Oregon Large Group Portfolio

health net

2023

Plan name	Member(s) In-Network responsibility									
	Deductible[1] (single / family)	Out-of-pocket maximum[2] (single / family)	Office / specialist visit	Coinsurance[3] (in-network / out-of-network	Lab / x-ray	CT / MRI / PET / SPEC	Inpatient hospital	Outpatient surgery (ASC / hospital)	Emergency room (copay waived if admitted)	Urgent care
Advantage LX PPO										
LX20-500-2-4000	$500 / $1,000	$4,000 / $8,000	$20 / $40	20% / 40%	$20	20%[4]	20%	20% / 10%	$250 + 20%	$50
LX25-1000-2-5000	$1,000 / $2,000	$5,000 / $10,000	$25 / $50	20% / 40%	$20	20%[4]	20%	20% / 10%	$250 + 20%	$50
Advantage PPO										
A10-0-2-4000	$0 / $0	$4,000 / $8,000	$10 / $20	20% / 40%	$20	20%	20%	20% / 10%	$250 + 20%	$50
A15-250-2-4000	$250 / $500	$4,000 / $8,000	$15 / $30	20% / 40%	$20	20%	20%	20% / 10%	$250 + 20%	$50
A20-500-2-4000	$500 / $1,000	$4,000 / $8,000	$20 / $40	20% / 40%	$20	20%	20%	20% / 10%	$250 + 20%	$50
A20-750-2-5000	$750 / $1,500	$5,000 / $10,000	$20 / $40	20% / 40%	$20	20%	20%	20% / 10%	$250 + 20%	$50
A20-2000-2-6600	$2,000 / $4,000	$6,600 / $13,200	$20 / $40	20% / 40%	$20	20%	20%	20% / 10%	$250 + 20%	$50
A25-1000-2-5000	$1,000 / $2,000	$5,000 / $10,000	$25 / $50	20% / 40%	$20	20%	20%	20% / 10%	$250 + 20%	$50
A30-1500-2-6600	$1,500 / $3,000	$6,600 / $13,200	$30 / $60	20% / 40%	$20	20%	20%	20% / 10%	$250 + 20%	$50
A30-2500-3-6600	$2,500 / $5,000	$6,600 / $13,200	$30 / $60	30% / 50%	$20	30%	30%	30% / 20%	$250 + 30%	$50
A30-3000-2-7350	$3,000 / $6,000	$7,350 / $14,700	$30 / $60	20% / 40%	$20	20%	20%	20% / 10%	$250 + 20%	$50
A35-3000-3-7350	$3,000 / $6,000	$7,350 / $14,700	$35 / $70	30% / 50%	$20	30%	30%	30% / 20%	$250 + 30%	$50
A35-5000-2-7350	$5,000 / $10,000	$7,350 / $14,700	$35 / $70	20% / 40%	$20	20%	20%	20% / 10%	$250 + 20%	$50
A35-5000-3-7350	$5,000 / $10,000	$7,350 / $14,700	$35 / $70	30% / 50%	$20	30%	30%	30% / 20%	$250 + 30%	$50
Value PPO										
V20-500-2-4000	$500 / $1,000	$4,000 / $8,000	$20 / $40	20% / 40%	20%	20%	20%	20% / 10%	20%	$50
V25-1000-2-5000	$1,000 / $2,000	$5,000 / $10,000	$25 / $50	20% / 40%	20%	20%	20%	20% / 10%	20%	$50
V30-2000-2-6000	$2,000 / $4,000	$6,000 / $12,000	$30 / $60	20% / 40%	20%	20%	20%	20% / 10%	20%	$50
V35-5000-2-7350	$5,000 / $10,000	$7,350 / $14,700	$35 / $70	20% / 40%	20%	20%	20%	20% / 10%	20%	$50
Essentials PPO										
E25-1000-2-5000	$1,000 / $2,000	$5,000 / $10,000	$25 / $50	20% / 40%	20%	20%	20%	20% / 10%	20%	$50
E30-2000-2-6600	$2,000 / $4,000	$6,600 / $13,200	$30 / $60	20% / 40%	20%	20%	20%	20% / 10%	20%	$50
E35-3000-2-7350	$3,000 / $6,000	$7,350 / $14,700	$35 / $70	20% / 40%	20%	20%	20%	20% / 10%	20%	$50
E50-3000-5-7350	$3,000 / $6,000	$7,350 / $14,700	$50 / $100	50% / 50%	50%	50%	50%	50% / 40%	50%	$50
E35-4000-2-7350	$4,000 / $8,000	$7,350 / $14,700	$35 / $70	20% / 40%	20%	20%	20%	20% / 10%	20%	$50
E35-5000-2-7350	$5,000 / $10,000	$7,350 / $14,700	$35 / $70	20% / 40%	20%	20%	20%	20% / 10%	20%	$50
E50-5000-5-7350	$5,000 / $10,000	$7,350 / $14,700	$50 / $100	50% / 50%	50%	50%	50%	50% / 40%	50%	$50
E35-6000-2-8150	$6,000 / $12,000	$8,150 / $16,300	$35 / $70	20% / 40%	20%	20%	20%	20% / 10%	20%	$50
E50-6000-5-8150	$6,000 / $12,000	$8,150 / $16,300	$50 / $100	50% / 50%	50%	50%	50%	50% / 40%	50%	$50
E5000-5-8150	$5,000 / $10,000	$8,150 / $16,300	50% / 50%	50% / 50%	50%	50%	50%	50% / 40%	50%	50%
E6000-5-8150	$6,000 / $12,000	$8,150 / $16,300	50% / 50%	50% / 50%	50%	50%	50%	50% / 40%	50%	50%
Essentials First Dollar PPO (First $500 on lab, x-ray and advanced imaging combined covered at 100%)										
FE25-1000-2-5000	$1,000 / $2,000	$5,000 / $10,000	$25 / $50	20% / 40%	20%	20%	20%	20% / 10%	20%	$50
FE25-1500-2-7350	$1,500 / $3,000	$7,350 / $14,700	$25 / $50	20% / 40%	20%	20%	20%	20% / 10%	20%	$50
FE30-2000-2-7350	$2,000 / $4,000	$7,350 / $14,700	$30 / $60	20% / 40%	20%	20%	20%	20% / 10%	20%	$50
FE35-3000-2-7350	$3,000 / $6,000	$7,350 / $14,700	$35 / $70	20% / 40%	20%	20%	20%	20% / 10%	20%	$50
FE35-5000-2-7350	$5,000 / $10,000	$7,350 / $14,700	$35 / $70	20% / 40%	20%	20%	20%	20% / 10%	20%	$50
FE50-5000-5-7350	$5,000 / $10,000	$7,350 / $14,700	$50 / $100	50% / 50%	50%	50%	50%	50% / 40%	50%	50%
FE5000-3-8150	$5,000 / $10,000	$8,150 / $16,300	30% / 30%	30% / 50%	30%	30%	30%	30% / 20%	30%	30%

(continued)

2023

Plan name	Member(s) In-Network responsibility									
	Deductible[1] (single / family)	Out-of-pocket maximum[2] (single / family)	Office / specialist visit	Coinsurance[3] (in-network / out-of-network	Lab / x-ray	CT / MRI / PET / SPEC	Inpatient hospital	Outpatient surgery (ASC / hospital)	Emergency room (copay waived if admitted)	Urgent care
Primary Advantage PPO										
PA0-0-4-2500	$0 / $0	$2,500 / $5,000	$0 / $25	40% / 50%	$0	40%	40%	40% / 30%	$300	$25
PA0-500-4-5000	$500 / $1,000	$5,000 / $10,000	$0 / $50	40% / 50%	$0	40%	40%	40% / 30%	$300	$50
PA0-1000-4-5000	$1,000 / $2,000	$5,000 / $10,000	$0 / $70	40% / 50%	$0	40%	40%	40% / 30%	40%	$70
PA10-3000-5-7350	$3,000 / $6,000	$7,350 / $14,700	$10 / $70	50% / 50%	$0	50%	50%	50% / 40%	50%	$70
PA20-5000-5-7350	$5,000 / $10,000	$7,350 / $14,700	$20 / $70	50% / 50%	$0	50%	50%	50% / 40%	50%	$70
PPO HDHP[5]										
HDE30008060 w/HD80	$3,000 / $6,000	$5,600 / $11,200	20%	20% / 40%	20%	20%	20%	20% / 10%	20%	20%
HDE35008060 w/HD80	$3,500 / $7,000	$6,550 / $13,100	20%	20% / 40%	20%	20%	20%	20% / 10%	20%	20%
HDE50008060 w/HD80	$5,000 / $10,000	$6,750 / $13,500	20%	20% / 40%	20%	20%	20%	20% / 10%	20%	20%
HD300010060 w/HD100	$3,000 / $6,000	$3,000 / $6,000	0%	0% / 40%	0%	0%	0%	0%	0%	0%
HDE650010060 w/HD100	$6,500 / $13,000	$6,500 / $13,000	0%	0% / 40%	0%	0%	0%	0%	0%	0%

Alternative Care plans

Alternative Care[6]	Member pays			
	Chiropractic office visit (visit are unlimited)	Acupuncture office visit (visit limits apply)	Massage Therapy office visit (visit limits apply)	Out-of-network
Base	$15	$15 (24 visits)	$25 (18 visits)	Not covered
Buy-Up 1 w/OON	$15	$15 (24 visits)	$25 (18 visits)	20%
Buy-Up 2	$15	$15 (36 visits)	$25 (27 visits)	Not covered
Buy-Up 3 w/OON	$15	$15 (36 visits)	$25 (27 visits)	20%

Vision plans

Vision	Member pays			
	Exam	Frame allowance	Lenses (single / bifocal / trifocal / progressive)	Frequency (months) (examination / lenses or contact lenses / frames)
Elite 1010-1	$10	$150 plus 20% off balance over allowance	$10 / $10 / $10 / $75	12 / 12 / 12
Supreme 010-2	$0	$120 plus 20% off balance over allowance	$10 / $10 / $10 / $75	12 / 12 / 24
Preferred 1025-2	$10	$100 plus 20% off balance over allowance	$25 / $25 / $25 / $90	12 / 12 / 24
Preferred 1025-3	$10	$100 plus 20% off balance over allowance	$25 / $25 / $25 / $90	12 / 24 / 24
Preferred Value 10-3	Not covered	$100 plus 20% off balance over allowance	$10 / $10 / $10 / $75	Not covered / 24 / 24
Plus 20-1	$20	35% discount off retail price	$50 / $70 / $105 / $135	12 / Unlimited / Unlimited
Exam Only	$0	Not covered	Not covered	24 / Not covered / Not covered

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Dental plans

Dental	Member pays					
	Annual deductible per person	Calendar year maximum	Coinsurance (preventive & diagnostics / basic / major / ortho)	Cleanings	Exams	X-rays
Plus D25-185- 1500	$25	$1,500	0% / 20% / 50% / Not covered	0%	0%	0%
Plus D25-1855-1500	$25	$1,500	0% / 20% / 50% / 50%	0%	0%	0%
Plus D25-1855-2000	$25	$2,000	0% / 20% / 50% / 50%	0%	0%	0%
Plus D50-185-1000	$50	$1,000	0% / 20% / 50% / Not covered	0%	0%	0%
Plus D50-185-1500	$50	$1,500	0% / 20% / 50% /Not covered	0%	0%	0%
Plus D50-1855-1500	$50	$1,500	0% / 20% / 50% / 50%	0%	0%	0%
Plus D50-185- 2000	$50	$2,000	0% / 20% / 50% / Not covered	0%	0%	0%
Plus D50-1855- 2000	$50	$2,000	0% / 20% / 50% / 50%	0%	0%	0%
Plus D100-185-1000	$100	$1,000	0% / 20% / 50% / Not covered	0%	0%	0%
Plus D100-1855-1000	$100	$1,000	0% / 20% / 50% / 50%	0%	0%	0%
Plus D100-185-1500	$100	$1,500	0% / 20% / 50% / Not covered	0%	0%	0%
Plus D100-185-2000	$100	$2,000	0% / 20% / 50% / Not covered	0%	0%	0%
Plus D100-1855-2000	$100	$2,000	0% / 20% / 50% / 50%	0%	0%	0%
Preferred Plus DP50-1855-1500	$50	$1,500	0% / 20% / 50% / 50%	0%	0%	0%
Value D50-185-1500V	$50	$1,500	0% / 20% / 50% / Not covered	0%	0%	0%
Value D100-185-1000V	$100	$1,000	0% / 20% / 50% / Not covered	0%	0%	0%
Preferred Value DP100-185-1000V	$100	$1,000	0% / 20% / 50% / Not covered	0%	0%	0%
Essential D50-16-500	$50	$500	0% / 40% / Not covered / Not covered	0%	0%	0%
Fifty D100-555-1000V	$100	$1,000	50% / 50% / 50% / Not covered	0%	0%	0%

Pharmacy plans[8]

Pharmacy	Member pays				
	Tier 1	Tier 2	Tier 3	Deductible	Specialty drug
No MAC					
NMSL5-10-25	$5	$10	$25	No	20% up to $250
NMSL10-20-40	$10	$20	$40	No	20% up to $250
NMSL10-35-60	$10	$35	$60	No	20% up to $250
NMSL10-50-75	$10	$50	$75	No	20% up to $250
NMSL15-30-50	$15	$30	$50	No	20% up to $250
NMSL15-40-65	$15	$40	$65	No	20% up to $250
NMSL15-30%-50%	$15	30%	50%	No	50%
No MAC Deductible plans (deductible waived on Tier 1)					
NMSL10-35-60-100D	$10	$35	$60	$100	20% up to $250
NMSL10-35-60-250D	$10	$35	$60	$250	20% up to $250
MAC A					
MASL10-10-DR	$10	$10	Member pays 100% at HN discounted rate	No	20% up to $250
MASL10-20%-DR	The greater of $10 or 20%	The greater of $10 or 20%	Member pays 100% at HN discounted rate	No	20% up to $250
MASL15-50%-DR	The greater of $15 or 50%	The greater of $15 or 50%	Member pays 100% at HN discounted rate	No	20% up to $250
MASL25-50%-DR	$25	50%	Member pays 100% at HN discounted rate	No	50%
PPO HDHP Rx[5] (No MAC)					
HD80	20%	20%	20%	Yes	20%
HD100	0%	0%	0%	Yes	0%

(continued)

2023

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

[2]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.

[3] Coinsurance is subject to the annual deductible.

[4]Deductible is waived.

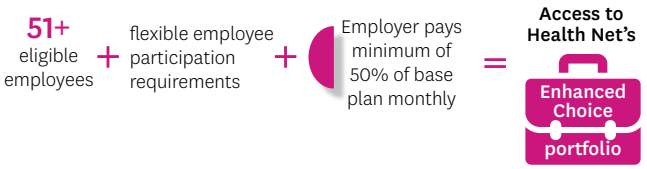
[5]All benefits including office visit copay, pharmacy, and alternative care are after deductible.

[6]All copayments accumulate to the medical out-of-pocket maximum.

[7]In- and out-of-network visits combined.

[8]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. 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 the Oregon Essential RX Drug List.

Enhanced Choice participation guidelines



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