Plan Overview

PPO Advantage - A25-1500-2-4500

Benefits	*Member pays*	
	In-network	**Out-of-network**
Deductible per calendar year	$1,500 single / $3,000 family in-network and out-of-network combined	
Out-of-pocket maximum includes deductible	$4,500 single / $9,000 family in-network and out-of-network combined	
Office visits		
Physician - includes family practice, pediatrics, internal medicine, naturopath, general practice, obstetrics/ gynecology, telemedicine services	$25 copay/visit (deductible waived)	40% MAA
Specialist physician – providers in specialties other than those listed above	$25 copay/visit (deductible waived)	40% MAA
Maternity delivery care (professional services only)	20% of contract rate	40% MAA
Preventive care – includes but is not limited to: preventive office visit, women's and men's health care, pap test, mammogram, pelvic exam, prostate screening (PSA) and digital rectal exam	$0 copay (deductible waived)	40% MAA (deductible waived)
Alternative care *administered by American Specialty Health (ASH)*		
Chiropractic (spinal manipulation)	$15 copay/visit (deductible waived)	not covered
Acupuncture care	$15 copay/visit (deductible waived)	not covered
Naturopathic care	$25 copay/visit (deductible waived)	not covered
Massage therapy– maximum 18 visits per year	$25 copay/visit (deductible waived)	not covered
Maximum benefit for acupuncture/massage therapy per calendar year	$1,000 (all services combined)	
Emergency and urgent care services		
Emergency room	$150 copay/visit, then 20% of contracted rate (deductible waived) ER copay waived if admitted	$150 copay/visit, then 20% (deductible waived) ER copay waived if admitted
Urgent care - physician services	$50 copay/visit (deductible waived)	$50 copay/visit MAA (deductible waived)
Ground ambulance – maximum 3 trips per year	20%	20%
Air ambulance – maximum 1 trip per year	20%	20%
Hospital services		
Inpatient hospital	20% of contract rate	40% MAA
Outpatient at hospital-based facility	20% of contract rate	40% MAA
Outpatient at ambulatory surgery center	15% of contract rate	40% MAA
Rehabilitative services		
Inpatient – maximum 30 days per year	20% of contract rate	40% MAA
Outpatient – maximum 30 days per year	20% of contract rate	40% MAA

(continued)

PPO Advantage - A25-1500-2-4500

Benefits	*Member pays*	
	In-network	**Out-of-network**
Skilled nursing facility – maximum 60 days per year	20% of contract rate	40% MAA
Diagnostic lab and X-ray, EKG, ultrasound	20% of contract rate (deductible waived)	40% MAA
Imaging and testing services CT/MRI/MRA/PET/SPECT/EEG/Holter Monitor/stress test	20% of contract rate	40% MAA
Allergy and therapeutic injections	20% of contract rate	40% MAA
Durable medical equipment (DME)	20% of contract rate	40% MAA
Home health visits	20% of contract rate	40% MAA
Hospice services	20% of contract rate	40% MAA
Behavioral Health *administered by MHN*		
Mental health and Chemical dependency		
Inpatient	20% of contract rate	40% MAA
Outpatient, office visits	$25 copay/visit (deductible waived)	40% MAA
Outpatient, other	20% of contract rate	40% MAA

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

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

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

The outpatient emergency room copay is waived if you are admitted

For Mental Health or Chemical Dependency services, call 800-977-8216
For Alternative Care benefits, call American Specialty Health (ASH) at 800-678-9133

Certain services require prior authorization or must be performed by a specialty care provider

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Medical services provided by a Naturopath do not apply to the alternative care calendar year benefit limit

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).

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 សូមទាក់ទងយើងខ្ញុំតាមរយៈទូរស័ព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក។ សមាជិកក្រុមនិយោជក សូមទាក់ទងទៅលេខ បេក្ខជន សូមទាក់ទងទៅលេខ 1-888-802-7001 (TTY: 711)។

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

Persian (Farsi)

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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).

OR Commercial Off-Exchange Member Notice of Language Assistance

Plan Overview

CommunityCare - CC3T10-0-2-3000DXB

Benefits	*Member pays*		
	CommunityCare Provider (Level 1)	**Other Participating Provider (Level 2)**	**Nonparticipating Provider (Level 3)**
Deductible per calendar year	None - single / family Level 1, Level 2 and Level 3 combined		
Out-of-pocket maximum includes deductible	$3,000 single / $6,000 family Level 1, Level 2 and Level 3 combined		
Office visits			
Physician - includes family practice, pediatrics, internal medicine, naturopath*, general practice, obstetrics/gynecology, telemedicine services	$10 copay/visit	40% of contract rate	40% MAA
Specialist physician– providers in specialties other than those listed above	$50 copay/visit	40% of contract rate	40% MAA
Maternity delivery care (professional services only)	20% of contract rate	40% of contract rate	40% MAA
Preventive care – includes but is not limited to: preventive office visit, women's and men's health care, pap test, mammogram, pelvic exam, prostate screening (PSA) and digital rectal exam	$0 copay	$0 copay	40% MAA
Alternative care*			
Chiropractic (spinal manipulation)	$15 copay/visit	not applicable at level 2	not covered
Acupuncture care	$15 copay/visit	not applicable at level 2	not covered
Massage therapy – maximum 18 visits per year	$25 copay/visit	not applicable at level 2	not covered
Maximum benefit for acupuncture and massage therapy per calendar year	$1,000 (both services combined)		
Emergency and urgent care services			
Emergency room	$250 copay/visit, then 20% of contracted rate ER copay waived if admitted	$250 copay/visit, then 20% of contracted rate ER copay waived if admitted	$250 copay/visit, then 20% of contracted rate ER copay waived if admitted
Urgent care - physician services	$50 copay/visit	$50 copay/visit	$50 copay/visit MAA
Ground ambulance– maximum 3 trips per year	20%	20%	20%
Air ambulance– maximum 1 trip per year	20%	20%	20%
Hospital services			
Inpatient hospital	20% of contract rate	40% of contract rate	40% MAA
Outpatient at hospital-based facility	20% of contract rate	40% of contract rate	40% MAA
Outpatient at ambulatory surgery center	15% of contract rate	35% of contract rate	40% MAA

**administered by American Specialty Health (ASH)*

(continued)

CommunityCare - CC3T10-0-2-3000DXB

Benefits	*Member pays*		
	CommunityCare Provider (Level 1)	**Other Participating Provider (Level 2)**	**Nonparticipating Provider (Level 3)**
Rehabilitative services			
Inpatient– maximum 30 days per year	20% of contract rate	40% of contract rate	40% MAA
Outpatient– maximum 30 days per year	20% of contract rate	40% of contract rate	40% MAA
Skilled nursing facility– maximum 90 days per year	20% of contract rate	40% of contract rate	40% MAA
Diagnostic lab and X-ray, EKG, ultrasound	20% of contract rate	40% of contract rate	40% MAA
Imaging and testing services CT/MRI/MRA/PET/SPECT/EEG/Holter Monitor/stress test	20% of contract rate	40% of contract rate	40% MAA
Allergy and therapeutic injections	20% of contract rate	40% of contract rate	40% MAA
Durable medical equipment (DME)	20% of contract rate	40% of contract rate	40% MAA
Home health visits	20% of contract rate	40% of contract rate	40% MAA
Hospice services	20% of contract rate	40% of contract rate	40% MAA
Behavioral Health *administered by MHN*			
Mental health and Chemical dependency			
Inpatient	20% of contract rate	not applicable at level 2	40% MAA
Outpatient, office visits	$10 copay/visit	not applicable at level 2	40% MAA
Outpatient, other	20% of contract rate	not applicable at level 2	40% MAA

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

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

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

The outpatient emergency room copay is waived if you are admitted

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Medical services provided by a Naturopath do not apply to the alternative care calendar year benefit limit

Chiropractic services do not apply to the alternative care calendar year benefit limit

Bariatric Surgery and Infertility Services are covered at 50%. Please refer to your Evidence of Coverage for benefit details, limitations, and exclusions.

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

Romanian
Servicii lingvistice gratuite. Puteți obține un interpret. Puteți avea documente citite pentru dvs. Pentru asistență telefonați-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

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Spanish

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Thai

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Ukrainian

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OR Commercial Off-Exchange Member Notice of Language Assistance

Plan Overview

EPO – 1020 w/QN

Benefits	*Member pays*
	EPO Provider
Deductible per calendar year	None – single / family
Out-of-pocket maximum includes deductible	$2,500 single / $5,000 family
Office visits	
Physician - includes family practice, pediatrics, internal medicine, naturopath*, general practice, obstetrics/gynecology, telemedicine services	$10 copay/visit
Specialist physician – providers in specialties other than those listed above	$10 copay/visit
Maternity delivery care (professional services only)	$100 copay per pregnancy
Preventive care – includes but is not limited to: preventive office visit, women's and men's health care, pap test, mammogram, pelvic exam, prostate screening (PSA) and digital rectal exam	$0 copay
Alternative care*	
Chiropractic (spinal manipulation)	$15 copay/visit
Acupuncture care	$15 copay/visit
Massage therapy– maximum 18 visits per year	$25 copay/visit
Maximum benefit for acupuncture and massage therapy per calendar year	$1,000 (both services combined)
Emergency and urgent care services	
Emergency room	$150 copay/visit, copay waived if admitted
Urgent care - physician services	$35 copay/visit
Ground ambulance – maximum 3 trips per year	20% coinsurance
Air ambulance – maximum 1 trip per year	20% coinsurance
Hospital services	
Inpatient hospital	$200 copay per day/$1,000 copay max per admit
Outpatient at hospital-based facility	$200 copay
Outpatient at ambulatory surgery center	$200 copay
Rehabilitative services	
Inpatient – maximum 30 days per year	$0 copay per day
Outpatient – maximum 30 days per year	$10 copay/visit

**administered by American Specialty Health (ASH)*

(continued)

EPO – 1020 w/QN

Benefits	*Member pays*
	EPO Provider
Skilled nursing facility – maximum 90 days per year	$0 copay per admission
Diagnostic lab and X-ray, EKG, ultrasound	$0 copay
Imaging and testing services CT/MRI/MRA/PET/SPECT/EEG/Holter Monitor/stress test	$0 copay
Allergy and therapeutic injections	$0 copay
Durable medical equipment (DME)	20% coinsurance
Home health visits	$0 copay/visit
Hospice services	$0 copay
Behavioral Health *administered by MHN*	
Mental health and Chemical dependency	
Inpatient	$200 copay per day/$1,000 copay max per admit
Outpatient, office visits	$10 copay/visit
Outpatient, other	$200 copay

The annual out-of-pocket maximum includes your copays and coinsurance. After you reach the out-of-pocket maximum in a calendar year, we will pay your covered services during the rest of that calendar year at 100% of our contract rates for participating provider services and at 100% of maximum allowable amount (MAA) for out-of-network (OON) services. You are still responsible for OON billed charges that exceed MAA

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

The outpatient emergency room copay is waived if you are admitted

For Mental Health or Chemical Dependency services, call 800-977-8216
For Alternative Care benefits, call American Specialty Health (ASH) at 800-678-9133

Certain services require prior authorization or must be performed by a specialty care provider

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Medical services provided by a Naturopath do not apply to the alternative care calendar year benefit limit

Chiropractic services do not apply to the alternative care calendar year benefit limit

Bariatric Surgery and Infertility Services are covered at 50%. Please refer to your Evidence of Coverage for benefit details, limitations, and exclusions.

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.

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English
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Korean
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Health Net®

Oregon Large Group

Health Net Pharmacy *Benefits*

NMSL15-30-50-1000

The following is a brief description of your Health Net Pharmacy benefits.

Benefit level	*In pharmacy (per fill, up to a 30-day supply)*[1]	*Mail order (per fill, up to a 90-day supply)*
Tier 1	$15	$30
Tier 2	$30	$60
Tier 3	$50	$100
Specialty pharmacy	10% to a maximum of $150	Mail order not available
Orally administered anticancer medications	10% to a maximum of $150	Mail order not available
Preventive pharmacy, tobacco cessation and women's contraception methods	No copay and/or coinsurance	No copay and/or coinsurance
Out-of-pocket maximum per calendar year	$1,000 single / $2,000 family combined both in pharmacy and mail order (separate from medical out-of-pocket maximum)	

[1] If certain requirements are met, you may be eligible for a 90-day supply when filled in a pharmacy (with three times the retail copay).

If your prescription is for a maintenance medication (a drug that you will be taking for an extended period of time), you have the option of filling it through our convenient and cost-saving mail order pharmacy program. For complete information, log on as a Health Net member at www.healthnet.com/drugs.

Essentials Drug List

A listing of preferred drugs and their corresponding benefit levels is shown on the Health Net Essential Drug List (EDL). To view the current EDL, go to www.healthnet.com/drugs.

Specialty Pharmacy

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

Preventive Pharmacy

Preventive Pharmacy medications require a prescription and are limited to prescription drugs and over-the-counter medications that are determined to be preventive. No Deductible, Copayment and/or Coinsurance apply for each prescription or refill of a generic class drug or brand name drug with no generic class drug available. Deductible, Copayment and/or Coinsurance will apply to brand name drugs that have generic equivalents.

Women's Contraception

Generic class Food and Drug Administration (FDA) approved contraceptive methods, patient education and counseling for all women with reproductive capacity are covered. FDA approved, over-the-counter contraceptive methods for women require a prescription from your participating provider. No Deductible, Copayment and/or Coinsurance apply for each prescription or refill of a generic class drug or brand name drug when no generic class drug is available. Deductible, Copayment and/or Coinsurance will apply to brand name drugs that have generic equivalents.

Tobacco Cessation

Food and Drug Administration (FDA) approved prescription drugs classified as smoking cessation medications are covered when dispensed by a participating provider pharmacy. FDA approved, over-the-counter tobacco cessation medications require a prescription from your participating provider. No Deductible, Copayment and/or Coinsurance apply for each prescription or refill of a generic class drug or brand name drug when no generic class drug is available. Deductible, Copayment and/or Coinsurance will apply to brand name drugs that have generic equivalents.

Participating Pharmacies

Participating Provider pharmacy must be used when filling all prescriptions under your plan. The plan does not cover prescriptions filled at a Non-Participating pharmacy.

What if I am on a medication that was covered by my previous health insurance?

Under the Continuity of Care Policy, within the first 90 days of Health Net coverage, you will receive authorization for any existing medication requiring prior authorization that was covered under your previous health insurance company. The health plan will require verification that the medication was covered by the previous insurance company. This policy excludes the following: injectables, compounded medications, pharmacy benefit exclusions, and overrides on quantity or dosage limits.

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Spanish

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Thai

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังได้ สำหรับความช่วยเหลือ โทรหาเราตามหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ สมาชิกกลุ่มนายจ้าง กรุณาโทร 1-888-802-7001 (TTY: 711)

Ukrainian

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Vietnamese

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OR Commercial Off-Exchange Member Notice of Language Assistance

Plan Overview

High Deductible Health Plan-HD15008060 & HD30008060

Benefits	*Member pays*	
	In-network	**Out-of-network**
Deductible per calendar year	$1,500 single / $3,000 family	$3,000 single / $6,000 family
Out-of-pocket maximum includes deductible	$3,000 single / $6,000 family	$9,000 single / $18,000 family
Office visits		
Physician - includes family practice, pediatrics, internal medicine, naturopath, general practice, obstetrics/gynecology, telemedicine services	20% of contract rate	40% MAA
Specialist physician – providers in specialties other than those listed above	20% of contract rate	40% MAA
Maternity delivery care (professional services only)	20% of contract rate	40% MAA
Preventive care – includes but is not limited to: preventive office visit, women's and men's health care, pap test, mammogram, pelvic exam, prostate screening (PSA) and digital rectal exam	$0 copay (deductible waived)	40% MAA (deductible waived)
Alternative care *Administered by American Specialty Health (ASH)*		
Chiropractic (Spinal Manipulation)	20% of contract rate	Not covered
Acupuncture care	20% of contract rate	Not covered
Massage therapy – maximum 18 visits per year	20% of contract rate	Not covered
Maximum benefit for acupuncture/naturopathy/ massage therapy per calendar year	$1,000 (all services combined)	
Emergency and urgent care services		
Emergency room	20% of contract rate	20%
Urgent care - physician services	20% of contract rate	20% MAA
Ground ambulance – maximum 3 trips per year	20%	20%
Air ambulance – maximum 1 trip per year	20%	20%
Hospital services		
Inpatient hospital	20% of contract rate	40% MAA
Outpatient at hospital-based facility	20% of contract rate	40% MAA
Outpatient at ambulatory surgery center	15% of contract rate	40% MAA
Rehabilitative services		
Inpatient – maximum 30 days per year	20% of contract rate	40% MAA
Outpatient – maximum 30 days per year	20% of contract rate	40% MAA

(continued)

High Deductible Health Plan-HD15008060 & HD30008060

Benefits	*Member pays*	
	In-network	**Out-of-network**
Skilled nursing facility – maximum 60 days per year	20% of contract rate	40% MAA
Diagnostic lab and X-ray, EKG, ultrasound	20% of contract rate	40% MAA
Imaging and testing services CT/MRI/MRA/PET/SPECT/EEG/Holter Monitor/stress test	20% of contract rate	40% MAA
Allergy and therapeutic injections	20% of contract rate	40% MAA
Durable medical equipment (DME)	20% of contract rate	40% MAA
Home health visits	20% of contract rate	40% MAA
Hospice services	20% of contract rate	40% MAA
Behavioral Health		
Mental health and Chemical dependency		
Inpatient	20% of contract rate	40% MAA
Outpatient, office visits	20% of contract rate	40% MAA
Outpatient, other	20% of contract rate	40% MAA

The specified deductible must be met each calendar year (January 1 through December 31) before Health Net pays any claims. Family coverage means the subscriber and spouse; the subscriber and child(ren); or the subscriber, spouse, and child(ren). Under family coverage, each member's covered expenses count toward the family deductible

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

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

The outpatient emergency room copay is waived if you are admitted

For Mental Health or Chemical Dependency services, call 800-977-8216
For Alternative Care benefits, call American Specialty Health at 800-678-9133

Certain services require prior authorization or must be performed by a specialty care provider

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

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.

Health Net®

Oregon Large Group

Health Net Pharmacy *Benefits*

NMSLHD80

The following is a brief description of your Health Net Pharmacy benefits.

Benefit level	*In pharmacy (per fill, up to a 30-day supply)*[1]	*Mail order (per fill, up to a 90-day supply)*
Tier 1	20%	20%
Tier 2	20%	20%
Tier 3	20%	20%
Specialty pharmacy	20%	Mail order not available
Orally administered anticancer medications	20%	Mail order not available
Preventive pharmacy, tobacco cessation and women's contraception methods	No copay and/or coinsurance	No copay and/or coinsurance
Out-of-pocket maximum per calendar year	Refer to your Medical plan Deductible/OOPM. Specialty pharmacy services and orally-administered anticancer medications apply toward your Medical plan Deductible and Out-of-Pocket maximum	

[1] If certain requirements are met, you may be eligible for a 90-day supply when filled in a pharmacy (with three times the retail copay).

If your prescription is for a maintenance medication (a drug that you will be taking for an extended period of time), you have the option of filling it through our convenient and cost-saving mail order pharmacy program. For complete information, log on to www.healthnet.com/mypharmacy.

Essentials Drug List

A listing of preferred drugs and their corresponding benefit levels is shown on the Health Net Essential Drug List (EDL). Log on to www.healthnet.com/mypharmacy.

Specialty Pharmacy

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

Preventive Pharmacy

Preventive Pharmacy medications require a prescription and are limited to prescription drugs and over-the-counter medications that are determined to be preventive. No Deductible, Copayment and/or Coinsurance apply for each prescription or refill of a generic class drug or brand name drug with no generic class drug available. Deductible, Copayment and/or Coinsurance will apply to brand name drugs that have generic equivalents.

Women's Contraception

Generic class Food and Drug Administration (FDA) approved contraceptive methods, patient education and counseling for all women with reproductive capacity are covered. FDA approved, over-the-counter contraceptive methods for women require a prescription from your participating provider. No Deductible, Copayment and/or Coinsurance apply for each prescription or refill of a generic class drug or brand name drug when no generic class drug is available. Deductible, Copayment and/or Coinsurance will apply to brand name drugs that have generic equivalents.

Tobacco Cessation

Food and Drug Administration (FDA) approved prescription drugs classified as smoking cessation medications are covered when dispensed by a participating provider pharmacy. FDA approved, over-the-counter tobacco cessation medications require a prescription from your participating provider. No Deductible, Copayment and/or Coinsurance apply for each prescription or refill of a generic class drug or brand name drug when no generic class drug is available. Deductible, Copayment and/or Coinsurance will apply to brand name drugs that have generic equivalents.

Participating Pharmacies

Participating Provider pharmacy must be used when filling all prescriptions under your plan. The plan does not cover prescriptions filled at a Non-Participating pharmacy.

What if I am on a medication that was covered by my previous health insurance?

Under the Continuity of Care Policy, within the first 90 days of Health Net coverage, you will receive authorization for any existing medication requiring prior authorization that was covered under your previous health insurance company. The health plan will require verification that the medication was covered by the previous insurance company. This policy excludes the following: injectables, compounded medications, pharmacy benefit exclusions, and overrides on quantity or dosage limits.

This is a brief description of your Health Net Pharmacy benefits and is intended for marketing purposes only and presents general information. Please refer to your *Prescription Supplemental Benefit Schedule* to determine the specific benefits, limitations, exclusions and all other terms and conditions of coverage.

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 សូមទាក់ទងយើងខ្ញុំតាមរយៈទូរស័ព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក។ សមាជិកក្រុមនិយោជក សូមទាក់ទងទៅលេខ បេក្ខជន សូមទាក់ទងទៅលេខ 1-888-802-7001 (TTY: 711)។

Romanian
Servicii lingvistice gratuite. Puteți obține un interpret. Puteți avea documente citite pentru dvs. Pentru asistență telefonați-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

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Spanish

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Ukrainian

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Vietnamese

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