Oregon Small Business Group Portfolio[1]

2021

Plan name	Member(s) responsibility											
	METAL LEVEL	DEDUCTIBLE[2] (SINGLE/ FAMILY)	OUT-OF-POCKET MAXIMUM[3] (SINGLE/FAMILY)	OFFICE VISIT (PCP/ SPEC.)	COINSURANCE[4] (IN-NETWORK/ OUT-OF-NETWORK)	LAB AND X-RAY	CT/MRI/ PET/SPEC	INPATIENT HOSPITAL	OUTPATIENT SURGERY (ASC/ HOSPITAL)	EMERGENCY ROOM (COPAY WAIVED IF ADMITTED)	URGENT CARE	PHARMACY[7]
PPO												
P10-250-1-4000LX	Platinum	$250 / $500	$4,000 / $8,000	$10 / $20	10% / 50%	$10	10%[5]	10%	5% / 10%	$250 + 10%	$50	$10 / $30 / $90 / 50%
P10-500-2-4000LX	Platinum	$500 / $1,000	$4,000 / $8,000	$10 / $20	20% / 50%	$10	20%[5]	20%	10% / 20%	$250 + 20%	$50	$10 / $30 / $90 / 50%
P10-750-2-4000LX	Platinum	$750 / $1,500	$4,000 / $8,000	$10 / $20	20% / 50%	$10	20%[5]	20%	10% / 20%	$250 + 20%	$50	$10 / $30 / $90 / 50%
P50-0-5-5000	Gold	$0 / $0	$5,000 / $10,000	50% / 50%	50% / 50%	50%	50%	50%	40% / 50%	50%	50%	$15 / $45 / $90 / 50%
P0-1500-4-7900DX	Gold	$1,500 / $3,000	$7,900 / $15,800	$0 / $50	40% / 50%	$0	40%	40%	30% / 40%	40%	$50	$250 deductible $0[5] / $45/ 50%/ 50%
P0-3500-4-7900DX	Gold	$3,500 / $7,000	$7,900 / $15,800	$0 / $50	40% / 50%	$0	40%	40%	30% / 40%	40%	$50	$250 deductible $0[5] / $45/ 50%/ 50%
P20-500-3-7900DX	Gold	$500 / $1,000	$7,900 / $15,800	$20 / $40	30% / 50%	$20	30%	30%	20% / 30%	$250 + 30%	$50	$15 / $45 / $90 / 50%
P20-1000-2-7900DX	Gold	$1,000 / $2,000	$7,900 / $15,800	$20 / $40	20% / 50%	$20	20%	20%	10% / 20%	$250 + 20%	$50	$15 / $45 / $90 / 50%
P20-2000-2-7900DX	Gold	$2,000 / $4,000	$7,900 / $15,800	$20 / $40	20% / 50%	$20	20%	20%	10% / 20%	$250 + 20%	$50	$20 / $45 / $90 / 50%
P20-2500-3-7900DX	Gold	$2,500 / $5,000	$7,900 / $15,800	$20 / $40	30% / 50%	$20	30%	30%	20% / 30%	$250 + 30%	$50	$20 / $45 / $90 / 50%
P30-1500-2-7900DX	Gold	$1,500 / $3,000	$7,900 / $15,800	$30 / $60	20% / 50%	$20	20%	20%	10% / 20%	$250 + 20%	$50	$15 / $45 / $90 / 50%
P30-3500-3-7900DX	Gold	$3,500 / $7,000	$7,900 / $15,800	$30 / $60	30% / 50%	$20	30%	30%	20% / 30%	$250 + 30%	$50	$20 / $45 / $90 / 50%
P20-5000-5-8150DX	Silver	$5,000 / $10,000	$8,150 / $16,300	$20 / $50	50% / 50%	$20	50%	50%	40% / 50%	50%	$50	$350 deductible $15[5] / $50 / 50% / 50%
P40-3000-3-8150ES	Silver	$3,000 / $6,000	$8,150 / $16,300	$40 / $80	30% / 50%	30%	30%	30%	20% / 30%	30%	$80	$25 / $50 / 50% / 50%
P40-4000-3-8150ES	Silver	$4,000 / $8,000	$8,150 / $16,300	$40 / $80	30% / 50%	30%	30%	30%	20% / 30%	30%	$80	$25 / $50 / 50% / 50%
P45-3500-5-8150ES	Silver	$3,500 / $7,000	$8,150 / $16,300	$45 / $90	50% / 50%	50%	50%	50%	40% / 50%	50%	$90	$25 / $50 / 50% / 50%
P45-5000-5-8150ES	Silver	$5,000 / $10,000	$8,150 / $16,300	$45 / $90	50% / 50%	50%	50%	50%	40% / 50%	50%	$90	$25 / $50 / 50% / 50%
P8250-0-8250ES	Bronze	$8,250 / $16,500	$8,250 / $16,500	0% / 0%	0% / 50%	0%	0%	0%	0% / 0%	0%	0%	0%[6] / 0%[6] /0%[6] / 0%[6]
High Deductible PPO[8]												
HD2800-2-5500ES	Silver	$2,800 / $5,600	$5,500 / $11,000	20% / 20%	20% / 50%	20%	20%	20%	10% / 20%	20%	20%	20%[6] / 20%[6] / 20%[6] / 50%[6]
HD3000-3-6750ES	Silver	$3,000 / $6,000	$6,750 / $13,500	30% / 30%	30% / 50%	30%	30%	30%	20% / 30%	30%	30%	30%[6] / 30%[6] / 30%[6] / 50%[6]
HD4000-3-6750ES	Silver	$4,000 / $8,000	$6,750 / $13,500	30% / 30%	30% / 50%	30%	30%	30%	20% / 30%	30%	30%	30%[6] / 30%[6] / 30%[6] / 50%[6]
HD6900-0-6900ES	Bronze	$6,900 / $13,800	$6,900 / $13,800	0% / 0%	0% / 50%	0%	0%	0%	0% / 0%	0%	0%	0%[6] / 0%[6] /0%[6] / 0%[6]
Standard PPO												
HEALTH NET OREGON STANDARD PLAN	Gold	$1,500 / $3,000	$7,300 / $14,600	$20 / $40	20% / 50%	20%	20%	20%	20% / 20%	20%	$60	$10 / $30 / 50% / 50% *($500 per script cap %)*
HEALTH NET OREGON STANDARD PLAN	Silver	$3,650 / $7,300	$8,550 / $17,100	$40 / $80	30% / 50%	30%	30%	30%	30% / 30%	30%	$70	$15 / $60 / 50% / 50%
HEALTH NET OREGON STANDARD PLAN	Bronze	$8,550 / $17,100	$8,550 / $17,100	$50 / $100	0% / 50%	0%	0%	0%	0% / 0%	0%	$100	$20[5] / 0%[6] / 0%[6] / 0%[6]
CommunityCare 1T												
15-500-1-3000DX	Platinum	$500 / $1,000	$3,000 / $6,000	$15 / $45	10% / Not covered	$15	10%	10%	5% / 10%	$250 + 10%	$45	$10 / $30 / $90 / 50%
20-750-2-3000DX	Platinum	$750 / $1,500	$3,000 / $6,000	$20 / $50	20% / Not covered	$20	20%	20%	10% / 20%	$250 + 20%	$50	$10 / $30 / $90 / 50%

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Coverage for every stage of life™

OTH039450EO00 (1/21)

Plan name	Member(s) responsibility											
	METAL LEVEL	DEDUCTIBLE[2] (SINGLE/ FAMILY)	OUT-OF-POCKET MAXIMUM[3] (SINGLE/FAMILY)	OFFICE VISIT (PCP/ SPEC.)	COINSURANCE[4] (IN-NETWORK/ OUT-OF-NETWORK)	LAB AND X-RAY	CT/MRI/ PET/SPEC	INPATIENT HOSPITAL	OUTPATIENT SURGERY (ASC/ HOSPITAL)	EMERGENCY ROOM (COPAY WAIVED IF ADMITTED)	URGENT CARE	PHARMACY[7]
CommunityCare 1T (continued)												
25-1000-2-7900DX	Gold	$1,000 / $2,000	$7,900 / $15,800	$25 / $65	20% / Not covered	$25	20%	20%	10% / 20%	$250 + 20%	$65	$15 / $45 / $100 / 50%
25-2000-2-7900DX	Gold	$2,000 / $4,000	$7,900 / $15,800	$25 / $65	20% / Not covered	$25	20%	20%	10% / 20%	$250 + 20%	$65	$15 / $45 / $100 / 50%
25-3500-2-7900DX	Gold	$3,500 / $7,000	$7,900 / $15,800	$25 / $65	20% / Not covered	$25	20%	20%	10% / 20%	$250 + 20%	$65	$15 / $45 / $100 / 50%
40-3000-3-8150ES	Silver	$3,000 / $6,000	$8,150 / $16,300	$40 / $80	30% / Not covered	30%	30%	30%	20% / 30%	30%	$80	$25 / $50 / 50% / 50%
40-4500-3-8150ES	Silver	$4,500 / $9,000	$8,150 / $16,300	$40 / $80	30% / Not covered	30%	30%	30%	20% / 30%	30%	$80	$25 / $50 / 50% / 50%
CommunityCare 3T												
15-500-1-3000DX	Platinum	$500 / $1,000	$3,000 / $6,000	$15 / $45	10% / 50%	$15	10%	10%	5% / 10%	$250 + 20%	$45	$10 / $30 / $90 / 50%
20-750-2-3000DX	Platinum	$750 / $1,500	$3,000 / $6,000	$20 / $50	20% / 50%	$20	20%	20%	10% / 20%	$250 + 20%	$50	$10 / $30 / $90 / 50%
25-1000-2-7900DX	Gold	$1,000 / $2,000	$7,900 / $15,800	$25 / $65	20% / 50%	$25	20%	20%	10% / 20%	$250 + 20%	$65	$15 / $45 / $100 / 50%
25-2000-2-7900DX	Gold	$2,000 / $4,000	$7,900 / $15,800	$25 / $65	20% / 50%	$25	20%	20%	10% / 20%	$250 + 20%	$65	$15 / $45 / $100 / 50%
25-3500-2-7900DX	Gold	$3,500 / $7,000	$7,900 / $15,800	$25 / $65	20% / 50%	$25	20%	20%	10% / 20%	$250 + 20%	$65	$15 / $45 / $100 / 50%
40-3000-3-8150ES	Silver	$3,000 / $6,000	$8,150 / $16,300	$40 / $80	30% / 50%	30%	30%	30%	20% / 30%	30%	$80	$25 / $50 / 50% / 50%
40-4500-3-8150ES	Silver	$4,500 / $9,000	$8,150 / $16,300	$40 / $80	30% / 50%	30%	30%	30%	20% / 30%	30%	$80	$25 / $50 / 50% / 50%

Plan name	Member(s) responsibility					
Alternative care[9,10]	OFFICE VISIT (CHIROPRACTIC / ACUPUNCTURE)	OFFICE VISIT (MASSAGE THERAPY)	OUT-OF-NETWORK	MAXIMUM CALENDAR YEAR BENEFIT FOR ACUPUNCTURE		
CAM 20-500 (EMBEDDED)	$20	$25 (9 visits)	N/A	$500		
CAM 15-1000	$15	$25 (18 visits)	N/A	$1,000		
CAM 15-1500	$15	$25 (27 visits)	N/A	$1,500		
CAM 15-1000 PLUS	$15	$25 (18 visits)	20% (18 visits)	$1,000[11]		
Dental	DEDUCTIBLE (SINGLE / FAMILY)	MAXIMUM CALENDAR YEAR	COINSURANCE (PREVENTIVE / BASIC / MAJOR / ORTHO)	CLEANINGS	EXAMS	X-RAYS
PLUS D50-1855-1500	$50 / $150	$1,500	0% / 20% / 50% / 50%	0%	0%	0%
VALUE D50-185-1500V	$50 / $150	$1,500	0% / 20% / 50% / Not covered	0%	0%	0%
PREFERRED PLUS DP50-1855-1500	$50 / $150	$1,500	0% / 20% / 50% / 50%	0%	0%	0%
ESSENTIALS D50-16-500	$50 / N/A	$500	0% / 40% / Not covered / Not covered	0%	0%	0%
Vision	EXAM	FRAME ALLOWANCE	LENSES (SINGLE / BIFOCAL / TRIFOCAL / PROGRESSIVE)	FREQUENCY (MONTHS) (EXAMINATION / LENSES / FRAME / CONTACT LENSES IN LIEU OF LENSES)		
ELITE 1010-1	$10	$150	$10 / $10 / $10 / $75	12 / 12 / 12 / 12		
PREFERRED 1025-2	$10	$100	$25 / $25 / $25 / $90	12 / 12 / 24 / 12		
PREFERRED 1025-3	$10	$100	$25 / $25 / $25 / $90	12 / 24 / 24 / 24		

1 All medical plans include pediatric vision coverage. Pediatric dental coverage must be purchased for dependents under 19 years of age through Health Net or another carrier. Pediatric dental is not available with the Health Net of Oregon Standard medical plans.

2 The specified deductible must be met each calendar year (January 1 through December 31) before Health Net pays any claims.

3 The annual out-of-pocket maximum includes the annual deductible, copayments and coinsurance. After the out-of-pocket maximum is reached in a calendar year, we will pay the covered services during the rest of that calendar year at 100% of our contract rates for participating provider services and at 100% of the maximum allowable amount (MAA) for out-of-network (OON) services. Members are still responsible for OON-billed charges that exceed MAA.

4 Coinsurance is subject to the annual deductible.

5 Deductible is waived.

6 After deductible.

7 Prescription drug tiers are Tier 1: Generic; Tier 2: Brand Preferred; Tier 3: Non-Preferred; SP: Specialty. Retail pharmacy – members may receive a 90-day fill at a retail pharmacy; one copayment coinsurance applies per 30-day supply. Tier 1, 2 or 3 prescription drugs may apply. Deductible waived unless otherwise noted. MAC A applies. Essential Rx Drug List – A listing of preferred drugs and their corresponding benefit levels is shown on the Health Net Essential Rx Drug List (EDL). Log in as a Health Net member at www.healthnetoregon.com to view Oregon Essential RX Drug List.

8 All benefits including office visit copay, pharmacy, and alternative care are after deductible.

9 All copayments accumulate to the medical out-of-pocket maximum.

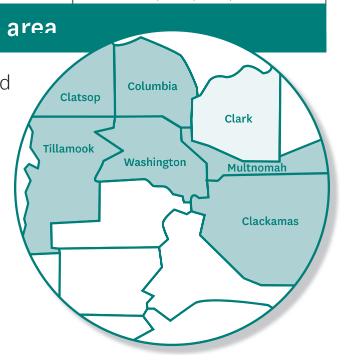
10 Benefit not available on Standard Plans.

11 In- and out-of-network visits combined.

This brochure is intended to be used for marketing purposes only and presents general information. Please refer to the Benefit Schedule and Agreement for details, limitations, exclusions, and other terms and conditions of coverage.

CommunityCare coverage area

- Employer groups must be located in Multnomah, Clackamas, Washington, Clatsop, Columbia, and Tillamook counties.
- Employees must live in Multnomah, Clackamas, Washington, Clatsop, Columbia, and Tillamook counties, and Clark County, WA.



Participation guidelines

1–5 eligible employees + **66%** minimum employee participation

6–50 eligible employees + **50%** minimum employee participation

+ Employer pays minimum of 50% of base plan monthly = **Access to Health Net's**