


2024

|  Plan name | Member(s) In-Network responsibility | | | | | | | | | |
|--|--|---|---------------------------|---|-------------|-----------------------|--------------------|-------------------------------------|---|-------------|
| | Deductible ¹ (single / family) | Out-of-pocket maximum ² (single / family) | Office / specialist visit | Coinsurance ³ (in-network / out-of-network) | Lab / x-ray | CT / MRI / PET / SPEC | Inpatient hospital | Outpatient surgery (ASC / hospital) | Emergency room (copay waived if admitted) | Urgent care |
| Advantage LX PPO | | | | | | | | | | |
| LX10-0-2-4000 | \$0 / \$0 | \$4,000 / \$8,000 | \$10 / \$30 | 20% / 40% | \$20 | 20% | 20% | 20% / 10% | \$250 + 20% | \$50 |
| Advantage PPO | | | | | | | | | | |
| A15-250-2-4000 | \$250 / \$500 | \$4,000 / \$8,000 | \$15 / \$30 | 20% / 40% | \$20 | 20% | 20% | 20% / 10% | \$250 + 20% | \$50 |
| A20-500-2-4000 | \$500 / \$1,000 | \$4,000 / \$8,000 | \$20 / \$40 | 20% / 40% | \$20 | 20% | 20% | 20% / 10% | \$250 + 20% | \$50 |
| A20-750-2-5000 | \$750 / \$1,500 | \$5,000 / \$10,000 | \$20 / \$40 | 20% / 40% | \$20 | 20% | 20% | 20% / 10% | \$250 + 20% | \$50 |
| A25-1000-2-5000 | \$1,000 / \$2,000 | \$5,000 / \$10,000 | \$25 / \$50 | 20% / 40% | \$20 | 20% | 20% | 20% / 10% | \$250 + 20% | \$50 |
| A30-1500-2-6600 | \$1,500 / \$3,000 | \$6,600 / \$13,200 | \$30 / \$60 | 20% / 40% | \$20 | 20% | 20% | 20% / 10% | \$250 + 20% | \$50 |
| A20-2000-2-6600 | \$2,000 / \$4,000 | \$6,600 / \$13,200 | \$20 / \$40 | 20% / 40% | \$20 | 20% | 20% | 20% / 10% | \$250 + 20% | \$50 |
| A30-2500-3-6600 | \$2,500 / \$5,000 | \$6,600 / \$13,200 | \$30 / \$60 | 30% / 50% | \$20 | 30% | 30% | 30% / 20% | \$250 + 30% | \$50 |
| A30-3000-2-7350 | \$3,000 / \$6,000 | \$7,350 / \$14,700 | \$30 / \$60 | 20% / 40% | \$20 | 20% | 20% | 20% / 10% | \$250 + 20% | \$50 |
| A35-3000-3-7350 | \$3,000 / \$6,000 | \$7,350 / \$14,700 | \$35 / \$70 | 30% / 50% | \$20 | 30% | 30% | 30% / 20% | \$250 + 30% | \$50 |
| A35-5000-2-7350 | \$5,000 / \$10,000 | \$7,350 / \$14,700 | \$35 / \$70 | 20% / 40% | \$20 | 20% | 20% | 20% / 10% | \$250 + 20% | \$50 |
| A35-5000-3-7350 | \$5,000 / \$10,000 | \$7,350 / \$14,700 | \$35 / \$70 | 30% / 50% | \$20 | 30% | 30% | 30% / 20% | \$250 + 30% | \$50 |
| Essentials PPO | | | | | | | | | | |
| E20-500-2-4000 | \$500 / \$1,000 | \$4,000 / \$8,000 | \$20 / \$40 | 20% / 40% | 20% | 20% | 20% | 20% / 10% | 20% | \$50 |
| E25-1000-2-5000 | \$1,000 / \$2,000 | \$5,000 / \$10,000 | \$25 / \$50 | 20% / 40% | 20% | 20% | 20% | 20% / 10% | 20% | \$50 |
| E30-2000-2-6600 | \$2,000 / \$4,000 | \$6,600 / \$13,200 | \$30 / \$60 | 20% / 40% | 20% | 20% | 20% | 20% / 10% | 20% | \$50 |
| E35-3000-2-7350 | \$3,000 / \$6,000 | \$7,350 / \$14,700 | \$35 / \$70 | 20% / 40% | 20% | 20% | 20% | 20% / 10% | 20% | \$50 |
| E35-4000-2-7350 | \$4,000 / \$8,000 | \$7,350 / \$14,700 | \$35 / \$70 | 20% / 40% | 20% | 20% | 20% | 20% / 10% | 20% | \$50 |
| E35-5000-3-8150 | \$5,000 / \$10,000 | \$8,150 / \$16,300 | \$35 / \$70 | 30% / 50% | 30% | 30% | 30% | 30% / 20% | 30% | \$50 |
| E35-6000-3-8150 | \$6,000 / \$12,000 | \$8,150 / \$16,300 | \$35 / \$70 | 30% / 50% | 30% | 30% | 30% | 30% / 20% | 30% | \$50 |
| E50-3000-5-7350 | \$3,000 / \$6,000 | \$7,350 / \$14,700 | \$50 / \$100 | 50% / 50% | 50% | 50% | 50% | 50% / 40% | 50% | \$50 |
| E50-5000-5-7350 | \$5,000 / \$10,000 | \$7,350 / \$14,700 | \$50 / \$100 | 50% / 50% | 50% | 50% | 50% | 50% / 40% | 50% | \$50 |
| E50-6000-5-8150 | \$6,000 / \$12,000 | \$8,150 / \$16,300 | \$50 / \$100 | 50% / 50% | 50% | 50% | 50% | 50% / 40% | 50% | \$50 |
| Essentials First Dollar PPO (First \$500 on lab, x-ray and advanced imaging combined covered at 100%) | | | | | | | | | | |
| FE25-1000-2-5000 | \$1,000 / \$2,000 | \$5,000 / \$10,000 | \$25 / \$50 | 20% / 40% | 20% | 20% | 20% | 20% / 10% | 20% | \$50 |
| FE25-1500-2-7350 | \$1,500 / \$3,000 | \$7,350 / \$14,700 | \$25 / \$50 | 20% / 40% | 20% | 20% | 20% | 20% / 10% | 20% | \$50 |
| FE30-2000-2-7350 | \$2,000 / \$4,000 | \$7,350 / \$14,700 | \$30 / \$60 | 20% / 40% | 20% | 20% | 20% | 20% / 10% | 20% | \$50 |
| FE35-3000-2-7350 | \$3,000 / \$6,000 | \$7,350 / \$14,700 | \$35 / \$70 | 20% / 40% | 20% | 20% | 20% | 20% / 10% | 20% | \$50 |
| FE35-5000-2-7350 | \$5,000 / \$10,000 | \$7,350 / \$14,700 | \$35 / \$70 | 20% / 40% | 20% | 20% | 20% | 20% / 10% | 20% | \$50 |
| FE50-5000-5-7350 | \$5,000 / \$10,000 | \$7,350 / \$14,700 | \$50 / \$100 | 50% / 50% | 50% | 50% | 50% | 50% / 40% | 50% | 50% |
| Primary Advantage PPO | | | | | | | | | | |
| PA0-500-4-5000 | \$500 / \$1,000 | \$5,000 / \$10,000 | \$0 / \$50 | 40% / 50% | \$0 | 40% | 40% | 40% / 30% | \$300 | \$50 |
| PA10-3000-5-7350 | \$3,000 / \$6,000 | \$7,350 / \$14,700 | \$10 / \$70 | 50% / 50% | \$0 | 50% | 50% | 50% / 40% | 50% | \$70 |
| PA20-5000-5-7350 | \$5,000 / \$10,000 | \$7,350 / \$14,700 | \$20 / \$70 | 50% / 50% | \$0 | 50% | 50% | 50% / 40% | 50% | \$70 |
| PPO HDHP⁴ | | | | | | | | | | |
| HDE32008060 w/HD80 | \$3,200 / \$6,400 | \$5,600 / \$11,200 | 20% | 20% / 40% | 20% | 20% | 20% | 20% / 10% | 20% | 20% |
| HDE35008060 w/HD80 | \$3,500 / \$7,000 | \$6,550 / \$13,100 | 20% | 20% / 40% | 20% | 20% | 20% | 20% / 10% | 20% | 20% |
| HDE50008060 w/HD80 | \$5,000 / \$10,000 | \$6,750 / \$13,500 | 20% | 20% / 40% | 20% | 20% | 20% | 20% / 10% | 20% | 20% |

(continued)

2024

Alternative Care plans^{5,6}

| Alternative care | Member pays | | | | | | | |
|----------------------|--|----------------|--|----------------|--|----------------|--|--|
| | Chiropractic (Unlimited visits) | | Acupuncture (36 visits combined in and out-of-network) | | Massage Therapy (27 visits combined in and out-of-network) | | Naturopath (Unlimited visits) | |
| | In-network | Out-of-network | In-network | Out-of-network | In-network | Out-of-network | In-network | Out-of-network |
| | Office visits are covered at the PCP copay under your medical plan | 20% | Office visits are covered at the PCP copay under your medical plan | 20% | Office visits are covered at the PCP copay under your medical plan | 20% | Office visits are covered at the PCP copay under your medical plan | Office visits are covered at the PCP out-of-network cost share under your medical plan |

Vision plans

| Vision | Member pays | | | |
|----------------------|-------------|---|---|---|
| | Exam | Frame allowance | Lenses (single / bifocal / trifocal / progressive) | Frequency (months) (examination / lenses or contact lenses / frames) |
| Elite 1010-1 | \$10 | \$150 plus 20% off balance over allowance | \$10 / \$10 / \$10 / \$75 | 12 / 12 / 12 |
| Supreme 010-2 | \$0 | \$120 plus 20% off balance over allowance | \$10 / \$10 / \$10 / \$75 | 12 / 12 / 24 |
| Preferred 1025-2 | \$10 | \$100 plus 20% off balance over allowance | \$25 / \$25 / \$25 / \$90 | 12 / 12 / 24 |
| Preferred 1025-3 | \$10 | \$100 plus 20% off balance over allowance | \$25 / \$25 / \$25 / \$90 | 12 / 24 / 24 |
| Preferred Value 10-3 | Not covered | \$100 plus 20% off balance over allowance | \$10 / \$10 / \$10 / \$75 | Not covered / 24 / 24 |
| Plus 20-1 | \$20 | 35% discount off retail price | \$50 / \$70 / \$105 / \$135 | 12 / Unlimited / Unlimited |
| Exam Only | \$0 | Not covered | Not covered | 24 / Not covered / Not covered |

Dental plans

| Dental | Member pays | | | | | |
|---------------------------------|------------------------------|-----------------------|---|-----------|-------|--------|
| | Annual deductible per person | Calendar year maximum | Coinsurance (preventive & diagnostics / basic / major / ortho) | Cleanings | Exams | X-rays |
| Plus D25-185- 1500 | \$25 | \$1,500 | 0% / 20% / 50% / Not covered | 0% | 0% | 0% |
| Plus D25-1855-1500 | \$25 | \$1,500 | 0% / 20% / 50% / 50% | 0% | 0% | 0% |
| Plus D25-1855-2000 | \$25 | \$2,000 | 0% / 20% / 50% / 50% | 0% | 0% | 0% |
| Plus D50-185-1000 | \$50 | \$1,000 | 0% / 20% / 50% / Not covered | 0% | 0% | 0% |
| Plus D50-185-1500 | \$50 | \$1,500 | 0% / 20% / 50% / Not covered | 0% | 0% | 0% |
| Plus D50-1855-1500 | \$50 | \$1,500 | 0% / 20% / 50% / 50% | 0% | 0% | 0% |
| Plus D50-185- 2000 | \$50 | \$2,000 | 0% / 20% / 50% / Not covered | 0% | 0% | 0% |
| Plus D50-1855- 2000 | \$50 | \$2,000 | 0% / 20% / 50% / 50% | 0% | 0% | 0% |
| Plus D100-185-1000 | \$100 | \$1,000 | 0% / 20% / 50% / Not covered | 0% | 0% | 0% |
| Plus D100-1855-1000 | \$100 | \$1,000 | 0% / 20% / 50% / 50% | 0% | 0% | 0% |
| Plus D100-185-1500 | \$100 | \$1,500 | 0% / 20% / 50% / Not covered | 0% | 0% | 0% |
| Plus D100-185-2000 | \$100 | \$2,000 | 0% / 20% / 50% / Not covered | 0% | 0% | 0% |
| Plus D100-1855-2000 | \$100 | \$2,000 | 0% / 20% / 50% / 50% | 0% | 0% | 0% |
| Preferred Plus DP50-1855-1500 | \$50 | \$1,500 | 0% / 20% / 50% / 50% | 0% | 0% | 0% |
| Value D50-185-1500V | \$50 | \$1,500 | 0% / 20% / 50% / Not covered | 0% | 0% | 0% |
| Value D100-185-1000V | \$100 | \$1,000 | 0% / 20% / 50% / Not covered | 0% | 0% | 0% |
| Preferred Value DP100-185-1000V | \$100 | \$1,000 | 0% / 20% / 50% / Not covered | 0% | 0% | 0% |
| Essential D50-16-500 | \$50 | \$500 | 0% / 40% / Not covered / Not covered | 0% | 0% | 0% |
| Fifty D100-555-1000V | \$100 | \$1,000 | 50% / 50% / 50% / Not covered | 0% | 0% | 0% |

2024

Pharmacy plans⁷

| Pharmacy | Member pays | | | | |
|--|----------------------------|----------------------------|--|------------|-----------------|
| | Tier 1 | Tier 2 | Tier 3 | Deductible | Specialty drug |
| No MAC | | | | | |
| NMSL5-10-25 | \$5 | \$10 | \$25 | No | 20% up to \$250 |
| NMSL10-20-40 | \$10 | \$20 | \$40 | No | 20% up to \$250 |
| NMSL10-35-60 | \$10 | \$35 | \$60 | No | 20% up to \$250 |
| NMSL10-50-75 | \$10 | \$50 | \$75 | No | 20% up to \$250 |
| NMSL15-30-50 | \$15 | \$30 | \$50 | No | 20% up to \$250 |
| NMSL15-40-65 | \$15 | \$40 | \$65 | No | 20% up to \$250 |
| NMSL15-30%-50% | \$15 | 30% | 50% | No | 50% |
| No MAC Deductible plans (deductible waived on Tier 1) | | | | | |
| NMSL10-35-60-100D | \$10 | \$35 | \$60 | \$100 | 20% up to \$250 |
| NMSL10-35-60-250D | \$10 | \$35 | \$60 | \$250 | 20% up to \$250 |
| MAC A | | | | | |
| MASL10-10-DR | \$10 | \$10 | Member pays 100% at HN discounted rate | No | 20% up to \$250 |
| MASL10-20%-DR | The greater of \$10 or 20% | The greater of \$10 or 20% | Member pays 100% at HN discounted rate | No | 20% up to \$250 |
| MASL15-50%-DR | The greater of \$15 or 50% | The greater of \$15 or 50% | Member pays 100% at HN discounted rate | No | 20% up to \$250 |
| MASL25-50%-DR | \$25 | 50% | Member pays 100% at HN discounted rate | No | 50% |
| PPO HDHP Rx⁴ (No MAC) | | | | | |
| HD80 | 20% | 20% | 20% | Yes | 20% |

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

²The 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.

³Coinsurance is subject to the annual deductible.

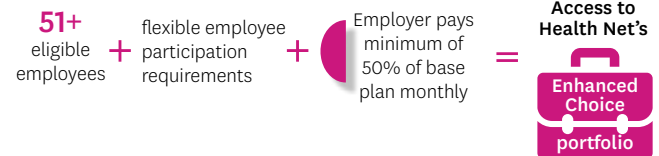
⁴All benefits including office visit copay, pharmacy, and alternative care are after deductible.

⁵All copayments accumulate to the medical out-of-pocket maximum.

⁶In- and out-of-network visits combined.

⁷Prescription 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. 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.healthnetoregon.com to view the Oregon Essential RX Drug List.

Enhanced Choice participation guidelines



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.

Health Net Health Plan of Oregon, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All rights reserved.

OTH063128EPO0 (1/24)