Oregon CommunityCare 3T 30-3000-3-7900ES *Plan Overview*

Benefit description	*Member(s) responsibility*		
Metal level	Silver		
Deductible – single / family[1]	$3,000 / $6,000		
Out-of-pocket maximum – single / family[2]	$7,900 / $15,800		
Network	CommunityCare network	Other participating provider	Out-of-network provider (MAA)
Coinsurance	30%	50%	50%
Physician / Professional / Outpatient care			
Preventive care – men's and women's health care – Pap test, breast exam, pelvic exam, mammogram, PSA test, and digital rectal exam	No charge	No charge	50%[3]
Physician office visits – includes family practice, pediatrics, internal medicine, naturopathy, general practice, obstetrics/gynecology	$30[3]	50%	50%
Specialty physician services – office visits to providers in specialties other than above	$70[3]	50%	50%
Urgent care – physician services	$50[3]	$50[3]	$50[3]
Physician hospital visits	30%	50%	50%
Diagnostic – X-ray/EKG/ultrasound	30%	50%	50%
Diagnostic – laboratory tests	30%	50%	50%
Deductible waived on lab and X-ray	No	No	No
Imaging – CT/MRI/PET/SPECT/EEG	30%	50%	50%
Deductible waived on imaging	No	No	No
Allergy and therapeutic injections	30%	50%	50%
Maternity delivery care – professional services	30%	50%	50%
Outpatient rehabilitation and habilitation therapy – 30 visits per year maximum	30%	50%	50%
Outpatient surgery at ambulatory surgery center	25%	50%	50%
Outpatient surgery at hospital-based facility	30%	50%	50%
Hospital care			
Inpatient hospital services[4]	30%	50%	50%
Inpatient rehabilitation and habilitation therapy – 30 days per year maximum	30%	50%	50%
Emergency services			
Outpatient emergency room services – copay waived if admitted; no MAA out-of-network	30%	30%	30%
Inpatient admission from emergency room	30%	30%	30%
Ambulance services – ground and air	30%	30%	30%
Behavioral services – chemical dependency and mental or nervous conditions[5]			
Physician services – office visit	$30[3]	50%	50%
Outpatient services	30%	50%	50%
Inpatient services	30%	50%	50%
Other services			
Durable medical equipment	30%	50%	50%
Diabetes management – one initial program	$30[3]	50%	50%
Hearing aids	30%	50%	50%
Home health visits	30%	50%	50%
Medical supplies – including allergy serum and injected substances	30%	50%	50%

(continued)

Benefit description	*Member(s) responsibility*		
	CommunityCare network	Other participating provider	Out-of-network provider (MAA)
Prosthetic devices/Orthotic devices[6]	30%	50%	50%
Skilled nursing facility care – 60 days per year maximum	30%	50%	50%
Outpatient chemotherapy – non-oral anticancer medications and administration	30%	50%	50%
Pharmacy[3,7] Generic / Brand preferred / Non-preferred	$20 / $50 / 50%	Not covered	Not covered
Specialty drugs – including most self-injectables[8]	50%	Not covered	Not covered
Mail order Generic / Brand preferred / Non-preferred	$40 / $100 / 50%	Not covered	Not covered
Orally administered anticancer medications	30%	Not covered	Not covered
Pediatric vision This plan covers routine vision services and supplies for children up to age 19.	Routine eye exam limit: 1 per calendar year. Provider-selected frames limit: 1 per calendar year.		
Pediatric dental This plan is offered with and without pediatric dental services. If your employer group has elected to purchase pediatric dental through Health Net Health Plan of Oregon, Inc. (Health Net), then pediatric dental services for covered members under age 19 are included as indicated here. If your employer group has elected pediatric dental services from another qualified plan, then this Health Net plan does not include pediatric dental services.	Diagnostic and preventive services: 100% after $100 deductible per member, per calendar year. Basic major services and medically necessary orthodontia: 50% after $100 deductible per member, per calendar year.		
Alternative care[9] Chiropractic (spinal manipulation)	$20[3]	Not covered	Out-of-network (OON) on all buy-ups is not covered except for CAM 15-1000 Plus is 20%
Naturopathic care	$30[3]	Not covered	Not covered
Acupuncture care	$20[3]	Not covered	Not covered
Massage therapy – 9 visits per year maximum	$25[3]	Not covered	Not covered
Maximum benefit for acupuncture and massage therapy	$500 per calendar year	Not covered	Not covered

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

[2]The annual out-of-pocket maximum includes the annual deductible, copayments and coinsurance. After the out-of-pocket maximum is reached in a calendar year, we will pay the covered services during the rest of that calendar year at 100% of our contract rates for participating provider services and at 100% of the maximum allowable amount (MAA) for out-of-network (OON) services. Members are still responsible for OON-billed charges that exceed MAA.

[3]Deductible is waived.

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

[5]For mental health or chemical dependency services, call 1-800-977-8216.

[6]Corrective shoes and arch supports, including foot orthotics, are excluded unless prescribed in the course of treatments for, or complications from, diabetes.

[7]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. **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*.

[8]Certain drugs identified on the Essential Rx Drug List are classified as Specialty drugs under your plan. Specialty drugs are high-cost biologic, injectable and oral drugs typically dispensed through a limited network of pharmacies and have significantly higher cost than traditional pharmacy benefit drugs. Prior authorization is required for these medications.

[9]For alternative care benefits, call American Specialty Health at 1-800-678-9133.

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.

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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).

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).

French
Services linguistiques sans frais. Vous pouvez obtenir un interprète. Les documents peuvent vous être lus. Pour obtenir de l'aide, appelez-nous au numéro indiqué sur votre carte d'identité. Membres du groupe employeur veuillez composer le 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 서비스를 받으실 수 있습니다. 도움을 원하시면, 보험 ID에 수록된 번호로 전화해 주십시오. 고용주 그룹 가입자분은 1-888-802-7001 (TTY: 711)번으로 전화해 주십시오.

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

Romanian
Servicii lingvistice gratuite. Puteţi obţine un interpret. Puteţi avea documente citite pentru dvs. Pentru asistenţă telefonaţi-ne la numărul indicat pe cardul de membru. Membrii grupului angajatorilor să telefoneze la 1-888-802-7001 (TTY: 711).

Persian (Farsi)

خدمات زبان به طور رایگان. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید که اسناد برای شما قرائت شوند. برای کسب اطلاعات، با ما به شماره ای که در کارت شناسایی شما قید شده تماس بگیرید. اعضای گروه کارفرما لطفاً با شماره 1-888-802-7001 (TTY: 711) تماس بگیرید.

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).

Thai

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังได้ สำหรับความช่วยเหลือ โทรหาเราตามหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ สมาชิกกลุ่มนายจ้าง กรุณาโทร 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 cầu 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).

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