Health Net Health Plan of Oregon, Inc., "Health Net"

Large Group

Plan Overview

COMMUNITYCARE 1T CC1T10-500-2-4500DX

YOU CAN USE THIS MATRIX TO HELP COMPARE COVERAGE BENEFITS. THIS MATRIX PRESENTS A HIGH-LEVEL SUMMARY. FOR A MORE DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS, REVIEW THE PLAN CONTRACT AND *EVIDENCE OF COVERAGE* (EOC).

The copayment amounts are the fees members will be charged for covered services received. Health Net and the contracted provider have agreed to the copayment amounts. Copayments can be a fixed-dollar amount or a percentage of Health Net's cost for the service or supply. You may also see percentage copayments referred to as coinsurance. Members pay fixed-dollar copayments when they receive the service. The provider will usually bill members for percentage copayments after the service is received. All services are subject to the deductible, unless noted otherwise.

Benefit description	You pay
Network	In-network
Deductible – single / family	$500 / $1,000
Out-of-pocket maximum – single / family *(includes deductible)*	$4,500 / $9,000
Preventive care Preventive health exams, colonoscopy *(age 50+)*, routine immunizations, gynecological exam and pap, mammograms, PSA screening, tobacco cessation	$0 copay *(deductible waived)*
Office visits Physician - includes family practice, naturopath, pediatrics, internal medicine, general practice, obstetrics/gynecology	$10 copay/visit *(deductible waived)*
Specialist physician - providers in specialties other than those listed above	$50 copay/visit *(deductible waived)*
Allergy and therapeutic injections	20% of contract rate
Telemedical services	$0 *(deductible waived)*
Diagnostic services Diagnostic lab and X-ray, EKG, ultrasound	20% of contract rate *(deductible waived)*
Advanced diagnostic imaging, CT, MRI, PET, EEG, Holter monitor/stress test	20% of contract rate
Maternity services Maternity delivery care *(professional services only)*	20% of contract rate
Inpatient hospital services	20% of contract rate
Emergency and urgent care services Urgent care physician services	$50 copay/visit *(deductible waived)*
Emergency room services	$250 copay/visit, then 20% of contract rate *(deductible waived)*
Ambulance services - ground and air	20%
Hospital services Inpatient hospital	20% of contract rate
Inpatient rehabilitative services *(physical, occupational and speech therapy)* - limit max 30 days per year	20% of contract rate
Skilled nursing facility - limit max 60 days per year	20% of contract rate
Outpatient services Surgery, infusion, dialysis, chemotherapy, radiation therapy	20% of contract rate
Surgery at hospital-based facility	20% of contract rate
Surgery at ambulatory surgical center (ASC)	10% of contract rate
Rehabilitative services - limit max 30 days per year	$10 copay/visit *(deductible waived)*

(continued)

Benefit description	You pay
Network	In-network
Medical equipment and supplies Durable medical equipment, prosthetics, orthotics, diabetes supplies, oral sleep apnea appliance	20% of contract rate (for Nonparticipating providers, member responsible for 20% of MAA + any add'l amount in excess of MAA)
Medical supplies, including allergy serum and injected substances	20% of contract rate
Home health and hospice Home health care	20% of contract rate
Hospice services	20% of contract rate
Behavioral health - mental health/chemical dependency Physician services - office visit	$10 copay/visit *(deductible waived)*
Inpatient and residential services	20% of contract rate

The specified deductible must be met each calendar year (January 1 through December 31) before Health Net Health Plan of Oregon, Inc. pays any claims.

Family coverage means the subscriber and spouse; the subscriber and child(ren); or the subscriber, spouse and child(ren). Family coverage includes the per person deductible. Under family coverage, each member's covered expenses count toward the family's deductible.

The annual out-of-pocket maximum includes your annual deductible, copayments and coinsurance. After you reach the out-of-pocket maximum in a calendar year, we will pay your 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. You are still responsible for OON-billed charges that exceed MAA.

For naturopathic care, call American Specialty Health, Inc. (ASH) at 1-800-678-9133.

Telemedical services include coverage provided by Teladoc. Teladoc provides supplemental telehealth services in addition to the mandated telemedicine services for medical, mental disorders and chemical dependency conditions. Teladoc services are not intended to replace services from your physician. Teladoc consultation services do not cover specialist services, and prescriptions for substances controlled by the DEA, non-therapeutic drugs or certain other drugs which may be harmful because of potential abuse.

If a newborn patient requires admission to an intermediate or intensive care nursery, the deductible and coinsurance for these services will accumulate under the newborn's coverage, not under the mother's coverage.

The outpatient emergency room copay is waived if admitted.

Certain services require prior authorization or must be performed by a specialty care provider.

Behavioral Health benefits are administered by MHN. For mental health or chemical dependency services, call MHN at 1-800-977-8216.

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

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