The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call the number on your Health Net ID card (current members) or 1-888-802-7001 or visit us at www.healthnetoregon.com/. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or www.healthnetoregon.com/ or you can call 1-888-802-7001 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$750 member/$1,500 family per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, primary care visits, specialist visits, diagnostic tests, prescription drugs, emergency room care, urgent care, outpatient mental health & substance use disorder office visits and pediatric vision are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $100 pediatric dental deductible required. There are no other specific deductibles.	You must pay all of the costs for these services up the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Combined medical/pharmacy limit: $3,000 member/$6,000 family per calendar year. Deductible included in OOPL.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.healthnetoregon.com/ or call 1-888-802-7001.	This plan uses a provider network. You will pay less if you use a provider in the CommunityCare network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your CommunityCare network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay CommunityCare Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit deductible does not apply	Not covered	None
	Specialist visit	$50 copay/visit deductible does not apply	Not covered	None
	Preventive care/screening/ immunization	No charge for covered services; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$20 copay/visit deductible does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	Requires preauthorization.
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.healthnetoregon.com/.**	Tier I (Generic drugs)	$10 copay/retail order deductible does not apply $20 copay/mail order deductible does not apply	Not covered	Supply/order: is for 30 day (retail); 60 and 90 day supplies available for additional charge. Mail order is for 35-90 days. May require preauthorization. Anti-cancer drugs at 20% coinsurance, deductible does not apply.
	Tier II (Preferred brand drugs)	$30 copay/retail order deductible does not apply $60 copay/mail order deductible does not apply	Not covered	
	Tier III (Non-preferred brand drugs)	$90 copay/retail order deductible does not apply $180 copay/mail order deductible does not apply	Not covered	
	Specialty drugs	50% coinsurance deductible does not apply	Not covered	Supply/order: is for 30 day supply. 60 and 90 day supplies available for additional charge. Filled by a specialty pharmacy. May require preauthorization.

Common Medical Event	Services You May Need	What You Will Pay CommunityCare Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Hospital-20% coinsurance ASC-10% coinsurance	Not covered	Requires preauthorization. Coverage includes abortion services.
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	$250 copay/visit + 20% coinsurance deductible does not apply	$250 copay/visit + 20% coinsurance deductible does not apply	Copay waived if admitted as inpatient.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	Medical-$50 copay/visit deductible does not apply Mental health & substance use disorders-$50 copay/visit deductible does not apply	Medical-$50 copay/visit deductible does not apply Mental health & substance use disorders-$50 copay/visit deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Requires preauthorization.
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office-$20 copay/visit deductible does not apply Other than office- 20% coinsurance	Not covered	Requires preauthorization except for office visits.
	Inpatient services	20% coinsurance	Not covered	Requires preauthorization.
If you are pregnant	Office visits	20% coinsurance	Not covered	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% coinsurance	Not covered	Requires preauthorization.
	Childbirth/delivery facility services	20% coinsurance	Not covered	Requires preauthorization.

Common Medical Event	Services You May Need	What You Will Pay CommunityCare Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Requires preauthorization.
	Rehabilitation services	20% coinsurance	Not covered	Outpatient-Max 30 visits per calendar year. Inpatient-Max 30 days per calendar year. May require preauthorization.
	Habilitation services	20% coinsurance	Not covered	Outpatient-Max 30 visits per calendar year. Inpatient-Max 30 days per calendar year. May require preauthorization.
	Skilled nursing center	20% coinsurance	Not covered	Max 60 days per calendar year. Requires preauthorization.
	Durable medical equipment	20% coinsurance	Not covered	May require preauthorization.
	Hospice services	20% coinsurance	Not covered	Requires preauthorization.
If your child needs dental or eye care	Children's eye exam	No charge deductible does not apply	Not covered	Eye exams are limited to 1 visit per year.
	Children's glasses	No charge deductible does not apply	Not covered	Glasses are limited to 1 pair per year.
	Children's dental check-up	No charge after deductible is met	50% coinsurance	$100 pediatric dental deductible required.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion services-All terminations of pregnancy (abortion) services provided by a licensed provider, including those for which federal funding is prohibited are covered by this plan	• Acupuncture • Chiropractic care • Cosmetic surgery (medically necessary)	• Hearing aids • Routine foot care (in connection with the treatment of diabetes)

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Health Net's Customer Contact Center at 1-888-802-7001, submit a grievance form through www.healthnetoregon.com/, or file your complaint in writing to, Health Net Appeals and Grievance Department, P.O. Box 10348, Van Nuys, CA 91410-0348. You have the right at any time to file a complaint with or seek assistance from the Division of Financial Regulation. If you choose to do so, assistance is available. Contact the Division of Financial Regulation at PO Box 14480, Salem, OR 97309-0405. Contact them by phone at 1-503-947-7984 or toll free at 1-888-877-4894, by email at cp.ins@state.or.us or online at www.cbs.state.or.us/ins/consumer/consumer.html. For information about group health care coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-802-7001.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-802-7001.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-802-7001.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-802-7001.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$750
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$400
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,110**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$750
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$900
Coinsurance	$10
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,680**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$750
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,250**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Nondiscrimination Notice

Health Net Health Plan of Oregon, Inc. (Health Net) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Net does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at 1-877-609-8715 (TTY: 711).

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Health Net's Customer Contact Center is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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English
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card. Applicants call 1-877-609-8715 (TTY: 711).

Amharic
ከፍያ የሌለው የቋንቋ አገልግሎት:: አስተርጓሚ ማግኘት ይችላሉ:: ሰነዶች እንዲዘጋጅልዎ ማድረግ ይችላሉ:: እርዳታ ለማግኘት በመታወቂያ ላይ ያለውን ቁጥር ይደውሉ:: የቀጣሪ ቡድን አባላት እባክዎ 1-877-609-8715 (TTY: 711) ቁጥር ይደውሉ::

Arabic
خدمات اللغة مجانية. يمكنك الحصول على مترجم فوري. ويمكنك الحصول على وثائق مقروءة لك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية. على مقدمي الطلبات الاتصال على الرقم 1-877-609-8715 (TTY:711) .

Chinese
免費語言服務。您可使用口譯員。您可請人將文件內容唸給您聽。如需協助，請致電您會員卡上所列的電話號碼與我們聯絡。申請人請致電 1-877-609-8715（TTY：711）。

Cushite (Oromo)
Waa Lacag la'aan Adeegyada Luuqada. Waxaad heli kartaa turjubaan. Waxaad heli kartaa in waraaqaha laguu aqriyo. Wixii caawin ah, naga soo wac lambarka ku qoran kaarka Aqoonsigaaga. Wicitaanka codsadayaasha 1-877-609-8715 (TTY: 711).

German
Kostenloser Sprachendienst. Dolmetscher sind verfügbar. Dokumente können Ihnen vorgelesen werden. Wenn Sie Hilfe benötigen, rufen Sie uns unter der Nummer auf Ihrer ID-Karte an. Antragsteller rufen unter 1-877-609-8715 (TTY: 711) an.

Japanese
無料の言語サービス。通訳をご利用いただけます。文書をお読みします。援助が必要な場合は、IDカードに記載されている番号までお電話ください。申込者の方は、1-877-609-8715 (TTY: 711) までお電話ください。

Korean
무료 언어 서비스. 통역 서비스를 받을 수 있습니다. 문서 낭독 서비스도 받으실 수 있습니다. 도움을 원하시면, 보험 ID에 수록된 번호로 전화해 주십시오. 신청자분은 1-877-609-8715 (TTY: 711) 번으로 전화해 주십시오.

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ អ្នកអាចស្តាប់គេអានឯកសារឱ្យអ្នក។ សម្រាប់ជំនួយ សូមទាក់ទងយើងខ្ញុំតាមយៈទូរស័ព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក។ បេក្ខជន សូមទាក់ទងទៅលេខ 1-877-609-8715 (TTY: 711)។

Laotian
ບໍລິການພາສາບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍຜູ້ແປພາສາໄດ້. ທ່ານສາມາດໃຫ້ອ່ານເອກະສານໃຫ້ທ່ານຟັງໄດ້. ເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ, ກະລຸນາໂທຫາພວກເຮົາໄດ້ຕາມເບີໂທທີ່ມີຢູ່ໃນບັດປະຈໍາຕົວຂອງທ່ານ. ຜູ້ຮ້ອງຂໍແມ່ນໃຫ້ໂທເບີ 1-877-609-8715 (TTY: 711).

Punjabi
ਬਿਨਾਂ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਆਂ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਡੇ ਲਈ ਦਸਤਾਵੇਜ਼ਾਂ ਪੜ੍ਹੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਬਿਨੈਕਾਰ 1-877-609-8715 (TTY: 711) 'ਤੇ ਫ਼ੋਨ ਕਰੋ।

Russian
Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика. Вам могут прочитать документы. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана. Если вы хотите стать участником плана, звоните по телефону 1-877-609-8715 (TTY: 711).

Spanish
Servicios de idiomas sin costo. Puede solicitar un intérprete. Puede obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación. Los solicitantes deben llamar al 1-877-609-8715 (TTY: 711).

Tagalog
Walang Gastos na Mga Serbisyo sa Wika. Maaari kayong kumuha ng isang interpreter. Maaari ninyong ipabasa ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa inyong ID card. Para sa mga aplikante, tumawag sa 1-877-609-8715 (TTY: 711)

Ukrainian
Безплатні послуги перекладу. Ви можете скористуватися послугами перекладача. Вам можуть прочитати ваші документи. Щоб отримати допомогу, телефонуйте нам за номером, який вказаний на вашій ідентифікаційній картці (ID). Заявники можуть телефонувати за номером 1-877-609-8715 (TTY: 711).

Vietnamese
Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu được đọc cho nghe tài liệu. Để nhận trợ giúp, hãy gọi cho chúng tôi theo số được liệt kê trên thẻ ID của quý vị. Người nộp đơn gọi số 1-877-609-8715 (TTY: 711).

OR WA Commercial Applicant Notice of Language Assistance