Health Net®

For Broker Use

Oregon *Small Group Portfolio*[1]

Teladoc® is a new telemedical services vendor for our 2020 portfolio.[2]

2020

Plan name	*Member(s) responsibility*											
	Metal level	Deductible[3] (single / family)	Out-of-pocket maximum[3] (single / family)	Office visit (PCP / Spec.)	Coinsurance[4] (In-network / Out-of-net-work)	Deduct. waived Lab and X-ray	Deduct. waived CT/MRI/ PET/SPEC	Inpatient hospital	Outpatient surgery (ASC / hospital)	Emergency room (copay waived if admitted)	Urgent care	Pharmacy[5]
PPO												
P10-250-1-4000LX	Platinum	$250 / $500	$4,000 / $8,000	$10 / $20	10% / 50%	10% / Yes	10% / Yes	10%	5% / 10%	$250 + 10% ded. waived	$50	$10 / $30 / $90 / 50%
P20-500-2-4000LX	Platinum	$500 / $1,000	$4,000 / $8,000	$20 / $40	20% / 50%	20% / Yes	20% / Yes	20%	15% / 20%	$250 + 20% ded. waived	$50	$10 / $30 / $90 / 50%
P20-750-2-4000LX	Platinum	$750 / $1,500	$4,000 / $8,000	$20 / $40	20% / 50%	20% / Yes	20% / Yes	20%	15% / 20%	$250 + 20% ded. waived	$50	$10 / $30 / $90 / 50%
P50-0-5-5000	Gold	$0 / $0	$5,000 / $10,000	50% / 50%	50% / 50%	50% / No	50% / No	50%	45% / 50%	50%	50%	$15 / $45 / $90 / 50%
P20-500-3-7900DX	Gold	$500 / $1,000	$7,900 / $15,800	$20 / $40	30% / 50%	30% / Yes	30% / No	30%	25% / 30%	$250 + 30% ded. waived	$50	$15 / $45 / $90 / 50%
P20-1000-2-7900DX	Gold	$1,000 / $2,000	$7,900 / $15,800	$20 / $40	20% / 50%	$20 / Yes	20% / No	20%	15% / 20%	$250 + 20% ded. waived	$50	$15 / $45 / $90 / 50%
P30-1500-2-7900DX	Gold	$1,500 / $3,000	$7,900 / $15,800	$30 / $60	20% / 50%	20% / Yes	20% / No	20%	15% / 20%	$250 + 20% ded. waived	$50	$15 / $45 / $90 / 50%
P20-2000-2-7900DX	Gold	$2,000 / $4,000	$7,900 / $15,800	$20 / $40	20% / 50%	20% / Yes	20% / No	20%	15% / 20%	$250 + 20% ded. waived	$50	$20 / $45 / $90 / 50%
P20-2500-3-7900DX	Gold	$2,500 / $5,000	$7,900 / $15,800	$20 / $40	30% / 50%	30% / Yes	30% / No	30%	25% / 30%	$250 + 30% ded. waived	$50	$20 / $45 / $90 / 50%
P30-3500-3-7900DX	Gold	$3,500 / $7,000	$7,900 / $15,800	$30 / $60	30% / 50%	30% / Yes	30% / No	30%	25% / 30%	$250 + 30% ded. waived	$50	$20 / $45 / $90 / 50%
P40-3000-3-8150ES	Silver	$3,000 / $6,000	$8,150 / $16,300	$40 / $80	30% / 50%	30% / No	30% / No	30%	25% / 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% / No	50% / No	50%	45% / 50%	50%	$90	$25 / $50 / 50% / 50%
P40-4000-3-8150ES	Silver	$4,000 / $8,000	$8,150 / $16,300	$40 / $80	30% / 50%	30% / No	30% / No	30%	25% / 30%	30%	$80	$25 / $50 / 50% / 50%
P45-5000-5-8150ES	Silver	$5,000 / $10,000	$8,150 / $16,300	$45 / $90	50% / 50%	50% / No	50% / No	50%	45% / 50%	50%	$90	$25 / $50 / 50% / 50%
P75-5000-5-8150ES	Bronze	$5,000 / $10,000	$8,150 / $16,300	$75 after ded. / $120 after ded.	50% / 50%	50% / No	50% / No	50%	45% / 50%	50%	50%	$25 / 30% after ded. / 50% after ded. / 50% after ded.
P7350-0-7350ES	Bronze	$7,350 / $14,700	$7,350 / $14,700	0% / 0%	0% / 50%	0% / No	0% / No	0%	0%	0%	0%	0% after ded.
High deductible PPO[6]												
HD2800-2-5500ES	Silver	$2,800 / $5,600	$5,500 / $11,000	20% / 20%	20% / 50%	20% / No	20% / No	20%	15% / 20%	20%	20%	20% after ded. / 20% after ded. / 20% after ded. / 50% after ded.
HD6550-0-6550ES	Bronze	$6,550 / $13,100	$6,550 / $13,100	0% / 0%	0% / 50%	0% / No	0% / No	0%	0%	0%	0%	0% after ded.
Standard PPO												
Health Net Oregon Standard Plan	Gold	$1,000 / $2,000	$7,300 / $14,600	$20 / $40	20% / 50%	20% / No	20% / No	20%	20%	20%	$60	$10 / $30 / 50% / 50% ($500 per script cap)
Health Net Oregon Standard Plan	Silver	$3,550 / $7,100	$8,150 / $16,300	$40 / $80	30% / 50%	30% / No	30% / No	30%	30%	30%	$70	$15 / $60 / 50% / 50%
Health Net Oregon Standard Plan	Bronze	$7,900 / $15,800	$7,900 / $15,800	$45 / $90	0% / 50%	0% / No	0% / No	0%	0%	0%	0%	$15 / 0% after ded. / 0% after ded.
CommunityCare 1T												
25-750-2-3000DX	Platinum	$750 / $1,500	$3,000 / $6,000	$25 / $55	20%	20% / Yes	20% / No	20%	15% / 20%	$250 + 20% ded. waived	$55	$10 / $30 / $90 / 50%
25-1000-2-7900DX	Gold	$1,000 / $2,000	$7,900 / $15,800	$25 / $65	20%	20% / Yes	20% / No	20%	15% / 20%	$250 + 20% ded. waived	$65	$15 / $45 / $100 / 50%
25-2000-2-7900DX	Gold	$2,000 / $4,000	$7,900 / $15,800	$25 / $65	20%	20% / Yes	20% / No	20%	15% / 20%	$250 + 20% ded. waived	$65	$15 / $45 / $100 / 50%
25-3500-2-7900DX	Gold	$3,500 / $7,000	$7,900 / $15,800	$25 / $65	20%	20% / Yes	20% / No	20%	15% / 20%	$250 + 20% ded. waived	$65	$15 / $45 / $100 / 50%
40-3000-3-8150ES	Silver	$3,000 / $6,000	$8,150 / $16,300	$40 / $80	30%	30% / No	30% / No	30%	25% / 30%	30%	$80	$25 / $50 / 50% / 50%
40-4500-3-8150ES	Silver	$4,500 / $9,000	$8,150 / $16,300	$40 / $80	30%	30% / No	30% / No	30%	25% / 30%	30%	$80	$25 / $50 / 50% / 50%

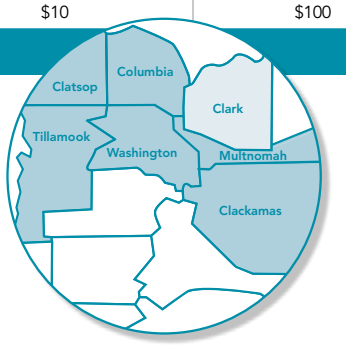
(continued)

Plan name	Member(s) responsibility											
	Metal level	Deductible[3] (single / family)	Out-of-pocket maximum[3] (single / family)	Office visit (PCP / Spec.)	Coinsurance[4] (In-network / Out-of-network)	Deduct. waived Lab and X-ray	Deduct. waived CT/MRI/ PET/SPEC	Inpatient hospital	Outpatient surgery (ASC / hospital)	Emergency room (copay waived if admitted)	Urgent care	Pharmacy[5]
CommunityCare 3T												
25-750-2-3000DX	Platinum	$750 / $1,500	$3,000 / $6,000	$25 / $55	20% / 50% / 50%	20% / Yes	20% / No	20%	15% / 20%	$250 + 20% ded. waived	$55	$10 / $30 / $90 / 50%
25-1000-2-7900DX	Gold	$1,000 / $2,000	$7,900 / $15,800	$25 / $65	20% / 50% / 50%	20% / Yes	20% / No	20%	15% / 20%	$250 + 20% ded. waived	$65	$15 / $45 / $100 / 50%
25-2000-2-7900DX	Gold	$2,000 / $4,000	$7,900 / $15,800	$25 / $65	20% / 50% / 50%	20% / Yes	20% / No	20%	15% / 20%	$250 + 20% ded. waived	$65	$15 / $45 / $100 / 50%
25-3500-2-7900DX	Gold	$3,500 / $7,000	$7,900 / $15,800	$25 / $65	20% / 50% / 50%	20% / Yes	20% / No	20%	15% / 20%	$250 + 20% ded. waived	$65	$15 / $45 / $100 / 50%
40-3000-3-8150ES	Silver	$3,000 / $6,000	$8,150 / $16,300	$40 / $80	30% / 50% / 50%	30% / No	30% / No	30%	25% / 30%	30%	$80	$25 / $50 / 50% / 50%
40-4500-3-8150ES	Silver	$4,500 / $9,000	$8,150 / $16,300	$40 / $80	30% / 50% / 50%	30% / No	30% / No	30%	25% / 30%	30%	$80	$25 / $50 / 50% / 50%

Plan name	Member(s) responsibility					
Alternative care[7,8]	**Office visit (chiropractic / acupuncture)**	**Office visit (massage therapy)**	**Out-of-network**	**Maximum calendar year (acupuncture and massage therapy combined)**		
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[9]		
Adult 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%
Adult 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		

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 Clark County, WA.



Participation guidelines

1–5 eligible employees + 66% employee participation minimum

6–50 eligible employees + 50% employee participation minimum

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

[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]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. Teladoc is covered at $0, deductible waived (except HDHP - $0, after deductible).

[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]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.healthnet.com > My Health Plan > Pharmacy Coverage > View My Drug List > OR Essential RX Drug List.

[6]All benefits including pharmacy and alternative care are after deductible.

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

[8]Benefit not available on Standard Plans.

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

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