Commercial

Small Business Group

Health Net Health Plan of Oregon, Inc. (Health Net)
Oregon

Renewal Guide

Health Net Small Group brings you perfect-fit coverage and price

Effective April 1, 2020

Health Net®

Simplified. Sustainable.

Small Business-Focused.

At Health Net, we're proud to serve communities throughout the state, from Portland to Bend and more. Our commitment to small businesses continues in 2020 with even more health care options to help you satisfy your clients and boost your business.

In response to feedback from members, employer groups and brokers, we've added four new competitive PPO plans to our product lineup: one Platinum, one Silver and two Golds, including our unique Gold 50/50 plan featuring a $0 deductible with 50% cost share. Also new this year, we're adding Teladoc® telehealth services, available 24 hours a day, at a $0 copayment for many plans, giving members lower-cost access to care and an expanded provider network. And the on-site local teams at our new Oregon-based Customer Contact Center are committed to providing quick answers and expert assistance for our members, brokers and providers.

Remember, with Health Net Small Group Enhanced Choice, any number of plans can be offered to meet your clients' needs. You can even mix and match various combinations of PPO and CommunityCare plans to provide more network and benefit design choice. If your clients would like several PPO plans, several CommunityCare plans, or an array of PPO and CommunityCare plans, we've got you covered! Plus, all plans come complete with an Active&Fit® Direct option, which gives members access to a national network of fitness centers - so employees can be their healthiest.

With our focus on your future, Health Net continues to combine right-size solutions and industry-leading support to help your Oregon small business flourish.

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Small Group *2020*

Simplified, sustainable, small business-focused

Account management

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2020 Portfolio Highlights

Keeping businesses like yours healthy and growing is the reason why we've further fine-tuned the portfolio to bring you simplified sustainability in 2020.

The health providers in our networks can change at any time. This can mean that members may have to change doctors to ensure benefit coverage. For CommunityCare 1T plans, seeing a network provider is a requirement; for CommunityCare 3T and PPO, staying in-network means lower out-of-pocket costs.

CommunityCare

CommunityCare comes in two network styles, both of which leverage strategic provider partnerships to strengthen the doctor-patient relationship and give people resources for lasting engagement in their health.

Option 1: CommunityCare 1T

CommunityCare 1T plans feature the familiar single-tier benefit structure and access to our CommunityCare providers. Members receive all covered services from this network. This plan option is our most affordable.

For specific service areas, see page 17.

Option 2: CommunityCare 3T

CommunityCare 3T plans give members the option to use CommunityCare providers, other Health Net-contracted providers or a non-network provider.

- **First tier –** Services received via the CommunityCare provider network are covered at a higher in-network benefit.
- **Second tier –** Services received from Health Net-contracted providers outside of the CommunityCare Network are reimbursed based on Health Net's negotiated network rates.
- **Third tier –** Services received from any out-of-network provider are reimbursed at a percentage of the maximum allowable amount (MAA).

For specific service areas, see page 17.

PPO plans

Flexing to fit your business is what our PPO designs are all about. We offer plans in all metal tiers and with a wide range of deductible options.

We continue to offer high-deductible PPO plans, which are compatible with a Health Savings Account. Available in Silver and Bronze designs, these options can save you money while encouraging your employees to take an active role in their health.

Standardized plans

Our Standard plans provide benefit offerings as designated by the State of Oregon.

We have three plans available:

- Standard Gold (PPO)
- Standard Silver (PPO)
- Standard Bronze (PPO)

Prescription drug coverage

All Health Net medical plans include prescription drug coverage for tiers 1 through 3, and Specialty Pharmacy:

Tier	*Prescription drug coverage*
Tier 1	Generic
Tier 2	Brand preferred
Tier 3	Non-preferred drugs
SP	Specialty Pharmacy

Member pharmacy expenses accumulate to the out-of-pocket maximum, and, in some cases, a deductible may apply.

Health Net uses a prescription drug formulary, called the Essential Rx Drug List (EDL), for therapeutic drugs, so our members receive quality medications at reasonable costs. The EDL is updated quarterly.

Prescription drug coverage is provided through the Caremark pharmacy network. See the benefit grids for specifics on each plan design.

Diagnostic services and deductibles

- **Platinum (LX) plans –** Deductible waived on all routine lab, X-ray and imaging services.
- **Gold (DX) plans –** Deductible waived for routine lab and X-ray services.
- **Silver (ES) plans –** Deductible applies to all routine lab, X-ray and imaging services.
- **Bronze (ES) plans –** Deductible applies to all routine lab, X-ray and imaging services.

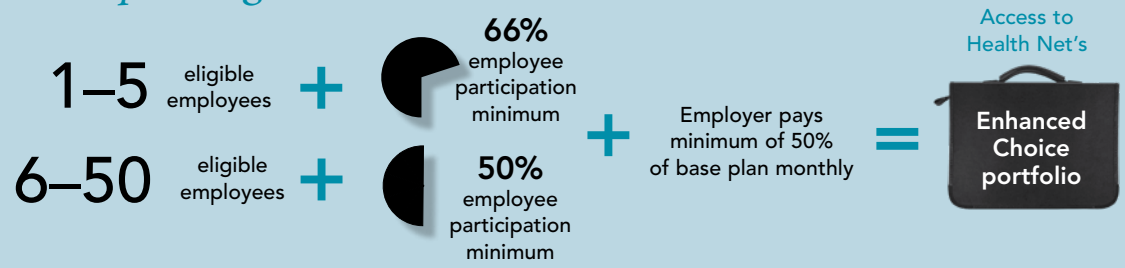
These deductible details apply to all plans except our high-deductible and State Standard plans.

Enhanced Choice

Health Net invites you to be choosy! With our Enhanced Choice option, you can offer any number or combination of plans to your employees.

You can even mix and match PPO and CommunityCare plans to provide more network and benefit design choices!

Participation guidelines



Key Changes *At-a-*Glance

Notice of Changes to Coverage Terms

Commercial Small Business Group plan contracts will contain updates as shown in the "Notice of Changes to Coverage Terms" document. For details on the benefit or coverage modifications, log in to www.healthnet.com/noc. For more information, please contact Health Net Account Management.

New 2020 plans

PPO
Platinum P10-250-1-4000LX
Gold P20-500-3-7900DX
Gold P50-0-5-5000
Silver P45-3500-5-8150ES

Medical benefit changes

CommunityCare (1T)	*2019*	*2020*
25-1000-2-6500DX changed to 25-1000-2-7900DX		
Out-of-pocket max (OOPM) Individual (in-network) Family (in-network)	 $6,500 $13,000	 $7,900 $15,800
25-2000-2-6500DX changed to 25-2000-2-7900DX		
Out-of-pocket max (OOPM) Individual (in-network) Family (in-network)	 $6,500 $13,000	 $7,900 $15,800
30-3500-2-6500DX changed to 25-3500-2-7900DX		
Out-of-pocket max (OOPM) Individual (in-network) Family (in-network)	 $6,500 $13,000	 $7,900 $15,800
Primary care physician (PCP) office visit	$30	$25
Specialist physician office visit	$60	$65
30-3000-3-7900ES changed to 40-3000-3-8150ES		
Out-of-pocket max (OOPM) Individual (in-network) Family (in-network)	 $7,900 $15,800	 $8,150 $16,300
Primary care physician (PCP) office visit	$30	$40
Specialist physician office visit	$70	$80
Prescription drugs (generic / brand preferred / non-preferred)	$20 / $50 / 50%	$25 / $50 / 50%
30-4500-2-7900ES changed to 40-4500-3-8150ES		
Out-of-pocket max (OOPM) Individual (in-network) Family (in-network)	 $7,900 $15,800	 $8,150 $16,300
Coinsurance	20%	30%
Primary care physician (PCP) office visit	$30	$40
Specialist physician office visit	$70	$80
Prescription drugs (generic / brand preferred / non-preferred)	$20 / 30% / 50%	$25 / $50 / 50%

(continued)

Medical benefit changes (continued)

CommunityCare (3T)	*2019*	*2020*
25-1000-2-6500DX changed to 25-1000-2-7900DX		
Out-of-pocket max (OOPM) Individual (in-network) Family (in-network)	 $6,500 $13,000	 $7,900 $15,800
25-2000-2-6500DX changed to 25-2000-2-7900DX		
Out-of-pocket max (OOPM) Individual (in-network) Family (in-network)	 $6,500 $13,000	 $7,900 $15,800
30-3500-2-6500DX changed to 25-3500-2-7900DX		
Out-of-pocket max (OOPM) Individual (in-network) Family (in-network)	 $6,500 $13,000	 $7,900 $15,800
Primary care physician (PCP) office visit	$30	$25
Specialist physician office visit	$60	$65
30-3000-3-7900ES changed to 40-3000-3-8150ES		
Out-of-pocket max (OOPM) Individual (in-network) Family (in-network)	 $7,900 $15,800	 $8,150 $16,300
Primary care physician (PCP) office visit	$30	$40
Specialist physician office visit	$70	$80
Prescription drugs (generic / brand preferred / non-preferred)	$20 / $50 / 50%	$25 / $50 / 50%
30-4500-2-7900ES changed to 40-4500-3-8150ES		
Out-of-pocket max (OOPM) Individual (in-network) Family (in-network)	 $7,900 $15,800	 $8,150 $16,300
Coinsurance	20%	30%
Primary care physician (PCP) office visit	$30	$40
Specialist physician office visit	$70	$80
Prescription drugs (generic / brand preferred / non-preferred)	$20 / 30% / 50%	$25 / $50 / 50%
PPO	*2019*	*2020*
P30-3000-3-7900ES changed to P40-3000-3-8150ES		
Out-of-pocket max (OOPM) Individual (in-network) Family (in-network)	 $7,900 $15,800	 $8,150 $16,300
Primary care physician (PCP)	$30	$40
Specialist physician office visit	$70	$80
Prescription drugs (generic / brand preferred / non-preferred)	$20 / $50 / 50%	$25 / $50 / 50%
P30-4000-3-7900ES changed to P40-4000-3-8150ES		
Out-of-pocket max (OOPM) Individual (in-network) Family (in-network)	 $7,900 $15,800	 $8,150 $16,300
Primary care physician (PCP)	$30	$40
Specialist physician office visit	$90	$80
Prescription drugs (generic / brand preferred / non-preferred)	$15 / 30% / 50%	$25 / $50 / 50%

(continued)

Medical benefit changes (continued)

P40-5000-3-7900ES changed to P45-5000-5-8150ES		
Out-of-pocket max (OOPM) Individual (in-network) Family (in-network)	 $7,900 $15,800	 $8,150 $16,300
Coinsurance	30%	50%
Primary care physician (PCP) office visit	$40	$45
Prescription drugs (generic / brand preferred / non-preferred)	$15 / 30% / 50%	$25 / $50 / 50%
P75-5000-5-7900ES changed to P75-5000-5-8150ES		
Out-of-pocket max (OOPM) Individual (in-network) Family (in-network)	 $7,900 $15,800	 $8,150 $16,300
Prescription drugs (generic / brand preferred / non-preferred)	$15 / 30% after ded. / 50% after ded.	$25 / 30% after ded. / 50% after ded.
HD2700-2-5500ES changed to HD2800-2-5500ES		

Underwriting

Guidelines Summary

Effective on the first day of your renewal month, you can choose between any of our plans as a standalone option or use our Enhanced Choice program to offer multiple plans to your employees.

Group eligibility

- 1–50 eligible employees with over 50% of the total group located in Oregon, subject to the out-of-area requirements below. **Note:** Owner-only groups are not eligible. There must be a minimum of one enrolled W-2 employee who is not a spouse of the owner or partner.
- Out-of-area requirements:
  - A maximum of 49% of the group's eligible population may be out of Oregon's service area.
  - A maximum of 49% of the group's enrolled population may be out of Oregon's service area.
  - Those eligible employees who are out of the Oregon service area but are in the out-of-state PPO service area may be written on a PPO plan.

Employee eligibility

- The employer group determines the number of hours an employee must work in order to be considered eligible.
- Probationary period for new hires can be first of the month following: date of hire, 1 month, 30 days, or 60 days. **Note:** All coverage must begin the first of the month following the date the probationary period is met.

  Note: A form 132 and ownership documentation must accompany a request for a first of the month following date of hire probationary period.
- Retirees are not eligible.
- Workers' compensation must cover all employees except owners and those exempt by the definition of the Oregon WCD.

Participation/Contribution

- For groups of 1–5 eligible employees, 66% participation is required. For groups of 6–50 eligible employees, 50% participation is required.
- Enhanced Choice is available for groups of 2–50 active enrolled employees.
- Employees waiving coverage due to group coverage through another employer (i.e., spousal coverage), Medicare, Medicaid, CHAMPUS, Indian Health Services, an individual plan, or the Oregon Health Plan will not be counted against minimum participation.
- A minimum employer contribution of 50% of the employee-only premium is required.

Rate information

- 12-month rate guarantee for new and renewing business.
- Rating is based on the employer's principal business address in Oregon for all employees, whether residing in Oregon or out of state.

Health Net dental and vision underwriting guidelines

Eligibility rules must be the same for medical, dental and vision. Minimum employer contribution must be 50% of the employee-only dental coverage.

A minimum of 2 employees must enroll. A minimum of 10 employees must enroll in any plan with orthodontia.

Riders

- Groups may only select one of each type of rider to accompany their medical plan selection(s).
- Standalone is not available.

Group number assignments

Certain plan changes will result in a new group number assignment.

Medicare secondary payer data collection

Please see the Renewal Election Form to record any changes to your TIN, or for updating your worldwide employee counts or other important information related to your policy.

This request is the result of a new federal reporting requirement for health plans to provide Centers for Medicare & Medicaid Services (CMS) with certain information that will enable CMS to more effectively pay for the health insurance benefits of Medicare beneficiaries who also have coverage under group health plan arrangements. We appreciate your assistance and timely response to our data request so that we may comply with this mandate.

Understanding Rates

At Health Net, our goal is to minimize rate adjustments, so you can continue to provide health care benefits to your employees.

Rates take into account many variables, such as new technologies and rising health care costs. Changes related to the Affordable Care Act (ACA) for ACA-compliant health plans also impact rates. Premiums are composite rated.

Rate variables for ACA-compliant plans

- Age – limited to a 1:3 ratio. Example: The rate for a 64-year-old can't be more than three times (300%) the rate for a 21-year-old.
- Each family member is rated individually based on his/her age. For the purpose of rating, the member's age is determined at the time a policy is issued or renewed.
- Only the first three children under age 21 are charged.
- Rating is based on the employer's physical address in Oregon for all employees, whether residing in Oregon or out of state.
- Regional rating areas are now grouped together for rating based upon the regions chosen by the State of Oregon.
- Health status has been removed as a rating factor.
- Your premium is priced as part of one Health Net rating pool.
- Your pricing is adjusted to reflect the average risk in the state of Oregon.

Rate increases and potential offsets

We give a 12-month rate guarantee for new and renewing business.

After that, rate increases are typically necessary for us to continue providing quality care. We realize that higher health expenditures have an impact on small businesses, especially in today's challenging economy.

You may be able to offset a renewal rate increase or even save over current rates by switching to a different plan or plans. For example, a plan with a deductible or a higher office visit copayment could lower rates.

In the event additional federal or state legislative guidance or regulatory requirements emerge that result in a modification of the estimated impact of the benefit mandates, taxes or fees, Health Net reserves the right to further adjust our premium schedule.

Reform *Refresher*

Learn more about the various ACA provisions at our ACA Information Center. Go to www.healthnet.com/employer/reformguide.

Notice of the exchange

All employers subject to the Fair Labor Standards Act (FLSA), Section 18, must provide written notice about the Health Insurance Exchange – Small Business Health Options Program (SHOP) – to each new employee at the time of hire.

- The written notification must include information about the Exchange and whether or not the employer's lowest-cost health plan meets minimum value and affordability standards as defined under the Affordable Care Act (ACA).
- A plan meets minimum value if it covers at least 60% of allowable costs and is considered affordable if the employee's share of the premium for the lowest-cost plan available to the employee is not more than 9.5% of the employee's W-2 wages.

Employers may use model notices provided by the Department of Labor to meet this requirement. Model notices are available at https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/model-notice-for-employers-who-offer-a-health-plan-to-some-or-all-employees.pdf.

Small business tax credits

The ACA offers a tax credit to qualifying small businesses. To be eligible for the tax credit, small employers must enroll through the Small Business Health Options Program, or SHOP, and must pay at least 50% of the health insurance premium, employ 25 full-time equivalent employees or less, and have an average annual full-time equivalent wage that is $50,000 or less.

The maximum available credit applies to firms with 10 or fewer full-time equivalent employees and an average full-time equivalent wage that is $25,000 or less. A sliding scale reduces the credit as average full-time equivalent compensation and the number of full-time equivalent employees increase. The maximum proportion is currently 50%. Finally, small employers must file the IRS Form 8941 to receive the tax credit. Form 8941 and more information about the tax credit can be found on the IRS website at http://www.irs.gov/pub/irs-pdf/i8941.pdf.

Employer mandate

Under the ACA employer mandate, employer groups with 50 or more full-time or full-time equivalent (FTE) employees may be subject to a tax penalty if they do not offer affordable medical coverage to their employees.

While the ACA does not specifically mandate that all employer groups with 50 or more full-time employees offer medical coverage, employers may be subject to potential tax penalties if they do not offer affordable coverage to employees and at least one employee receives a premium tax credit or cost-sharing subsidy for an Exchange plan.

Note: To be subject to the mandate, an employer group must have at least 50 full-time employees or a combination of full-time and part-time employees that is equivalent to at least 50 full-time employees (for example, 100 half-time employees equals 50 full-time employees). As defined by the statute, a full-time employee is an individual employed an average of at least 30 hours per week.

Probationary periods

Federal law requires that a group health plan and a health insurance issuer offering group health insurance coverage shall not apply any probationary period that exceeds 90 days.

The probationary period is the period of time set by an employer before coverage becomes effective for a new employee enrolling into the group's health benefit coverage.

The following probationary periods are available:

- First of the month following:
  - Date of hire
  - 1 month
  - 30 days
  - 60 days

We cannot allow split probationary periods.

Please give us a call if you have questions about how these issues may impact your health plan. We recommend that, before making any new health care coverage decisions, you consult with your legal counsel and tax advisors to determine the best approach for your company.

Summary of Benefits and Coverage document requirements[1]

As required by the ACA, health plans and employer groups must provide the *Summary of Benefits and Coverage* (SBC) to eligible employees and family members, who are:

- currently enrolled in the group health plan, or
- eligible to enroll in the plan, but not yet enrolled, or
- covered under COBRA Continuation coverage.

Health Net is committed to ensuring compliance with all timing and content requirements with regard to the distribution of the SBC. To meet this goal, you are required to provide the SBC in the **exact and unmodified form**, including appearance and content, as provided to you by Health Net. To search for an SBC, go to www.healthnet.com/sbc and follow the instructions as indicated.

Please follow the instructions below so you will know how to distribute the SBC.

SBC form and manner

You may provide the SBC to eligible or covered individuals in paper or electronic form (i.e., email or Internet posting).

- If you provide a paper copy, the SBC must be in the exact format and font provided by Health Net, and, as required under the ACA, must be copied on *four double-sided pages.*
- If you mail a paper copy, you may provide a single SBC to the employee's last known address, unless you know that a family member resides at a different address. In that case, you must provide a separate SBC to that family member at the last known address.
- For covered individuals, you may provide the SBC electronically if certain requirements from the U.S. Department of Labor are met.[2]
- If you email the SBC, you must send the SBC in the exact electronic PDF format provided to you by Health Net.
- If you post the SBC on the Internet, you must advise your employees by email or paper that the SBC is available on the Internet, and provide the Internet address. You must also inform your employees that the SBC is available in paper form, free of charge, upon request. You may use the Model Language in the box on the next page for an e-card or postcard in connection with a website posting of an SBC.

[1]26 C.F.R. § 54.9815-2715; 29 C.F.R. § 2590.715-2715; and 45 C.F.R. § 147.200.

[2]Such requirements can be found at 29 C.F.R. § 2520.104b-1(c).

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC). The SBC summarizes important information about any health coverage option in a standard format to help you compare across options.

The SBC is available online at: https://www.healthnet.com/portal/shopping/sbc.action or at <[group's website.com]>. A paper copy is also available, free of charge, by calling the toll-free number on your ID card.

Timing of SBC distribution

- **Upon application.** If you distribute written application materials, you must include the SBC with those materials. If you do not distribute written application materials for enrollment, you must provide the SBC *by the first day the employee is eligible to enroll in the plan.*
- **Special enrollees.** For special enrollees,[3] you must provide the SBCs *within 90 days following enrollment.*
- **Upon renewal.** If open enrollment materials are required for renewal, you must provide the SBC *no later than the date on which the open enrollment materials are distributed.*

If renewal is automatic, you must provide the SBC *no later than 30 days prior to the first day of the new plan year.* If your group health plan is renewed less than 30 days prior to the effective date, you must provide the SBC *as soon as practicable, but no later than 7 business days after issuance of the new policy or the receipt of written confirmation of intent to renew your group health plan.*

At the time your plan renews, you are not required to provide the Health Net SBC to an employee who is not currently enrolled in a Health Net plan. However, if an employee requests a Health Net SBC, you must provide the SBC as soon as you can, but no later than 7 business days following your receipt of the request.

Notice of SBC modification

Occasionally, there will be a material change(s) to the SBCs other than in connection with a renewal, such as changes in coverage. You must provide notice of the material changes to employees *no later than 60 days prior to the date on which change(s) become effective.* You must provide this notice in the same number, form and manner as described above. When such changes are initiated by Health Net, Health Net will provide you with modified SBCs for distribution.

Uniform glossary

Employees and family members can access a glossary of bolded terms used in the SBC by visiting www.cciio.cms.gov, or by calling Health Net at the number on the ID card to request a copy. Health Net shall provide a written copy of the glossary to callers within 7 business days after Health Net receives their request.

If you have any questions, please contact your Health Net account manager.

[3]Special enrollees are individuals who request coverage through special enrollment. Regulations regarding special enrollment are found in the U.S. Code of Federal Regulations, at 45 C.F.R. 146.117 and 26 C.F.R. 54.9801-6, and 29 C.F.R. 2590.701-6.

Plans At-a-Glance

Health Net®

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)	Deductible waived		Inpatient hospital	Outpatient surgery (ASC / hospital)	Emergency room (copay waived if admitted)	Urgent care	Pharmacy[5]
						Lab and X-ray	CT/MRI/ PET/SPEC					
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-net-work)	Deductible waived		Inpatient hospital	Outpatient surgery (ASC / hospital)	Emergency room (copay waived if admitted)	Urgent care	Pharmacy[5]
						Lab and X-ray	CT/MRI/ PET/SPEC					
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%

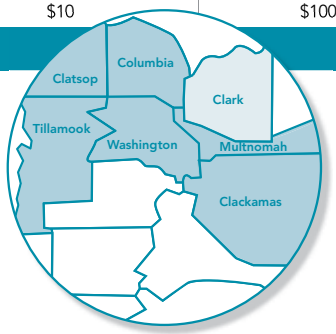
Plan name	Member(s) responsibility			
Alternative care[7,8]	**Office visit (chiropractic / acupuncture)**	**Office visit (massage therapy)**	**Out-of-network**	**Maximum calendar year (acupuncture and massage therapy combined)**
CAM 20-500 (embedded)	$20	$25 (9 visits)	N/A	$500
CAM 15-1000	$15	$25 (18 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.

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

Ancillary Programs

One-stop shopping for dental, vision and alternative care

Designing a well-rounded benefits package is easy with Health Net. Complementing our collection of medical plans are the essentials that help your employees be their healthiest and most productive, which is good for business!

Pediatric Vision *and* Dental

(Available to children up to age 19)

Pediatric vision

Highlights

- $0 copayments for vision exams and lenses.
- Large network of independent providers, including optical retailers LensCrafters, Pearle Vision, Sears Optical, and Target Optical.
- Secondary purchase plan – discounts up to 40% on all covered materials and services once the initial benefit has been used.

Vision summary of benefits

Benefit	*Copayment*
Routine eye exam (limit: 1 per calendar year)	$0
Lenses (limit: 1 per calendar year), including: • Single vision, bifocal, trifocal, lenticular • Glass or plastic	$0
Provider-selected frames (limit: 1 per calendar year)	$0
Optional lenses and treatments, including: • UV treatment • Tint (solid and gradient) • Standard plastic scratch coating • Standard polycarbonate • Photochromatic / transitions plastic • Standard anti-reflective coating • Polarized • Standard progressive lenses • Hi-index lenses	$0
Provider-selected contact lenses (in lieu of eyeglass lenses): • Disposable: Daily wear – up to 3-month supply of daily disposable, single vision Extended wear – up to 6-month supply of monthly or 2-week disposable, single vision • Conventional: 1 pair from selection of provider-designated contact lenses • Medically necessary[1]	$0

[1]Medically necessary contact lenses: Contact lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression.

Contact lenses may be determined to be medically necessary for the treatment of conditions, including, but not limited to, keratoconus, pathological myopia, aphakia, anisometropia, aniridia, corneal disorders, post-traumatic disorders, and irregular astigmatism.

Medically necessary contact lenses are dispensed in lieu of other eyewear. Participating providers will obtain the necessary preauthorization for these services.

Pediatric dental

The Affordable Care Act requires that pediatric dental services be covered as one of the 10 required Essential Health Benefits. You can purchase pediatric dental coverage through Health Net or any certified carrier.

Highlights

- Choice of providers.
- Lower copayments by seeing Health Net participating providers for covered services.
- Any dental deductibles, copayments and/or coinsurance or other amounts do not apply toward the plan's medical deductible.

Dental summary of benefits

Benefit		
Annual deductible	$100 deductible applies to all services	
Annual calendar year benefit maximum	None	
	Coinsurance	
	In-network	**Out-of-network[1]**
Preventive Routine exams	0%	0%
Bitewing X-rays	0%	0%
Prophylaxis (cleanings)	0%	0%
Fluoride	0%	0%
Basic Sealants	50%	50%
Restorative	50%	50%
Space maintainers	50%	50%
Oral surgery	50%	50%
Endodontics	50%	50%
Periodontics	50%	50%
Major Crowns	50%	50%
Dentures and bridgework	50%	50%
Orthodontics Medically necessary orthodontics	50%	50%

[1]Maximum allowable amount (MAA) is the amount Health Net Health Plan of Oregon, Inc. uses to calculate what we pay for necessary dental care provided by a nonparticipating provider. The MAA is determined by Health Net Health Plan of Oregon, Inc., based on data obtained on fees usually charged by providers for the same services within the same geographic areas.

Dental and vision benefits are underwritten by Health Net Health Plan of Oregon, Inc. Dental benefits are administered by Dental Benefit Providers, Inc. Vision benefits are serviced by Envolve Vision, Inc.

Dental Benefit Providers, Inc. is not affiliated with Health Net Health Plan of Oregon, Inc. Envolve Vision, Inc. and Health Net Health Plan of Oregon, Inc. are subsidiaries of Centene Corporation.

Optional Adult Dental

(Available to members ages 19 and up)

Benefits	*Plus D50-1855-1500*	*Value D50-185-1500V*	*Preferred Plus DP50-1855-1500*	*Essentials D50-16-500*
Annual deductible per person	$50	$50	$50	$50
Annual deductible per family	$150	$150	$150	N/A
Annual plan maximum per person	$1,500	$1,500	$1,500	$500
Lifetime orthodontic services per person	$1,500	Not covered	$1,500	Not covered
	In-network / Out-of-network	**In-network / Out-of-network**	**In-network / Out-of-network**	**In-network / Out-of-network**
Diagnostic and preventive[1]	100%	100%	100% / 80%	100% / 80%
Basic services	80%	80%	80% / 60%	60% / 50%
Endodontic, periodontal and oral surgery	80%	50%	80% / 60%	Not covered
Major services	50%	50%	50% / 50%	Not covered
Orthodontic services	50%	Not covered	50% / 50%	Not covered

[1]The deductible does not apply to diagnostic and preventive services.

Plus plan

- Includes orthodontia.
- Endodontics, periodontia and oral surgery are reimbursed at tier 2 (Major).
- Hold harmless on MAA if network provider used; otherwise, no benefit distinction in- versus out-of-network.
- MAA is 90th percentile of HIAA for out-of-network.

Value plan

- No orthodontia.
- Endodontics, periodontia and oral surgery are covered at tier 3 (Major).
- Hold harmless on MAA if network provider used; otherwise, no benefit distinction in- versus out-of-network.
- MAA is 90th percentile of HIAA for out-of-network.

Preferred Plus plan

- PPO-type dental plan, higher benefit in-network.
- DP 50: Endodontics, periodontia and oral surgery are reimbursed at tier 2 (Basic); plan includes orthodontia.
- MAA is 90th percentile of HIAA for out-of-network.

Essentials plan

- No orthodontia.
- Covers preventive and basic services only, no major services.

Optional Adult Vision[1]

(Available to members ages 19 and up)

Benefits	*Elite E1010-1*	*Preferred 1025-2*	*Preferred 1025-3*
Exam with dilation as necessary	$10 copay	$10 copay	$10 copay
Exam options (fit and follow-up)			
Standard contact lenses	Up to $55 copay	Up to $55 copay	Up to $55 copay
Premium contact lenses	10% discount	10% discount	10% discount
Eyewear, lenses and frames			
Single vision	$10 copay	$25 copay	$25 copay
Bifocal	$10 copay	$25 copay	$25 copay
Trifocal	$10 copay	$25 copay	$25 copay
Lenticular	$10 copay	$25 copay	$25 copay
Standard progressive lenses	$75 copay	$90 copay	$90 copay
Premium progressive lenses	$75 copay, then 80% of total charges less $120 allowance	$90 copay, then 80% of total charges less $120 allowance	$90 copay, then 80% of total charges less $120 allowance
Retail allowance for any frames at provider location	$150 plus 20% off balance over allowance	$100 plus 20% off balance over allowance	$100 plus 20% off balance over allowance
Lens options			
UV coating	$15	$15	$15
Tint (solid and gradient)	$15	$15	$15
Standard scratch-resistant	$15	$15	$15
Standard polycarbonate	$40	$40	$40
Standard anti-reflective	$45	$45	$45
Other add-ons and services	20% discount	20% discount	20% discount
Contact lenses			
(Includes materials only)	$120 allowance	$90 allowance	$90 allowance
Conventional	$0 copay plus 15% discount off balance over allowance	$0 copay plus 15% discount off balance over allowance	$0 copay plus 15% discount off balance over allowance
Disposables	$0 copay plus balance over allowance	$0 copay plus balance over allowance	$0 copay plus balance over allowance
Medically necessary	Paid in full	Paid in full	Paid in full
Laser vision correction			
LASIK or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	15% off retail price or 5% off promotional price	15% off retail price or 5% off promotional price
Secondary purchase plan			
Discounts on eyewear purchases after initial benefits used	Scheduled benefits up to 40% off retail	Scheduled benefits up to 40% off retail	Scheduled benefits up to 40% off retail
Frequency			
Examination	Once every 12 months	Once every 12 months	Once every 12 months
Lenses or contact lenses	Once every 12 months	Once every 12 months	Once every 24 months
Frames	Once every 12 months	Once every 24 months	Once every 24 months

[1]Members receive an out-of-network allowance for all plans, including exam with dilation as necessary up to a $40 allowance; standard plastic lenses up to allowances of $40 (single vision), $60 (bifocal) or $80 (trifocal or lenticular), as applicable; retail allowance for any frame at provider location up to a $45 allowance; and contact lenses up to a $105 allowance. Refer to the contract for terms and conditions of coverage. Members will receive a 20 percent discount on the remaining balance beyond plan coverage at participating providers, which may not be combined with any other discounts or promotional offers. The discount does not apply to the provider's professional services or to contact lenses. Retail prices may vary by location. Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time-use benefits; no remaining balance. Lost or broken materials are not covered.

WellNet

When you go with one of our Small Group plans, you get Health Net's WellNet. WellNet[1] connects employees with chiropractic, acupuncture, naturopathic, and massage therapy services for all plans except the State Standard plans. Core coverage includes a combined WellNet maximum benefit per calendar year. If you like, you may purchase a higher maximum benefit for your employees.

For questions, please contact your Health Net Account Management team.

Plan[2]	*Office visit*[3]		*Office visit massage therapy*			*Max/calendar year*
	In-network	**Out-of-network**	**In-network**	**Out-of-network**	**Max visits/calendar year**	**Max/calendar year (acupuncture and massage therapy combined)**
Core CAM (included with plan)	$20	N/A	$25	N/A	9	$500
CAM 15-1000	$15	N/A	$25	N/A	18	$1,000
CAM 15-1500	$15	N/A	$25	N/A	27	$1,500
CAM 15-1000 Plus (includes out-of-network option)	$15	20%	$25	20%	18 (in- and out-of-network combined)	$1,000 (in- and out-of-network combined)

[1]See the supplemental benefit schedule for details, limitations and exclusions.

[2]Copayments and coinsurance apply to the out-of-pocket maximum. Medical services provided by naturopaths and chiropractors do not apply to the alternative care calendar year benefit limit.

[3]Applies to chiropractic and acupuncture. Naturopath office visit is based on medical plan.

Alternative care

Health Net offers a full range of alternative care options to members, provided by American Specialty Health Group, Inc. (ASH Group). With ASH Group, members can choose from a broad network of credentialed health care providers who offer alternative health care services.

More Than an ID Card

At Health Net, we're about more than just health care coverage. Sure, comprehensive benefits are essential, but so is making it easy for people to get the most from their health plan.

Decision Power®: Health & Wellness

Decision Power is an integrated program created to engage people in their health. With personalized tools and achievable goals, employees can feel confident in their ability to make positive and lasting behavioral changes.

Through Decision Power, we deliver a personalized and accessible approach to wellness. Here are just a few of the ways we help employees achieve improved wellness:

- Get help with a specific health goal.
- Learn about treatment options.
- Try an online Health Promotion program.
- Assess health risks with a Health Risk Questionnaire.
- Track diet, exercise or cholesterol.
- Better manage chronic illness.
- Take advantage of discounts on health products and services.

Focus on early access and prevention

Here at Health Net, we don't wait until people get sick to help out. Our job, always, is to connect your client's employees with the care they need. We want them to use their benefits!

That's why we conduct outreach – phone calls, mailings and more – to encourage our members to get their annual wellness exam. It costs $0 out-of-pocket and is the best way for people to know their health status – and for Health Net to know how best to meet their health needs. From there, we can connect people to the care and resources to help them be their healthiest. Our resources span the full spectrum of health from timesaving conveniences to in-depth support.

Our outreach efforts elevate the core Decision Power priority: to help reduce high-cost service utilization and support workplace productivity by connecting employees with information, resources and support. Boosting health through prevention and early access to care is another way we're doing just that.

Nurse Advice Line

Members get 24/7 access to licensed nurses via phone or chat for questions about injuries, illnesses, chronic conditions, and preventive care.

Teladoc®

For many people, leaving work to see the doctor is a major inconvenience. With Teladoc, you can talk to a U.S. board-certified doctor at work – anytime, anywhere.

- Members can resolve health care needs through on-demand or scheduled visits with licensed doctors spanning multiple specialties.
- 24/7 access anywhere.
- Convenience by phone or video.
- Prescriptions sent to your preferred pharmacy when medically necessary.

The Active&Fit® Direct Program

A member fitness discount program through American Specialty Health (ASH) is available with all our portfolio plans.

- Members receive access to 10,000+ participating fitness centers nationwide.
- Member-funded: $25/month fee, with a $25 enrollment fee, plus any applicable taxes and an online link through the Health Net member portal.

Support online and on the go

Self-service at www.healthnet.com

HealthNet.com guides you and your employees to the information you want and need with intuitive navigation and useful links.

It's also the place to find network doctors, hospitals and other services. ProviderSearch at HealthNet.com delivers results by location, specialty or office hours. Bookmark www.healthnet.com for fast and easy access to ProviderSearch, benefit information, wellness programs, ID cards, and more!

Health Net Mobile

Keeping track of the details – even critical details like health care information – can be daunting with our on-the-go, jam-packed lives. That's why we created the Health Net Mobile app.

All it takes is an iPhone, Android or other web-enabled smartphone, and Health Net members have everything they need to track their health plan details – no matter where they are or how busy.

Group Administration

Group *Administration*

This quick reference section provides tips for applications, handling group changes and using our convenient online billing and enrollment tools. You'll find all the forms you need in the Forms & Brochures section at www.healthnet.com.

Application tips

Double-check that these items are complete to speed up processing of your application:

- Group numbers, including the suffix (alpha letter).
- Date of hire.
- Date of birth.
- Signatures – Employees must sign both the acceptance and declination sections.
- Signatures – If an employee is accepting some form of coverage but is declining another benefit, then the employee must sign both the acceptance and declination sections.

Group numbers

A group number is created for your organization and will stay the same unless you change or add plans. In addition, if you offer Adult Vision and/or Adult Dental plans, there will be a separate group number for each of those plans.

Handling group changes

Adding employees or dependents

Groups can add employees at the following times:

- **New hire** (after meeting the company's probationary period) – Applications must be received within 30 days of member effective date.

  Example: The probationary period is the first of the month following date of hire. An employee hired on January 15 would have a March 1 effective date.

  1. Counting from January 15 to January 31 is 16 or 17 days (depending on if you use date of hire as day 1 or not), so February 1 through February 13 is the 30th day.
  2. Coverage effective date would be March 1 (first of the month following date of hire, after 30 days).

- **Rehires –** If a terminated employee is rehired within 30 days, she or he and dependent(s) will be reinstated without a coverage lapse (i.e., a period where there is no coverage).

  Example:

  – Terminated: 8/25
  – Coverage ends: 9/01
  – Rehired: 9/18
  – Coverage reinstated: 9/01

  Since the period between termination and rehire is less than 30 days, continuous coverage is provided.

  If more than 30 days have elapsed between the termination and rehire dates, the employee must again fulfill your group's eligibility period as if she or he were a new hire. This will produce a coverage lapse. The eligibility period varies with each group.

  Example:

  – Terminated: 8/25
  – Coverage ends: 9/01
  – Rehired: 10/09
  – Coverage reinstated: 12/01

  Eligibility period: First of the month following the group's eligibility period.

- **Open Enrollment** – During the annual renewal period, groups can enroll employees and dependents who had previously declined coverage.

- **Loss of coverage** – Application requires a copy of the Prior Coverage Certificate with the enrollment form.

Outside of Open Enrollment, dependents can only be added if there is a qualifying event, which includes, but is not limited to:

- Birth
- Marriage
- Court order
- Adoption
- Loss of coverage

All applications for adding new employees and dependents due to a qualifying event must be signed by the subscriber and received by Health Net within 30 days of the event.

Billing contacts

Our Membership Accounting team is available to answer any billing or eligibility questions. Below are several ways to contact our Membership Accounting Department.

Phone: 1-888-802-7001
Email: HNOregon_Enrollment@healthnet.com
Fax: 1-855-607-0982

To pay your bill, mail payments to:

Health Net Health Plan of Oregon, Inc.
PO Box 749393
Los Angeles, CA 90074-9393

When mailing in a premium, remember to write your group number on the check and mail it by the first of the month. Please remember to send allocation directions if you have multiple medical plans and are sending one payment. Health Net billing will need to know how to apply specific portions of the total check to the separate group numbers.

If you intend to cancel or change insurance coverages, Health Net must receive notice on or before the first of the month prior to the effective date of the replacement coverage. Failure to do so may result in continued billing and additional premiums owed.

Canceling employee/dependent coverage

When should Health Net be notified of a cancellation?

Health Net must be notified as soon as possible prior to the last day that the member is eligible for coverage, but no later than 30 days[1] after the effective date of the cancellation. Premium credit cannot be issued for more than 30 days[1] retroactively.

Why is timely notification important?

Members who are no longer eligible, but who have not, in fact, been canceled by their employer, may incur substantial medical expenses between the time they cease to meet eligibility requirements and the time they are actually removed from the plan. According to the eligibility rules of your Health Net plan, if you notify us of a cancellation more than 30 days after what should have been the last day of coverage, Health Net will require that you pay subscription charges/premiums for the affected member up to the time that you provided us with proper notification.

How does cancellation of the subscriber's coverage affect the coverage of his or her dependents?

When the subscriber's coverage is canceled, all covered dependents also lose eligibility and are canceled automatically.

How is employee coverage canceled?

The group administrator may process the change through the Online Billing and Enrollment tool at www.healthnet.com. You may also use the following methods:

Email: HNOregon_Enrollment@healthnet.com

Regular fax: 1-855-607-0982
(Non-urgent – Membership has 3 business days to complete.)

Urgent fax: 1-855-346-5774
(Must enter "Urgent" in the subject line. Will be processed within 24 hours.)

[1]Permitted days are subject to contract agreement.

How can a dependent's coverage be canceled if the subscriber continues to be covered?

Follow the same procedure as when canceling an employee; or, to cancel a dependent's coverage when the subscriber continues to be covered, you must submit the following form:

Enrollment and Change Form

The "Delete Dependent" change option should be indicated below "Reason for Change." A completed, signed and dated Enrollment and Change Form must be submitted for each subscriber who is canceling a dependent's coverage.

Online billing and enrollment

Convenience and control 24/7

Health Net makes it easy for you to simplify health plan administration with Online Billing and Enrollment, our free, user-friendly Web portal for enrolled employer groups. Visit our website at www.healthnet.com.

With Online Billing and Enrollment, groups can:

- Edit payment amount.
- View and print billing statements.
- Make an online payment (checking/savings accounts).
- Set up a one-time payment date for an automatic payment.
- Retain up to 24 months of billing and payment history for easy access (Active payor parent group only).
- Set up recurring monthly payments.
- Track and update eligibility.
- View, add and update enrollment information anytime.
- Utilize convenient reporting features.
  - Active member roster
  - Canceled member roster
  - Enrollment requests

All reports are easily downloaded into a PDF or CSV format.

Online Billing and Enrollment is fully integrated to work with the rest of Health Net's systems, so the updates that you make will always be reflected online.

Important!

Recurring bill payment – For group renewals, any plan changes (i.e., new and/or existing plans canceled) will auto delete a recurring payment date.

1) Log in to your employer account at www.healthnet.com.

2) Your recurring payment date must be reestablished. If your bill is already online, you will need to make a one-time manual payment, then reestablish your recurring payment date. A recurring payment will schedule and draft your next bill that cycle. If you elect not to reestablish a recurring payment date, you can simply make an online manual payment or mail a check for your premium. Making payments by the due date keeps your account current and out of risk of termination because of nonpayment.

Appendix/Forms

Health Net®

2020 Renewal *Election Form*

Small Business Group – Oregon

In working with your broker and Health Net Health Plan of Oregon, Inc. (Health Net) account manager, you may have been provided with additional renewal proposals to assist you in selecting the best coverage for your group. To help us serve you better, please provide the quote number of the renewal proposal you are accepting. The quote number can be found on the cover page and in the header of the renewal proposal pages.

Quote #: _____ Renewal effective date: _____

1. Employee information

New hire waiting period (Please check the waiting period for new hires. Federal law prohibits waiting periods beyond 90 days.)
First of the month following: ☐ Date of hire ☐ 30 days ☐ 1 month ☐ 60 days

What is the employer monthly contribution percentage? Employee: _____ Dependent: _____

On a typical business day, how many employees are eligible for health benefit plan coverage (count all employees throughout the U.S.)?
Total eligible employees: _____ In-state employees: _____ Out-of-state employees: _____

Total worldwide employees: _____
(Count all employees regardless of if they are eligible for coverage. Include full-time and part-time employees. Do not include 1099 and seasonal employees.)

What type of COBRA[1] are you subject to? ☐ Federal COBRA ☐ State Continuation

Average number of employees you employed for the entire previous calendar year regardless of whether or not they were eligible for coverage: _____

An employee is defined as any person for whom the company issues a W-2, including full-time, part-time, and seasonal workers, and regardless of insurance eligibility.[2]

To calculate the average number of employees, determine the number of employees for each month, add each month's number to get an annual total, and then divide by 12 (or # of months in business if less than 12 months). Round up or down to the nearest whole number – example: 30.5 = 31. Do not spell out the number – example: write 30, not thirty.

How many full-time employees were in the group during the prior calendar year? _____

How many full-time equivalent employees were in the group during the prior calendar year? _____

How many employees are there as of the effective date of coverage? _____
(For the purposes of determining eligibility, employers must have one common law employee at the time of enrollment.)

Are you a part of a controlled group (see definition on page 3 of this form)? ☐ Yes ☐ No
If "Yes," who is the employer for purposes of filing taxes? _____

2. Medical plan offerings *(Check the plans you wish to offer. All medical plans include pediatric vision coverage.)*

Health Net CommunityCare 1T

☐ Platinum 25-750-2-3000DX
☐ Gold 25-1000-2-7900DX
☐ Gold 25-2000-2-7900DX
☐ Gold 25-3500-2-7900DX
☐ Silver 40-3000-3-8150ES
☐ Silver 40-4500-3-8150ES

Health Net CommunityCare 3T

☐ Platinum 25-750-2-3000DX
☐ Gold 25-1000-2-7900DX
☐ Gold 25-2000-2-7900DX
☐ Gold 25-3500-2-7900DX
☐ Silver 40-3000-3-8150ES
☐ Silver 40-4500-3-8150ES

Health Net PPO

☐ Platinum P10-250-1-4000LX
☐ Platinum P20-500-2-4000LX
☐ Platinum P20-750-2-4000LX
☐ Gold P20-500-3-7900DX
☐ Gold P20-1000-2-7900DX
☐ Gold P20-2000-2-7900DX
☐ Gold P20-2500-3-7900DX
☐ Gold P30-1500-2-7900DX
☐ Gold P30-3500-3-7900DX
☐ Gold P50-0-5-5000
☐ Silver P40-3000-3-8150ES
☐ Silver P40-4000-3-8150ES
☐ Silver P45-3500-5-8150ES
☐ Silver P45-5000-5-8150ES
☐ Bronze P75-5000-5-8150ES
☐ Bronze P7350-0-7350ES

High Deductible PPO

☐ Silver HD2800-2-5500ES
☐ Bronze HD6550-0-6550ES

Standard PPO

☐ Health Net Oregon Standard Gold Plan
☐ Health Net Oregon Standard Silver Plan
☐ Health Net Oregon Standard Bronze Plan

(continued)

[1]Note: Generally, employers who normally employed 20 or more employees during the previous calendar year are subject to federal COBRA. Employers who employed 2–19 employees on at least 50% of its working days the previous calendar year are subject to State Continuation. Please consult your legal counsel if you need help determining which law applies to you.

[2]This information is for rating purposes and not to determine group size. The determination of how to count employees of related corporate entities when calculating group size for medical loss ratio (MLR) purposes is based on whether the entities are considered a single employer under Section 414 of the Internal Revenue Code (subsection (b), (c), (m), or (o)) and is not based on the multiple tax identification status of the related entities.

3. Supplemental renewal offering

(Check the plans you wish to offer – only 1 dental, 1 vision and 1 WellNet plan may be checked.)

Reminder: Health Net auto-enrolls the employees' eligible dependents who elect medical coverage into adult dental and/or vision coverage, if offered by their employer group. If an employee declines adult dental and/or vision coverage for an eligible dependent during open enrollment, then the employee must complete the *Declination of Coverage* section of the *Group Enrollment and Change Application*. Employers must ensure that their employees who wish to decline coverage for their eligible dependents during open enrollment complete the *Declination of Coverage* section of the *Group Enrollment and Change Application* prior to submitting to Health Net. If an employee does not decline adult dental and/or vision coverage for their eligible dependents during open enrollment, then they will have that coverage during their plan year. Current employees can make changes to their coverage during their open enrollment period.

Adult Dental

☐ Plus D50-1855-1500 ☐ Value D50-185-1500V ☐ Preferred Plus DP50-1855-1500 ☐ Essentials D50-16-500

Adult Vision

☐ Elite 1010-1 ☐ Preferred 1025-2 ☐ Preferred 1025-3

WellNet

☐ Core CAM (included) ☐ CAM 15-1000 ☐ CAM 15-1500 ☐ CAM 15-1000 Plus

Purchasing pediatric dental coverage with Health Net?
☐ Yes ☐ No (I confirm that I am purchasing pediatric dental coverage with another carrier as required by ACA mandate.)

I/We have reviewed and understand my/our medical plan renewal notification along with the following informational pieces provided by Health Net. After reviewing the renewal information, by my/our signature below, I/we confirm that I/we intend to renew my/our health benefit plan(s).

I/We understand that Health Net is relying on my/our answers to the above questions to determine if my/our group meets the definition of a small employer group as defined by the State of Oregon. I/We also understand that the final rates will be based on the actual enrollment and may be different than the rates originally quoted and that additional information may be required to verify the eligibility of the group.

Policyholder name:		
Policyholder/Case ID (located on the cover page and header of renewal proposal pages):		
Physical address:		
City:	State:	ZIP:
Billing address:		
City:	State:	ZIP:
Company authorized representative (please print):	Title:	
Signature:	Date:	
Email address:	Phone:	
Broker:		

This form must be completed and returned to your Health Net account manager in order to perform renewal election changes. If the completed form is not received by Health Net by the 10th of the month prior to the effective date of your renewal, your health benefit plan(s) will be auto-renewed to the closest matching plan(s).

Additional information when completing the Employer Group Questionnaire

If an employer has more than 50 full-time equivalent (FTE) employees, Health Net may provide the employer a quote as a large group. Health Net must treat the employer as a small group if the employer has at least one but not more than 50 FTEs.

When counting employees to determine group size, temporary, seasonal, leased, and contracted employees are excluded.

In answering the questions about employees, an owner is generally not considered an employee even if the owner performs services for the business for compensation; however, an owner may participate in a group plan as long as the group employs at least one common law employee. An owner includes:

- A sole proprietor and the sole proprietor's spouse;
- A member of a single-member limited liability company and the member's spouse;
- The owner of a wholly owned corporation and the owner's spouse.

Controlled and Affiliated Groups

Controlled and Affiliated Groups means groups that are commonly controlled and/or affiliated as described in subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986. If a group is a controlled or affiliated group of employers, a carrier must treat the group as a single group, and the controlled group must complete one group profile form. Controlled groups include parent-subsidiary, brother-sister and the combination of both of the preceding.

FTE employees

The total number of employees, full-time and part-time, working an average of 30 hours or more a week.

FTE counting instructions:

A. Count each employee working 30 hours or more as 1 FTE.

B. Total the hours worked per week by all employees working less than 30 hours and divide by 30.

C. Add the numbers from A and B together. This is your FTE count. You may also use the FTE calculator at healthcare.gov: https://www.healthcare.gov/shop-calculators-fte/.

Benefit-eligible employees

The total number of employees eligible for coverage as determined by the employer.

Open Enrollment Medical Plan Change Request *Form*

Oregon

Please use this form to indicate plan changes for your employees and their dependents during your renewal. Please call your authorized Health Net Health Plan of Oregon, Inc. (Health Net) broker or Health Net account manager for acceptable plan changes and guidelines.

Group contact information

Group number:	Group name:		Renewal effective date:
Group contact:	Contact phone:	Contact fax:	Contact email address:

NOTE: You must provide the *Summary of Benefits and Coverage* (SBC) to each individual listed on this form before the individual makes the plan choice and PRIOR TO SUBMITTING THIS FORM TO HEALTH NET. To download and print an SBC, go to www.healthnet.com/sbc. Please indicate with a check, using blue or black ink, the plan each member wishes to move into.

Please list all **currently enrolled** members making plan changes during open enrollment on this form. **New enrollment applications must be submitted for new enrollees.** Please photocopy this form if more space is required. Please email completed and signed forms to your broker or your Health Net account manager.

			PPO														HD PPO		Standard PPO		
			Platinum			Gold							Silver				Bronze		Silver	Bronze	Gold	Silver	Bronze
Member's name	Member's SSN or Health Net reference ID #	Group #	P10-250-1-4000LX	P20-500-2-4000LX	P20-750-2-4000LX	P20-500-3-7900DX	P20-1000-2-7900DX	P20-2000-2-7900DX	P20-2500-3-7900DX	P30-1500-2-7900DX	P30-3500-3-7900DX	P50-0-5-5000	P40-3000-3-8150ES	P40-4000-3-8150ES	P45-3500-5-8150ES	P45-5000-5-8150ES	P75-5000-5-8150ES	P7350-0-7350ES	HD2800-2-5500ES	HD6550-0-6550ES	Health Net of Oregon Standard Plan	Health Net of Oregon Standard Plan	Health Net of Oregon Standard Plan

(continued)

As an owner or officer of stated company, I hereby authorize the above changes to our Health Net Group medical coverage. I have informed the employees listed above that the enrollment terms of the Health Net form they completed previously at enrollment are still in force and a copy is available upon request.

Printed name	Signature	Date

Member's name	Member's SSN or Health Net reference ID #	Group #	Primary care physician's enrollment ID #	CommunityCare 1T						CommunityCare 3T					
				Platinum	Gold			Silver		Platinum	Gold			Silver	
				25-750-2-3000DX	25-1000-2-7900DX	25-2000-2-7900DX	25-3500-2-7900DX	40-3000-3-8150ES	40-4500-3-8150ES	25-750-2-3000DX	25-1000-2-7900DX	25-2000-2-7900DX	25-3500-2-7900DX	40-3000-3-8150ES	40-4500-3-8150ES

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 1-888-802-7001 (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.

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. Employer group members please call 1-888-802-7001 (TTY: 711).

Amharic
ክፍያ የሌለው የቋንቋ አገልግሎት። አስተርጓሚ ማግኘት ይችላሉ። ሰነዶች እንዲዘጋጅልዎ ማድረግ ይችላሉ። እርዳታ ለማግኘት በመታወቂያ ላይ ያለውን ቁጥር ይደውሉ። አመልካቾች 1-888-802-7001 (TTY: 711) 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. يرجى من أعضاء مجموعة أصحاب العمل الاتصال على الرقم 1-888-802-7001 (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。雇主團體的會員請致電 1-888-802-7001（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. Xubnaha kooxda badrooniga fadlan soo wac 1-888-802-7001 (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. Arbeitgeber-Gruppenmitglieder rufen bitte unter 1-888-802-7001 (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。雇用主を通じた団体保険のメンバーの方は、1-888-802-7001（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. 고용주 그룹 가입자분은 1-888-802-7001 (TTY: 711) 번으로 전화해 주십시오.

Cambodian (Khmer)
សេវាភាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ អ្នកអាចស្តាប់គេអានឯកសារឱ្យអ្នក។ សម្រាប់ជំនួយ សូមទាក់ទងយើងខ្ញុំតាមរយៈលេខទូរស័ព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក។ សមាជិកក្រុមនិយោជក សូមទាក់ទងទៅលេខ 1-888-802-7001 (TTY: 711)។

Laotian
ລິການພາສາບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍຜູ້ແປພາສາໄດ້. ທ່ານສາມາດຂໍໃຫ້ອ່ານເອກະສານໃຫ້ທ່ານຟັງໄດ້. ເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ, ກະລຸນາໂທຫາພວກເຮົາໄດ້ຕາມເບີທີ່ມີຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ. ສະມາຊິກກຸ່ມນາຍຈ້າງ ກະລຸນາໂທຫາເບີ 1-888-802-7001 (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। ਰੋਜ਼ਗਾਰਦਾਤਾ ਗਰੁੱਪ ਦੇ ਸਦੱਸ, ਕਿਰਪਾ ਕਰਕੇ 1-888-802-7001 (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 участник коллективного плана, предоставляемого работодателем, звоните по телефону 1-888-802-7001 (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 afiliados del grupo del empleador deben llamar al 1-888-802-7001 (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 miyembro ng grupo ng employer, mangyaring tumawag sa 1-888-802-7001 (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). Учасників групового страхового плану від працедавця просимо телефонувати за номером 1-888-802-7001 (TTY: 711).

Vietnamese
Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu c ầu 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. Các thành viên thuộc chương trình theo nhóm của chủ sử dụng lao động vui lòng gọi số 1-888-802-7001 (TTY: 711).

OR WA Commercial Notice of Language Assistance

Simplified. Sustainable. Small business-focused.
Health Net has you covered.

Questions? We're here with answers.

- Call your Health Net account manager.
- Visit us online at www.healthnet.com.
- See ACA-related information at www.healthnet.com/employer/reformguide.
- Read the latest news about Health Net at www.healthnetpulse.com.

For more information, please contact:

Health Net Health Plan of Oregon, Inc.
13221 SW 68th Pkwy., Ste. 200
Tigard, OR 97223

Small Business Group
Sales and Account Management
1-888-802-7001, option 2, option 1

Assistance for the hearing and speech impaired
TTY users call 711, Monday through Friday, 8:00 a.m. to 5:00 p.m.

www.healthnet.com

BKT036758EO00 (4/20)