

# Portability

Prevailing Benefit Design  
 Indemnity or PPO/POS and HMO  
 Exhibit I

Department of Consumer  
 & Business Services  
 Insurance Division  
 350 Winter St. NE, Rm. 440  
 Salem, Oregon 97301-3883  
 Phone (503) 947-7983

BENEFITS	PPO/POS IN-NETWORK OR INDEMNITY	PPO/POS OUT-OF- NETWORK	HMO
Separate Annual Deductible for in and out-of-network	In-network only	Out-of-network only	
Individual	\$750	\$750	N/A
Family	\$2,250	\$2,250	N/A
Coinsurance	80%	60%	N/A
Out-of-Pocket Maximum			
Individual	N/A	N/A	\$1,500
Family	N/A	N/A	\$4,500
Stop-loss Maximum			
Individual	\$15,000 or equivalent Out-of-pocket	\$15,000 or equivalent Out-of-pocket	N/A
Lifetime Maximum Benefits	\$2,000,000 total		N/A
Prescription Drugs (Outpatient)	\$20 or 20% Generic \$40 preferred	\$20 or 20% Generic \$40 preferred	\$20 or 20% Generic \$40 preferred
First Dollar Benefits	\$60 non-preferred	\$60 non-preferred	\$60 non-preferred
Doctor's Visits Including Maternity	80%	60%	\$30 co-pay
Surgery	80%	60%	\$100 co-pay
Preventive services	80%	Not covered <sup>1</sup>	\$0 co-pay
Immunizations	80%	Not covered <sup>1</sup>	\$0 co-pay
Well Baby	80%	Not covered <sup>1</sup>	\$20 co-pay
Well Child	80%	Not covered <sup>1</sup>	\$20 co-pay
Women's Health Care Services	80%	Not covered <sup>1</sup>	\$20 co-pay
Hospital inpatient services	80%	60%	\$100 daily co-pay for up to 5 days admission
Outpatient surgery Including OP Surgery, Ambulatory Services, MRI, CT, Angiogram	80%	60%	\$100 co-pay
Skilled nursing facilities <sup>2</sup>	80%	60%	\$100 daily co-pay for up to 5 days admission
Home health care <sup>3</sup>	80%	60%	\$20 co-pay per day
Urgent care facilities	80%	60%	\$50 co-pay
Emergency room (waived if admitted)	\$100 co-pay then 80% <sup>4</sup>	\$100 co-pay then 80% <sup>4</sup>	\$100 co-pay
X-Ray and Lab (outpatient)	80%	60%	\$15 co-pay lab <sup>5</sup> \$25 co-pay x-ray <sup>5</sup>

BENEFITS	PPO/POS IN-NETWORK OR INDEMNITY	PPO/POS OUT-OF-NETWORK	HMO
Ambulance <sup>6</sup>	80%	80%	\$100 co-pay
Mental Health and Chemical Dependency <sup>7</sup>	80%	60%	\$20 co-pay
Transplants	Per Medicaid	Per Medicaid	Per Medicaid
Durable medical equipment	80%	60%	20% co-pay
Physical, Occupational and Speech Therapy (30 visits/calendar year)	80%	60%	\$20 co-pay
Experimental or Investigational	Not covered	Not covered	Not covered
Hospice Care	80%	60%	\$20 co-pay

1. No payment for out of network services.
2. 60 days per calendar year maximum.
3. 60 visits maximum, must follow carrier's prevailing group health benefit plans.
4. Co-pay not part of deductible or stop loss.
5. Co-pay is per lab test and per x-ray procedure.
6. Use the same maximum for ground and air ambulance as carrier's prevailing group plans.
7. Coverage must include treatment of chemical dependency, including alcoholism, and mental or nervous conditions that is no less than the coverage limits set forth in OAR 743.556.

**Stop-loss maximum** means the insurer pays 80% and the enrollee pays 20% (or insurer pays 60% and enrollee pays 40% as indicated for out-of-network services) of covered expenses incurred until those covered expense total \$15,000. The insurer then pays 100% of covered expenses, in-network or out-of-network, incurred during the remainder of the contract year. Any deductible must be paid before the insurer pays any percentage of covered expenses.

**Out-of-pocket maximum** means the individual pays \$750 and the family pays \$2,250 of covered benefits as defined under the health policy per contract year before any covered benefit is paid by the insurer. The insurer then pays 100% of covered expenses incurred during the rest of the contract year.

**Covered** means subject to applicable deductible, co-payment, coinsurance, out-of-pocket and stop-loss maximum.

**Medicaid Transplant List:**

- Liver
- Kidney
- Heart, lung and heart/lung
- Corneal
- Bone marrow for aplastic anemia, leukemia, lymphoma, severe combined immunodeficiency disease or Wiskott-Aldrich syndrome
- Immunosuppressive drugs associated with covered transplants

These transplants must be covered subject to the same terms and conditions as any other illness under the carrier's prevailing group health benefit plans. An exclusion period must follow the carrier's prevailing group health plans. The exclusion period may not exceed 24 months and credit for prior creditable coverage is applied to the excluded period.