



2026

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
Essentials PPO										
E15-250-2-3000	\$250 / \$500	\$3,000 / \$6,000	\$15 / \$30	20% / 40%	20%	20%	20%	20% / 10%	20%	\$50
E20-500-2-4000	\$500 / \$1,000	\$4,000 / \$8,000	\$20 / \$40	20% / 40%	20%	20%	20%	20% / 10%	20%	\$50
E20-750-2-5000	\$750 / \$1,500	\$5,000 / \$10,000	\$20 / \$40	20% / 40%	20%	20%	20%	20% / 10%	20%	\$50
E25-1000-2-5000	\$1,000 / \$2,000	\$5,000 / \$10,000	\$25 / \$50	20% / 40%	20%	20%	20%	20% / 10%	20%	\$50
E30-1500-2-6600	\$1,500 / \$3,000	\$6,600 / \$13,200	\$30 / \$60	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
E30-2500-3-6600	\$2,500 / \$5,000	\$6,600 / \$13,200	\$30 / \$60	30% / 50%	30%	30%	30%	30% / 20%	30%	\$50
E35-3000-2-7350	\$3,000 / \$6,000	\$7,350 / \$14,700	\$35 / \$70	20% / 40%	20%	20%	20%	20% / 10%	20%	\$50
E35-4000-2-7350	\$4,000 / \$8,000	\$7,350 / \$14,700	\$35 / \$70	20% / 40%	20%	20%	20%	20% / 10%	20%	\$50
E35-5000-3-8150	\$5,000 / \$10,000	\$8,150 / \$16,300	\$35 / \$70	30% / 50%	30%	30%	30%	30% / 20%	30%	\$50
E35-6000-3-8150	\$6,000 / \$12,000	\$8,150 / \$16,300	\$35 / \$70	30% / 50%	30%	30%	30%	30% / 20%	30%	\$50
E50-6000-4-8150	\$6,000 / \$12,000	\$8,150 / \$16,300	\$50 / \$100	40% / 50%	40%	40%	40%	40% / 30%	40%	\$50
Essentials First Dollar PPO (First \$500 on lab, x-ray and advanced imaging combined covered at 100%)										
FE25-1500-2-7350	\$1,500 / \$3,000	\$7,350 / \$14,700	\$25 / \$50	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
PPO HDHP										
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%


Alternative Care plans^{5,6}

Alternative care 	Member pays							
	Chiropractic (Unlimited visits)		Acupuncture (36 visits combined in and out-of-network)		Massage Therapy (27 visits combined in and out-of-network)		Naturopath (Unlimited visits)	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
	Office visits are covered at the PCP copay under your medical plan	20%	Office visits are covered at the PCP copay under your medical plan	20%	Office visits are covered at the PCP copay under your medical plan	20%	Office visits are covered at the PCP copay under your medical plan	Office visits are covered at the PCP out-of-network cost share under your medical plan


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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

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%

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Pharmacy plans⁷

Pharmacy 	Member pays				
	Tier 1	Tier 2	Tier 3	Deductible	Specialty drug
No MAC					
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					
MASL10-20%-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
PPO HDHP Rx⁴ (No MAC)					
HD80	20%	20%	20%	Yes	20%

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

²The 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.

³Coinsurance is subject to the annual deductible.

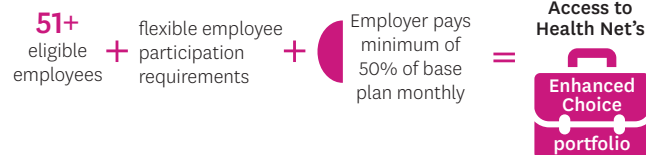
⁴All benefits including office visit copay, pharmacy, and alternative care are after deductible.

⁵All copayments accumulate to the medical out-of-pocket maximum.

⁶In- and out-of-network visits combined.

⁷Prescription 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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