Plan Overview

Triple Option Plan - S1099F

Benefits	*Member pays*		
	EPO (Level 1)	PPO (Level 2)	Out-of-network (Level 3)
Deductible per calendar year	None (single and family) Level 1 and Level 2 combined		$100 single / $200 family
Out-of-pocket maximum includes deductible	$1,500 single / $3,000 family Level 1 and Level 2 combined		$4,500 single / $9,000 family
Office visits			
Physician - includes family practice, pediatrics, internal medicine, naturopath, general practice, obstetrics/gynecology	$10 copay/visit	20% of contract rate	20% MAA
Specialist physician– providers in specialties other than those listed above	$10 copay/visit	20% of contract rate	20% MAA
Maternity delivery care (professional services only)	$100 copay/pregnancy	20% of contract rate	20% 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	20% MAA (deductible waived)
Alternative care *administered by American Specialty Health (ASH)*			
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
Naturopathic care	$10 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 chiropractic/ acupuncture/naturopathy/massage therapy per calendar year	$1,000 (all services combined)		
Emergency and urgent care services			
Emergency room	$150 copay/visit (copay waived if admitted)	$150 copay/visit (copay waived if admitted)	$150 copay/visit (deductible waived / copay waived if admitted)
Urgent care - physician services	$35 copay/visit	$35 copay/visit	$35 copay/visit MAA (deductible waived)
Ground ambulance– maximum 3 trips per year	20%	20%	20%
Air ambulance– maximum 1 trip per year	20%	20%	20%
Hospital services			
Inpatient hospital	$100 copay/day (maximum of 5 copays / admission)	20% of contract rate	20% MAA
Outpatient at hospital-based facility	$100 copay/visit	20% of contract rate	20% MAA
Outpatient at ambulatory surgery center	$100 copay/visit	15% of contract rate	15% MAA

(continued)

Triple Option Plan - S1099F

Benefits	*Member pays*		
	EPO (Level 1)	PPO (Level 2)	Out-of-network (Level 3)
Rehabilitative services			
Inpatient– maximum 30 days per year	$0 copay	20% of contract rate	20% MAA
Outpatient– maximum 30 days per year	$10 copay/visit	20% of contract rate	20% MAA
Skilled nursing facility– maximum 60 days per year	$0 copay	20% of contract rate	20% MAA
Diagnostic lab and X-ray, EKG, ultrasound	$0 copay	20% of contract rate	20% MAA
Imaging and testing services CT/MRI/MRA/PET/SPECT/EEG/Holter Monitor/stress test	$0 copay	20% of contract rate	20% MAA
Allergy and therapeutic injections	$0 copay	20% of contract rate	20% MAA
Durable medical equipment (DME)	20%	20% of contract rate	20% MAA
Home health visits	$0 copay	20% of contract rate	20% MAA
Hospice services	$0 copay	20% of contract rate	20% MAA
Behavioral Health *administered by MHN*			
Mental health and Chemical dependency			
Inpatient	$100 copay/day (maximum of 5 copays)	not applicable at level 2	20% MAA
Outpatient, office visits	$10 copay/visit	not applicable at level 2	20% MAA
Outpatient, other	$100 copay/visit	not applicable at level 2	20% 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

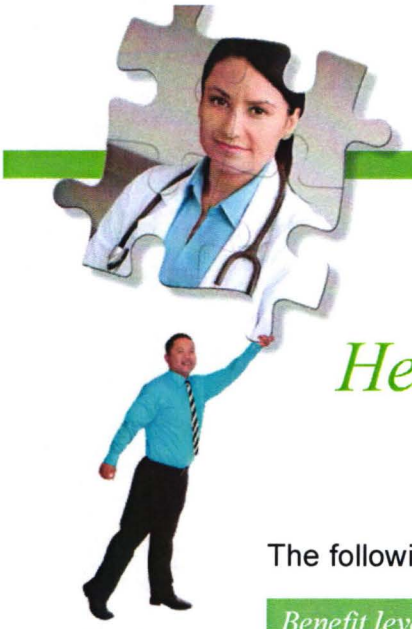
The outpatient emergency room copay is waived if you are admitted

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

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

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



Kim Aung
Health Net

Health Net®

Oregon Large Group

Health Net Pharmacy *Benefits*

NMSL10-15-25-1000

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	$10	$20
Tier 2	$15	$30
Tier 3	$25	$50
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 > My Prescriptions > Order by mail.

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 as a Health Net member at www.healthnet.com > My Health Plan > Pharmacy Coverage > View My Drug List > 2016 Essential Health Benefit Drug Lists > OR Essential RX Drug List or Preventive Drug List.

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 pharmacy plan provides Creditable Coverage for Medicare Part D

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.

Health Net®

Health Net Health Plan of Oregon, Inc.
Vision Benefits
SUPPLEMENTAL BENEFIT SCHEDULE PREFERRED 1025-2/12

Purpose and Function of this Schedule

The purpose of this schedule is to provide vision benefits to Subscriber Groups selecting this supplemental benefit in addition to the basic benefits. This schedule is an amending attachment to the Basic Benefit Schedule.

Subject to all terms, conditions, exclusions and definitions in the Group Medical and Hospital Service Agreement and its attachments, except as expressly amended by benefits provision of this Schedule, you are entitled to receive benefits set forth in this Schedule upon payment of the relevant premiums and Copayments.

Benefits

Benefits are based on the following Schedule:

	Participating Provider	Any Other Provider
Exam	After you pay a $10 Copayment, covered services are paid in full by the plan.	You are reimbursed up to $40 of the cost for covered services.
Exam Options (fit and follow-up)		
Standard contact lenses	After you pay up to $55, covered services are paid in full by the plan.	You receive no discount.
Premium contact lenses	You receive 10% off retail cost.	You receive no discount.
Eyewear (lenses and frame)		
Single vision lenses	Covered in full after a $25 Copayment.	You are reimbursed up to $40.
Lined bifocal lenses	Covered in full after a $25 Copayment.	You are reimbursed up to $60.
Lined trifocal lenses	Covered in full after a $25 Copayment.	You are reimbursed up to $80.
Lenticular lenses	Covered in full after a $25 Copayment.	You are reimbursed up to $80.
Standard progressive lenses	Covered in full after a $90 Copayment	You are reimbursed up to $60.
Premium progressive lenses	$90 Copayment, then 80% of total charge less $120 allowance.	You are reimbursed up to $60.
Frame	Covered up to $100 allowance. You will receive a 20% discount on the balance over your allowance.	You are reimbursed up to $45.
Lens Options		
UV Coating	Covered in full after a $15 Copayment. **	You receive no discount.
Tint, solid and gradient	Covered in full after a $15 Copayment. **	You receive no discount.
Standard scratch-resistance	Covered in full after a $15 Copayment. **	You receive no discount.
Standard polycarbonate	Covered in full after a $40 Copayment. **	You receive no discount.
Standard anti-reflective	Covered in full after a $45 Copayment. **	You receive no discount.
Other add-ons and services	You receive 20% off retail cost. **	You receive no discount.

** Your Copayment or eyewear discount applies to any optional items purchased with your lenses and/or frames from a Participating Provider. Listed items are examples of optional items.

Contact lenses (instead of spectacle lenses and frame) –Materials		
Conventional	You receive a maximum allowance of $90, plus a discount of 15% over your allowance.	You are reimbursed up to $105 of the cost for covered services.
Disposables	You receive a maximum allowance of $90, you are responsible for remaining balance over your allowance.	You are reimbursed up to $105 of the cost for covered services.
Medically Necessary	Paid in full.	You are reimbursed up to $210 of the cost for covered services.

Frequency of Service

Examination	Once every 12 months from the last date of service.
Lenses	Once every 12 months from the last date of service.
Frame	Once every 24 months from the last date of service.
Contact lenses in lieu of lenses	Once every 12 months from the last date of service.

Limitations, Options and Exclusions

- To receive maximum benefits, you must utilize Participating Providers. A list of Participating Providers is available at www.healthnet.com or by calling our Customer Contact Center.

  When services are received from a Participating Provider, we make payment directly to the Provider. You are responsible for paying the Copayment to the Provider.

- There is no benefit for professional services or materials connected with:
  a. Orthoptics or vision training, subnormal vision aids and any associated supplemental testing.

  b. Aniseikonic lenses.

  c. Medical or surgical treatment of the eyes or supporting structures.

  d. Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under this plan.

  e. Services provided as a result of any Workers' Compensation law.

  f. Plano non-prescription lenses and non-prescription sunglasses.

  g. Lost or broken materials except at normal intervals when services are otherwise available.

- Benefits may not be combined with any discount, promotional offering, or other group benefits plans. Allowances are one-time use benefits; no remaining balance.

- Value Added Discounts

  Contact Lenses – Participating Providers offer preferred pricing and direct delivery on annual supplies of select brands of disposable contact lenses.

  Lasik or PRK – You may have a discount available for these services. Please contact our Customer Contact Center for more information.

Continued Eyewear Savings – After your initial benefits have been utilized, you may be able to receive ongoing discounts on additional eyewear purchases at Participating Provider locations. Please contact our Customer Contact Center for more information.

This summary presents general information only and does not include all benefits, details and exclusions.