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

Small Group

Plan Overview

PPO P15-1500-2-8500DX

YOU CAN USE THIS MATRIX TO HELP COMPARE COVERAGE BENEFITS. THIS MATRIX PRESENTS A HIGH-LEVEL SUMMARY. FOR A MORE DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS, REVIEW THE PLAN CONTRACT AND *EVIDENCE OF COVERAGE* (EOC).

The copayment amounts are the fees members will be charged for covered services received. Health Net and the contracted provider have agreed to the copayment amounts. Copayments can be a fixed-dollar amount or a percentage of Health Net's cost for the service or supply. You may also see percentage copayments referred to as coinsurance. Members pay fixed-dollar copayments when they receive the service. The provider will usually bill members for percentage copayments after the service is received. All services are subject to the deductible, unless noted otherwise.

Benefit description	Member responsibility	
Metal Level	Gold	
Network	**In-network**	**Out-of-network (MAA)**
Deductible – single / family	$1,500 / $3,000	$5,000 / $10,000
Out-of-pocket maximum – single / family *(includes deductible)*	$8,500 / $17,000	$17,000 / $34,000
Preventive care Preventive health exams, colonoscopy *(age 50+)*, routine immunizations, gynecological exam and pap, mammograms, PSA screening, tobacco cessation	$0 / visit (deductible waived)	50% (deductible waived)
Office visits Physician - includes family practice, naturopath, pediatrics, internal medicine, general practice, obstetrics/gynecology	Visits 1-3: $5 deductible waived Visits 4+: $15 deductible waived	50%
Specialist physician - providers in specialties other than those listed above	$30 / visit (deductible waived)	50%
Allergy and therapeutic injections	20%	50%
Telehealth services	$0 / visit (deductible waived)	50%
Diagnostic services Diagnostic lab and X-ray, EKG, ultrasound	$20 / visit (deductible waived)	50%
Advanced diagnostic imaging, CT, MRI, PET, EEG, Holter monitor/ stress test	20%	50%
Maternity services Maternity delivery care *(professional services only)*	20%	50%
Inpatient hospital services	20%	50%
Emergency and urgent care services Urgent care physician services	$30 / visit (deductible waived)	$30 / visit (deductible waived)
Outpatient emergency room services *(no MAA out-of-network)*	20%	20%
Ambulance services - ground and air	20%	20%
Hospital services Inpatient hospital	20%	50%
Inpatient rehabilitative services *(physical, occupational, and speech therapy)* - limit max 30 days per year	20%	50%
Skilled nursing facility - limit max 60 days per year	20%	50%
Outpatient services Surgery, infusion, dialysis, chemotherapy, radiation therapy	20%	50%
Surgery at hospital-based facility	20%	50%
Surgery at ambulatory surgical center (ASC)	10%	50%

Benefit description	Member responsibility	
Rehabilitative services - limit max 30 days per year	$30 / visit (deductible waived)	50%
Medical equipment and supplies Durable medical equipment, prosthetics, orthotics, diabetes supplies, oral sleep apnea appliance	20%	50%
Medical supplies, including allergy serum and injected substances	20%	50%
Home health and hospice Home health care	20%	50%
Hospice services	20%	50%
Mental health and substance use disorder services Physician services - office visit	Visits 1-3: $5 deductible waived Visits 4+: $15 deductible waived	50%
Inpatient and residential services	20%	50%
Pharmacy Pharmacy Deductible	None	Not Covered
Generic/Preferred/Non-Preferred	$15 / $45 / $90	Not Covered
Specialty drugs - including most self-injectable	50%	Not Covered
Mail order - 2 times copay for 90-day supply	$30 / $90 / $180	Not Covered
Orally administered anticancer medication	20% ded waived	Not Covered
Pediatric vision This plan covers routine vision services and supplies for children up to age 19. *You must utilize participating providers.*	• Routine eye exam limit: 1 per calendar year. • Provider-selected frames limit: 1 per calendar year.	• 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, 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 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.	• 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.

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

The annual out-of-pocket maximum includes your annual deductible, copayments 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 the maximum allowable amount (MAA) for out-of-network (OON) services. You are still responsible for OON-billed charges that exceed MAA.

For naturopathic care, call American Specialty Health, Inc. (ASH) at 1-800-678-9133.

Telehealth 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.

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.

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

Behavioral Health benefits are administered by MHN. For mental health or chemical dependency services, call MHN at 1-800-977-8216.

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). Visit Health Net at www.healthnetoregon.com to view Oregon Essential Rx Drug List.

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.

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.