-59	$701
Age 60-64	$701
Age 65+	$737

Creditable Coverage Defined. For purposes of FMIP, the term ***"creditable coverage"*** means, with respect to an individual, coverage of the individual under any of the following:

A group health plan; health insurance coverage; Medicare; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a public health plan; or Tri-care.

*The following is **NOT** considered creditable coverage and should not affect your eligibility for FMIP:* Coverage only for accident or disability income insurance; coverage issued as a supplement to liability insurance; liability insurance including general liability insurance and automobile liability insurance; workers' compensation insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; coverage only for a specified disease or illness; and hospital indemnity or other fixed indemnity insurance.

Acceptable proof of lawful presence in the U.S.

I-327 (Reentry Permit), I-551 (Permanent Resident Card), I-571 (Refugee Travel Document), I-766 (Employment Authorization Card) accompanied by either the I-94 and an Unexpired Foreign Passport or an I-797 (Notice of Action), Machine Readable Immigrant Visa (with Temporary I-551 Language) affixed to Unexpired Foreign Passport, Temporary I-551 Stamp (on passport or I-94) affixed to I-94 or Unexpired Foreign Passport, I-94 (Arrival/Departure Record) with Unexpired Foreign Passport, Unexpired Foreign Passport, I-20 (Certificate of Eligibility for Nonimmigrant (F-1) Student Status) accompanied by I-94 and an Unexpired Foreign Passport, DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status) accompanied by I-94 and an Unexpired Foreign Passport, Other Document with an I-94 or Alien Number.

OMIP Portability Eligibility • 2011 Monthly Rate Schedule C

PLAN 750

	Individual	Two-party	Family
Age 0-17	$290	$580	$870
Age 18-19	$290	$580	$870
Age 20-24	$290	$580	$870
Age 25-29	$356	$712	$1,002
Age 30-34	$437	$874	$1,164
Age 35-39	$447	$894	$1,184
Age 40-44	$538	$1,076	$1,366
Age 45-49	$555	$1,110	$1,400
Age 50-54	$683	$1,366	$1,656
Age 55-59	$700	$1,400	$1,690
Age 60-64	$714	$1,428	$1,718
Age 65+	$714	$1,428	$1,718

PLAN 1500

	Individual	Two-party	Family
Age 0-17	$223	$446	$669
Age 18-19	$223	$446	$669
Age 20-24	$223	$446	$669
Age 25-29	$274	$548	$771
Age 30-34	$322	$644	$867
Age 35-39	$335	$670	$893
Age 40-44	$400	$800	$1,023
Age 45-49	$427	$854	$1,077
Age 50-54	$516	$1,032	$1,255
Age 55-59	$534	$1,068	$1,291
Age 60-64	$546	$1,092	$1,315
Age 65+	$546	$1,092	$1,315

Note: Individuals who are eligible for OMIP due to ***portability*** reasons may only select the Portability Plans 750 and 1500. However, if you think you might also be eligible due to ***medical*** reasons and you would like to select a Medical Plan 500, 750, 1000, or 1500, then you must apply for and meet the medical eligibility criteria as well as complete ***Section C of the OMIP/FMIP application.*** Please refer to the ***OMIP Member Handbook*** to review the medical eligibility criteria and the portability eligibility criteria. The ***OMIP Member Handbook*** will explain to you whether or not you qualify for ***medical*** or ***portability*** coverage.

Application 2011

Oregon Medical Insurance Pool (**OMIP**) and the Federal Medical Insurance Pool (**FMIP**) both offer health insurance benefits for those who qualify.

To determine which high risk pool you are eligible for, please review the following questions:

1. **Are you an Oregon resident?** Oregon residency means you must be a permanent resident of Oregon to be eligible for OMIP/FMIP. A resident is a person who maintains a residence in Oregon, lives there at least 180 days ***per benefit enrollment year***.
   a. If yes, then please continue onto question number 2.
   b. ***If no, STOP you are not eligible for benefits through either high risk pool.***
2. **Have you been uninsured for the past six months and are you a U.S. citizen or non-citizen U.S. national, or a non-citizen who is lawfully present in the U.S.? (See page 4 of the *Member Handbook*.)**
   a. If yes, you are eligible for health care benefits through FMIP. Please read the eligibility requirements for FMIP to see if you qualify on page 3 of the ***Member Handbook***.
   b. If no, then you are ***not*** eligible for health care benefits through FMIP. Please read the eligibility requirements for OMIP to see if you qualify on page 7 of the ***Member Handbook***.
   c. ***If you are Health Care Tax Credit (HCTC) eligible you only qualify for OMIP. Please read the eligibility requirements for OMIP.***

Please return this completed application to:

Oregon Medical Insurance Pool
PO Box 1271
Mail Station 5K
Portland, OR 97207-1271

Customer Service: 1-800-848-7280
Fax: 503-225-5474

A Applicant Information

COMPLETE ALL SECTIONS IN INK.

Applicant's Name Last	First	Middle	Age
Birthdate (M/D/Y)	Social Security Number		Gender: ❑ Male ❑ Female
Home Phone	Work Phone	E-mail Address	

Oregon Residence Address		
Home Address		County
City	State	ZIP

Mailing Address (if different than listed above)		
Mailing Address		County
City	State	ZIP

OMIP ONLY

List all dependents you would like to insure – ***See Member Handbook for the definition of a dependent*:**

Name *(Last, first, middle initial)*	**Gender**	**Birthdate**	**Relationship**	**SSN**
Spouse/Domestic Partner:				
Child:				
Child:				
Child:				

B Health Plan Options — You must select a Plan

Select One Plan — ***See Section D for plan eligibility*** (Note: Plan changes are only allowed during open enrollment):

OMIP including HCTC:

- ❑ **Medical Plan 500**[1]
- ❑ **Medical Plan 750**[1]
- ❑ **Medical Plan 1000**
- ❑ **Medical Plan 1500**

FMIP (Individual Applicants Only):

- ❑ **Medical Plan 500**[1]
- ❑ **Medical Plan 750**[1]

OMIP Portability:

- ❑ **Portability Plan 750**[1]
- ❑ **Portability Plan 1500**

[1] *FHIAP members may only select Medical Plans 500 and 750 or Portability Plan 750*

— OFFICE USE ONLY —

Group No.	Class Code	ID	OED	Credits	BE	Misc.

C Health Conditions

Within the last five (5) years, have you (the applicant) had ANY diagnosis, treatment, or professional medical advice relating to any of the following medical conditions? If yes, please check those conditions which apply. If you have one of these conditions and you are an Oregon resident you automatically qualify for OMIP/FMIP coverage under the Medical Eligibility Criteria. A physician must verify and confirm the presence of any pre-existing condition(s).

- ❑ AIDS/HIV+
- ❑ Alcohol Dependence/ Chemical Dependency
- ❑ Alzheimer's
- ❑ Amyotrophic Lateral Sclerosis
- ❑ Aneurysm
- ❑ Angina Pectoris
- ❑ Anorexia/Bulimia
- ❑ Aplastic/Sickle Cell/Splenic Anemia
- ❑ Arteriosclerosis Obliteran
- ❑ Artificial Heart Valve
- ❑ Ascites
- ❑ Barrett's Esophagitis
- ❑ Blood Coagulation Disorder
- ❑ Brain Tumors
- ❑ Cancer/Metastatic Cancer
- ❑ Celiac Disease
- ❑ Cerebral Palsy
- ❑ Chronic Obstructive Pulmonary Disease
- ❑ Cirrhosis of the Liver
- ❑ Congestive Heart Failure/ Cardiomyopathy
- ❑ Coronary Insufficiency/Occlusion/ Artery Disease
- ❑ Crohn's Disease
- ❑ Cystic Fibrosis
- ❑ Dementia
- ❑ Dermatomyositis
- ❑ Diabetes
- ❑ Emphysema
- ❑ Fibromyalgia
- ❑ Friedreich's Disease
- ❑ Gastric Bypass Surgery
- ❑ Hemophilia
- ❑ Hepatitis B, C, D, E
- ❑ Hodgkin's Disease
- ❑ Huntington's Chorea
- ❑ Hydrocephalus
- ❑ Hypertensive Renal Disease
- ❑ Intermittent Claudication
- ❑ Joint Replacement
- ❑ Kidney Failure
- ❑ Lead Poisoning (Cerebral)
- ❑ Liver Failure
- ❑ Lupus
- ❑ Malignant Tumor
- ❑ Melanoma
- ❑ Multiple or Disseminated Sclerosis
- ❑ Muscular Atrophy/Dystrophy
- ❑ Myasthenia Gravis
- ❑ Myotonia
- ❑ Obesity (BMI >30)
- ❑ Open Heart Surgery
- ❑ Pancreatitis
- ❑ Paraplegia/Quadriplegia
- ❑ Parkinson's Disease
- ❑ Pending Surgery
- ❑ Peripheral Arteriosclerosis
- ❑ Pituitary Gland Disorders
- ❑ Polyarteritis
- ❑ Polycystic Kidney
- ❑ Polycystic Ovarian Syndrome
- ❑ Postero-Lateral Sclerosis
- ❑ Pregnant (currently)
- ❑ Pulmonary Fibrosis
- ❑ Rheumatoid Arthritis
- ❑ Schizophrenia
- ❑ Silicosis
- ❑ Sleep Apnea
- ❑ Still's Disease
- ❑ Stroke
- ❑ Syringomyelia
- ❑ Topectomy and Lobotomy
- ❑ Transient Ischemic Attack
- ❑ Transplants
- ❑ Ulcerative Colitis
- ❑ Von Willebrand's Disease
- ❑ Wilson's Disease

Newborn *ONLY* Conditions:

- ❑ Imperforate anus
- ❑ Prematurity
- ❑ Spina Bifida

Identify condition from the list above and last date(s) of treatment. Applicant ***MUST*** *have been treated within the last 5 years. Physician's note specifying one of the above conditions is acceptable.*

Physician's name (please print): ______________________________

Physician's signature: ______________________________ **Date:** ______________

Please do not modify or write in conditions that are not listed above.

D Proof of Eligibility

Oregon resident: means you must be a permanent resident of Oregon to be eligible for OMIP/FMIP. A resident is a person who maintains a residence in Oregon, lives there at least 180 days ***per benefit enrollment year*** and files personal income taxes in Oregon.

Once you enroll in OMIP/FMIP, you must maintain a principal place of residence in Oregon and physically reside in this state at least 180 days each benefit enrollment year and file personal income taxes in Oregon.

________ **Initial here showing you read and understand the eligibility requirements, attesting you are an Oregon resident**

The applicant must attach a copy of *one* of the following documents showing applicant's name and address:

1. Current Oregon Driver License or Oregon identification card; or
2. Current utility bill (utility bills include, gas, garbage, phone, or electric); or
3. Current rental or lease agreement; or
4. Current FHIAP ***Letter of Eligibility*** with the date of eligibility and applicant's name.

Please **check** the boxes below that apply:

1. Medical Eligibility

- ❑ I have one or more of the conditions listed in ***Section C of this application. (Complete Section C).***
- ❑ Within the last six months, I was denied an individual health insurance policy due to health reasons. ***(Attach a copy of the carrier's denial letter).***
- ❑ Within the last six months, I was offered an individual health insurance policy that excluded coverage for a specific medical condition. ***(Attach copy of letter from carrier denying specific condition).***
- ❑ Within the last six months, I was offered an individual health insurance policy but the carrier limited my choice of plans it was willing to offer me due to a specific medical condition. ***(Attach copy of carrier letter only offering a limited policy).***
- ❑ I have permanently moved to Oregon and am transferring from another state's high-risk pool. ***(Attach Certificate of Creditable Coverage from prior high-risk pool.)***

  State: ______________ Name of State High Risk Pool: ________________________ ID #:______________
- ❑ I have permanently moved to Oregon and am transferring from another federal high-risk pool. ***(Attach Certificate of Creditable Coverage from prior federal high-risk pool.)***

  State: ______________ Name of Federal High Risk Pool: ______________________ ID #:______________

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2. Portability Eligibility — *OMIP applicants only*

In all cases below, you must submit a Certificate of Coverage to verify your coverage is terminated, you had at least 180 consecutive days of group coverage or at least 18 months of creditable coverage without a gap in coverage greater than 63 days, with the most recent coverage ending in group insurance. Your application must be received by OMIP within 63 days of the termination date of your prior coverage. You must obtain a Certificate of Coverage from your prior health insurance company. Please call 1-800-848-7280 with questions.

Note: Your OMIP coverage starts the date your former coverage ends meaning you will owe premiums from that date which may include more than one month of premium.

- ❑ I have exhausted all COBRA or state continuation benefits available, and no portability options are available from my previous health carrier. ***Attach a letter from your previous health insurer indicating all COBRA or state continuation benefits are exhausted and terminated and no portability options are available.***
- ❑ No COBRA, state continuation coverage, or portability coverage was available through my previous group plan. ***(Attach a letter from your current carrier or former employer stating that these plans are not available.)***
- ❑ I am eligible for Oregon portability through my previous plan but I moved from my prior insurance carrier's service area or my insurance carrier no longer services the area where I live. ***(Attach a letter from your current carrier that you have moved from the carrier's service area and no further coverage is available.)***

3. Federal Health Coverage Tax Credit Eligibility — *OMIP only*

- ❑ If you are eligible to receive a Federal Health Coverage Tax Credit (HCTC) under Section 36 of the Internal Revenue Code, then you are automatically eligible to receive health coverage through one of the four medical plan options. ***(Attach documentation from the federal government showing you are eligible for this program.)***

E OMIP Credit Toward Pre-Existing Limitation Period

Not applicable to enrollees in OMIP under the age of 19, portability, and FMIP.

OMIP will not pay benefits during the first six months of enrollment for coverage of expenses incurred for a pre-existing condition unless we grant you credits. A pre-existing condition is one for which professional medical advice, diagnosis, care, or treatment was recommended or received or a treatment plan was prescribed in the six months prior to your OMIP effective date.

We will grant credits toward the pre-existing limitation period for each month of prior creditable health coverage you or your enrolled dependents had prior to becoming insured by OMIP. ***To receive credits, your application must be received by OMIP no later than 63 days from the termination date of the prior creditable coverage.***

There is ***not*** a six-month waiting period for qualified Federal HCTC enrollees who have had 90 days of prior creditable coverage without any breaks in coverage greater than 63 days and whose application was received by OMIP within 70 days from the date on the HCTC eligibility certificate.

Creditable coverage means prior substantially equivalent health insurance coverage that reimburses for medical and hospital expenses without regards to a specific medical condition or disease and has comparable, similar benefits and payout amounts to OMIP's health benefit plan.

OMIP may not credit coverage for benefits and services that your previous health plan did not cover or credit benefits that had not been satisfied during the previous plan's exclusion period except portability.

- ❑ I have credit toward the six-month pre-existing limitation period. ***(Attach a copy of your prior plan's benefit summary with a Certificate of Coverage stating your begin and end dates.)***

F Statistical & Eligibility Information

We require that you complete the following information. The program will use only information about other insurance or employer-based benefits to determine eligibility. We also use this data for evaluating future insurance market reform.

1. Are you (check one) ❑ an employee ❑ self-employed ❑ not employed ❑ retired

   If you are an employee, or self-employed, what is your occupation?____________________

   What is the name and location of your employer?____________________

   Does your employer offer health insurance to its employees? ❑ Yes ❑ No

   If yes, are you currently, or have you ever been, covered under your employer's plan? ❑ Yes ❑ No

   If yes, on what date did that coverage end and why? End date:__________ Reason: ____________________

   If your employer offers health insurance to its employees and you are not covered under your employer plan, why didn't you take your employer's insurance? ____________________

2. Have you ever been enrolled in OMIP? ❑ Yes ❑ No

   If yes, what date did your coverage begin?__________________What date did your coverage end?____________________

3. Has OMIP paid up to $2 million in health care benefits for you? ❑ Yes ❑ No

4. In the last 6 months, have you applied for Medicaid/Oregon Health Plan (OHP)?
   ❑ Yes Month applied: ____________________ ❑ No
   If yes, were you eligible? ❑ Yes ❑ No ❑ Do not know

5. In the last 12 months, have you or your eligible dependent(s) been insured by any other insurance program (including Medicare, Medicaid/OHP, employer-sponsored insurance (group), private insurance (individual), or COBRA)?
   ❑ Yes ❑ No
   If no, why have you gone without coverage? ____________________

   If yes, answer the following:

   Who was listed as the primary insured under the policy? ____________________

   What is that person's social security or ID number? ____________________

   What is the name of the insurance company? ____________________

   What is the policy number? ____________________ What is the group number? ____________________

   What date did the policy begin? ____________________ What date did the policy end? ____________________

   Why did the policy end? ____________________

   Was this policy purchased through an agent? If so, please provide the agent's name: ____________________

   Was the insurance group ***(through the employer)*** or individual insurance? ❑ Group ❑ Individual ❑ Do not know

   If it was group insurance, what is the name of the employer who offered the policy? ____________________

The following section is for statistical purposes only and does not determine eligibility.

6. Are you (check one) ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Child

7. If you are married, is your spouse employed? ❑ Yes ❑ No
   If yes, does your spouse's employer offer health insurance to its employees? ❑ Yes ❑ No
   If yes, are you currently enrolled in your spouse's employer's plan? ❑ Yes ❑ No
   If no, why not? ____________________

8. If you are under age 18, is your parent or guardian employed? ❑ Yes ❑ No
   If yes, does their employer offer health insurance for its employees? ❑ Yes ❑ No
   If yes, are you currently enrolled in your parent or guardian's employer's plan? ❑ Yes ❑ No
   If no, why not? ____________________

9. What is your total annual gross household income
   ❑ $0-$11,076 ❑ $25,001-$35,000 ❑ $45,001-$55,000 ❑ $65,001-$75,000
   ❑ $11,077-$15,000 ❑ $35,001-$45,000 ❑ $55,001-$65,000 ❑ $75,001 or more
   ❑ $15,001-$25,000

10. What is your ethnic heritage? ❑ Hispanic ❑ Latino ❑ Not Hispanic or Latino

11. What is your racial heritage?
    ❑ American Indian/Alaskan Native ❑ Asian ❑ Black or African American
    ❑ Native Hawaiian or Other Pacific Islander ❑ White

G Affirmation, Understanding & Disclosure Authorization

I understand that I am applying to the Oregon Medical Insurance Pool (OMIP)/Federal Medical Insurance Pool (FMIP), a State of Oregon program located within the Oregon Health Authority, for an individual policy of medical, surgical, prescription and hospital insurance. I also understand that my coverage will become effective on the first of the month following approval and acceptance of the application by OMIP/FMIP, unless I am eligible for portability coverage. If eligible for portability coverage, I understand that my coverage will become effective the date my prior group coverage is terminated. I will be responsible for paying premiums from my effective date forward.

I affirm that the foregoing answers on the application are complete and correct. I understand that no coverage will be in effect until the full initial premium is paid after this application has been approved and accepted by OMIP/FMIP.

1. Pre-existing conditions will **not** be covered until the OMIP policy has been in effect for six months, unless OMIP waives the pre-existing condition limitation period. The pre-existing limitation period will be waived if you are under the age of 19, applying for portability (with a certificate of creditable coverage) or FMIP. A pre-existing condition is a condition for which medical treatment or diagnosis was rendered during the six-month period immediately preceding the OMIP effective date of coverage. Pregnancy, alcoholism, and transplants are considered pre-existing conditions.

   _____ ***ALL*** **parties on this application *MUST* initial here showing you have read and understand the above paragraph.**

   (Parent/legal guardian if applicant is under 18 years of age or legally incompetent.)

2. If this application contains any material misrepresentations or omissions or you falsified or concealed eligibility requirements we may terminate your policy back to the effective date of OMIP/FMIP coverage. In addition, we may retain your premiums to cover any claims and administration costs OMIP/FMIP paid retroactive to the date we terminate your policy and recover from you any amounts we paid in excess of the premiums.

   _____ ***ALL*** **parties on this application *MUST* initial here showing you have read and understand the above paragraph.**

   (Parent/legal guardian if applicant is under 18 years of age or legally incompetent.)

3. The information you provide on this application may be shared with other government agencies for the purposes of establishing eligibility.

   _____ ***ALL*** **parties on this application *MUST* initial here showing you have read and understand the above paragraph.**

   (Parent/legal guardian if applicant is under 18 years of age or legally incompetent.)

FMIP Applicants Only

You must sign either 1a or 1b AND 2 to acknowledge the following:

1a. *I am a U.S. citizen:*

Signature: **Maiden name:** **Date:**

1b. *I am not a citizen but am lawfully present in the U.S. (Attach proof of lawful presence. See page 4 of the Member Handbook):*

Signature: **Date:**

2. *I have been uninsured for the past six months. Exception: My most recent insurance was the Affordable Care Act Pre-existing Condition Insurance Program from another state.*

Signature: **Date:**

INDIVIDUAL AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

On behalf of ourselves and the family member(s) listed on this application, I authorize any physician, health-care provider, hospital, insurance or reinsurance company, or other insurance information exchange to disclose to the Oregon Medical Insurance Pool (OMIP)/Federal Medical Insurance Pool (FMIP), an agency of the State of Oregon, or its representatives, our health information (including alcohol, chemical dependency, mental treatment, genetic testing or HIV treatment). We acknowledge and understand that this information will be used only for the purpose of determining enrollment, eligibility for benefits, and payment of claims, case management, quality assurance reviews or audits. Health information may include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

If I choose not to sign this authorization, OMIP/FMIP may refuse to enroll us in an OMIP/FMIP health plan or pay future claims that we may incur if we obtain OMIP/FMIP insurance coverage.

I may cancel this authorization at any time by sending a written request to OMIP/FMIP. My cancellation of this authorization will not affect any action OMIP/FMIP took before it received my request.

Federal law requires OMIP/FMIP to tell me that, if the party to whom OMIP/FMIP discloses my personal information shares it with anyone else, some state and federal laws may no longer protect it. This excludes alcohol and drug abuse records, which are protected by federal confidentiality rules (42 CFR, Part 2). Federal law prohibits redisclosure of this information without specified written authorization.

My signature on this application authorizes disclosure to OMIP/FMIP of health insurance coverage, health insurance applications, Medicaid eligibility and medical record information about myself and my family members, listed on this application, if needed to: 1) determine eligibility for coverage; 2) preauthorize or process claims for benefits; 3) perform case management (including concurrent review) or quality assurance reviews; or 4) conduct an audit. OMIP/FMIP shall not release the medical record information it obtains to anyone else except as allowed by state and federal law.

This authorization takes effect on the date I sign this application and remains in effect for the lifetime of the OMIP/FMIP coverage or the duration of any claim, whichever is longer.

A photocopy of this authorization is as valid as the original.

Signature of applicant (or parent/legal guardian if applicant is under 18 years of age or legally incompetent):

Date:

Signature of spouse/domestic partner if covered in this application:

Date:

Signature of dependent over the age of 18 if covered in this application:

Date:

If signed by a personal representative of the applicant, please complete the following:

Personal representative name (please print): ____________________

Relationship to individual: ____________________(attach legal documentation if other than parent)

Date you want your insurance to begin? ____________________

Applications are processed in the order they are received. It may take up to 30 days for processing. However, if you are applying to OMIP/FMIP because you are medically eligible, your insurance starts the first of the month after we receive a complete (including all required documents) application unless you ask for a future date.

H Premium Payment

DO NOT SEND PREMIUM PAYMENT WITH THIS APPLICATION

You cannot have OMIP/FMIP premiums paid or reimbursed by a public entity, employer, or a health care provider for the purpose of reducing the payer's financial loss or obligation.

If you are approved, you will receive information regarding your premium payment.

I would like to pay my premium with the following method (check one):

- ❑ Monthly automatic payment directly from my bank *(If checked, complete authorization agreement that follows.)*
- ❑ Monthly billed directly
- ❑ Quarterly billed directly
- ❑ FHIAP ID # ______________________________
  Please attach a copy of the signed ***FHIAP Certificate of Eligibility*** listing all eligible parties, to this application.
- ❑ CareAssist ID # ______________________________

AUTHORIZATION AGREEMENT FOR MONTHLY AUTOMATIC BANK PAYMENT (SUREPAY)

Name of Applicant or Policy Holder	Social Security Number

Authorization to my bank: ❑ Checking Account ❑ Savings Account

As a convenience and on behalf of the Account Holder identified below, I/we hereby request and authorize you to pay and charge to the account identified below, checks or electronic debits drawn on the account by and payable to the order of Regence BlueCross BlueShield of Oregon, Portland, Oregon on behalf of the Oregon Medical Insurance Pool/Federal Medical Insurance Pool. I/we agree that your rights to each such check or electronic debit shall be the same as if it were an actual check drawn on you and signed by me/us. This authority is to remain in effect until revoked by me/us in writing, and until you actually receive such notice, I/we agree that you shall be fully protected in honoring any such check. I/we further agree that if any checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. A photocopy of this executed authorization shall be as valid as the original.

Please provide a voided check.

Financial Institution	Transit/Routing Numbers	Account Number

____
Account Holder's Name (please print)

______________________________ ______________
Account Holder's Authorized Signature(s) – as it appears on bank statement Date

Billing Address (if different than mailing address)		
Billing Address		
City	State	ZIP

I Agent Information

I certify by my signature that follows, that I have explained eligibility provisions to the applicant and have reviewed the application to assure that the application is complete and accurate. I have made no statements of benefits, conditions, limitations or exclusions of the agreement except through written material furnished by OMIP. I have informed the applicant that the Oregon Medical Insurance Pool/Federal Medical Insurance Pool will determine the effective date of coverage upon receipt of a complete application, which includes the required attachments, and verification of eligibility.

Agent signature certifies that the agent has reviewed the application ***AFTER*** it was completed and the application is complete and accurate. **If the application is not complete, including all of the agent information below, OMIP/FMIP may choose not to pay the agent fee.**

Print Agent Name			Tax I.D. No.	
Agency Name			Oregon Lic. No.	
Street Address	City		State	Zip
E-mail	Phone		Fax	
Agent Signature			Date	

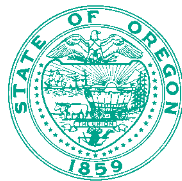
NOTE: This page is removed before the "original" application is returned back to the enrollees.

Document Checklist

Did you remember to:

Yes No

- ❑ ❑ Answer all questions completely?
- ❑ ❑ If an applicant doesn't provide a declination letter a physician's signature in Section C needs to be provided or a letter confirming the condition(s) checked in Section C on application.
- ❑ ❑ Attach proof of residency? ***(Section D on application)***
- ❑ ❑ Initial residency acknowledgement statement ***(Section D on application)***
- ❑ ❑ Attach proof of lawful presence in the U.S. if you are not a citizen. ***(See page 4 of the Member Handbook)***
- ❑ ❑ Initial the affirmations, understandings, and disclosure authorization and then sign and date the application. ***(Section G on application)***
- ❑ ❑ If applying for credit toward the six-month pre-existing condition exclusion, attach ***Certificate of Coverage*** from prior insurance carrier reflecting your beginning and ending dates of coverage and stating your previous coverage has been terminated?
- ❑ ❑ If applying through portability eligibility, please attach a COBRA exhaustion letter. This tells us that your COBRA coverage is exhausted and that no portability options are available. Or, attach any of the other required documents reflecting portability eligibility. Please also provide a ***Certificate of Coverage*** with termination dates to verify that this coverage has been terminated.



Oregon Medical Insurance Pool/Federal Medical Insurance Pool