

# Portability

Low Cost Benefit Design  
 Indemnity or PPO/POS and HMO  
 Exhibit II

Department of Consumer  
 & Business Services  
 Insurance Division  
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<b>BENEFITS</b>	<b>PPO/POS IN-NETWORK OR INDEMNITY</b>	<b>PPO/POS OUT-OF-NETWORK</b>	<b>HMO</b>
Separate Annual Deductible for in and out-of-network	In-network only	Out-of-network only	
Individual	\$1,500	\$1,500	N/A
Family	\$4,500	\$4,500	N/A
Coinsurance	70%	50%	N/A
Out-of-Pocket Maximum			
Individual	N/A	N/A	\$3,000
Family	N/A	N/A	\$9,000
Stop-loss Maximum			
Individual	\$20,000 or equivalent Out-of-pocket	\$20,000 or equivalent Out-of-pocket	N/A
Lifetime Maximum	\$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
Separate deductible for in- network and out-of-network	\$60 non-preferred Deductible: \$1,000	\$60 non-preferred Deductible: \$1,000	\$60 non-preferred Deductible: \$1,000
Doctor's Visits Including Maternity	70%	50%	\$30 co-pay
For Surgery	70%	50%	\$150 co-pay
Preventive services	70%	Not covered <sup>1</sup>	\$0 co-pay
Immunizations	70%	Not covered <sup>1</sup>	\$30 co-pay
Well Baby	70%	Not covered <sup>1</sup>	\$30 co-pay
Well Child	70%	Not covered <sup>1</sup>	\$30 co-pay
Women's Health Care Services	70%	Not covered <sup>1</sup>	\$30 co-pay
Hospital Inpatient Services	70%	50%	\$500 daily co-pay for up to 5 days admission
Outpatient surgery Including OP Surgery, Ambulatory Services, MRI, CT, Angiogram	70%	50%	\$150 co-pay
Skilled nursing facilities <sup>2</sup>	70%	50%	\$500 daily co-pay for up to 5 days admission
Home health care <sup>3</sup>	70%	50%	\$30 co-pay per day
Urgent care facilities	70%	50%	\$50 co-pay
Emergency room (waived if admitted)	\$100 co-pay then 70% <sup>4</sup>	\$100 co-pay then 70% <sup>4</sup>	\$150 co-pay
X-Ray and Lab (outpatient)	70%	50%	\$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>	70%	70%	\$150 co-pay
Mental Health and Chemical Dependency <sup>7</sup>	70%	50%	\$30 co-pay
Transplants	Per Medicaid	Per Medicaid	Per Medicaid
Durable medical equipment	70%	50%	50% co-pay
Physical, Occupational and Speech Therapy (30 visits/calendar year)	70%	50% coinsurance	\$30 co-pay
Experimental or Investigational	Not covered	Not covered	Not covered
Hospice Care	70%	50%	\$30 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 \$1,500 and the family pays \$4,500 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.