



2022

 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										
LX20-500-2-4000	\$500 / \$1,000	\$4,000 / \$8,000	\$20 / \$40	20% / 40%	\$20	20% ⁴	20%	20% / 10%	\$250 + 20%	\$50
LX25-1000-2-5000	\$1,000 / \$2,000	\$5,000 / \$10,000	\$25 / \$50	20% / 40%	\$20	20% ⁴	20%	20% / 10%	\$250 + 20%	\$50
Advantage PPO										
A10-0-2-4000	\$0 / \$0	\$4,000 / \$8,000	\$10 / \$20	20% / 40%	\$20	20%	20%	20% / 10%	\$250 + 20%	\$50
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
A20-1000-2-5000	\$1,000 / \$2,000	\$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
Value PPO										
V20-500-2-4000	\$500 / \$1,000	\$4,000 / \$8,000	\$20 / \$40	20% / 40%	20%	20%	20%	20% / 10%	20%	\$50
V25-1000-2-5000	\$1,000 / \$2,000	\$5,000 / \$10,000	\$25 / \$50	20% / 40%	20%	20%	20%	20% / 10%	20%	\$50
V30-2000-2-6000	\$2,000 / \$4,000	\$6,000 / \$12,000	\$30 / \$60	20% / 40%	20%	20%	20%	20% / 10%	20%	\$50
V35-4000-2-7350	\$4,000 / \$8,000	\$7,350 / \$14,700	\$35 / \$70	20% / 40%	20%	20%	20%	20% / 10%	20%	\$50
V35-5000-2-7350	\$5,000 / \$10,000	\$7,350 / \$14,700	\$35 / \$70	20% / 40%	20%	20%	20%	20% / 10%	20%	\$50
V40-6000-2-8150	\$6,000 / \$12,000	\$8,150 / \$16,300	\$40 / \$80	20% / 40%	20%	20%	20%	20% / 10%	20%	\$50
Essentials PPO										
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
E50-3000-5-7350	\$3,000 / \$6,000	\$7,350 / \$14,700	\$50 / \$100	50% / 50%	50%	50%	50%	50% / 40%	50%	\$50
E35-4000-2-7350	\$4,000 / \$8,000	\$7,350 / \$14,700	\$35 / \$70	20% / 40%	20%	20%	20%	20% / 10%	20%	\$50
E35-5000-2-7350	\$5,000 / \$10,000	\$7,350 / \$14,700	\$35 / \$70	20% / 40%	20%	20%	20%	20% / 10%	20%	\$50
E50-5000-5-7350	\$5,000 / \$10,000	\$7,350 / \$14,700	\$50 / \$100	50% / 50%	50%	50%	50%	50% / 40%	50%	\$50
E35-6000-2-7350	\$6,000 / \$12,000	\$7,350 / \$14,700	\$35 / \$70	20% / 40%	20%	20%	20%	20% / 10%	20%	\$50
E50-6000-5-8150	\$6,000 / \$12,000	\$8,150 / \$16,300	\$50 / \$100	50% / 50%	50%	50%	50%	50% / 40%	50%	\$50
E5000-3-7350	\$5,000 / \$10,000	\$7,350 / \$14,700	30% / 30%	30% / 50%	30%	30%	30%	30% / 20%	30%	30%
E5000-5-7350	\$5,000 / \$10,000	\$7,350 / \$14,700	50% / 50%	50% / 50%	50%	50%	50%	50% / 40%	50%	50%
E6000-5-8150	\$6,000 / \$12,000	\$8,150 / \$16,300	50% / 50%	50% / 50%	50%	50%	50%	50% / 40%	50%	50%
E7000-3-8150	\$7,000 / \$14,000	\$8,150 / \$16,300	30% / 30%	30% / 50%	30%	30%	30%	30% / 20%	30%	30%
E7000-5-8150	\$7,000 / \$14,000	\$8,150 / \$16,300	50% / 50%	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


(continued)

2022

 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
FE50-5000-5-7350	\$5,000 / \$10,000	\$7,350 / \$14,700	\$50 / \$100	50% / 50%	50%	50%	50%	50% / 40%	50%	50%
FE5000-3-8150	\$5,000 / \$10,000	\$8,150 / \$16,300	30% / 30%	30% / 50%	30%	30%	30%	30% / 20%	30%	30%
FE50/50-3500	\$0 / \$0	\$3,500 / \$7,000	50% / 50%	50% / 50%	50%	50%	50%	50% / 40%	50%	50%
FE50/50-5000	\$0 / \$0	\$5,000 / \$10,000	50% / 50%	50% / 50%	50%	50%	50%	50% / 40%	50%	50%
PPO Fifty-Fifty										
50/50-2500	\$0 / \$0	\$2,500 / \$5,000	50% / 50%	50% / 50%	50%	50%	50%	50% / 40%	50%	50%
50/50-3500	\$0 / \$0	\$3,500 / \$7,000	50% / 50%	50% / 50%	50%	50%	50%	50% / 40%	50%	50%
50/50-5000	\$0 / \$0	\$5,000 / \$10,000	50% / 50%	50% / 50%	50%	50%	50%	50% / 40%	50%	50%
Primary Advantage PPO										
PA0-0-4-2500	\$0 / \$0	\$2,500 / \$5,000	\$0 / \$25	40% / 50%	\$0	40%	40%	40% / 30%	\$300	\$25
PA0-500-4-5000	\$500 / \$1,000	\$5,000 / \$10,000	\$0 / \$50	40% / 50%	\$0	40%	40%	40% / 30%	\$300	\$50
PA0-1000-4-5000	\$1,000 / \$2,000	\$5,000 / \$10,000	\$0 / \$70	40% / 50%	\$0	40%	40%	40% / 30%	40%	\$70
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
CommunityCare 1T										
CC1T10-0-2-4500DX	\$0 / \$0	\$4,500 / \$9,000	\$10 / \$50	20% / NA	20%	20%	20%	20% / 10%	\$250 + 20%	\$50
CC1T10-500-2-4500DX	\$500 / \$1,000	\$4,500 / \$9,000	\$10 / \$50	20% / NA	20%	20%	20%	20% / 10%	\$250 + 20%	\$50
CC1T10-750-2-5500DX	\$750 / \$1,500	\$5,500 / \$11,000	\$10 / \$50	20% / NA	20%	20%	20%	20% / 10%	\$250 + 20%	\$50
CC1T15-1000-2-5500DX	\$1,000 / \$2,000	\$5,500 / \$11,000	\$15 / \$55	20% / NA	20%	20%	20%	20% / 10%	\$250 + 20%	\$55
CC1T15-1000-3-5500ES	\$1,000 / \$2,000	\$5,500 / \$11,000	\$15 / \$55	30% / NA	30%	30%	30%	30% / 20%	\$250 + 30%	\$55
CC1T10-1500-2-5500DX	\$1,500 / \$3,000	\$5,500 / \$11,000	\$10 / \$50	20% / NA	20%	20%	20%	20% / 10%	\$250 + 20%	\$50
CC1T20-2000-2-6000DX	\$2,000 / \$4,000	\$6,000 / \$12,000	\$20 / \$60	20% / NA	20%	20%	20%	20% / 10%	\$250 + 20%	\$60
CC1T20-2000-3-6000ES	\$2,000 / \$4,000	\$6,000 / \$12,000	\$20 / \$60	30% / NA	30%	30%	30%	30% / 20%	\$250 + 30%	\$60
CC1T25-3000-2-7350DX	\$3,000 / \$6,000	\$7,350 / \$14,700	\$25 / \$65	20% / NA	20%	20%	20%	20% / 10%	\$250 + 20%	\$65
CC1T25-3000-3-7350ES	\$3,000 / \$6,000	\$7,350 / \$14,700	\$25 / \$65	30% / NA	30%	30%	30%	30% / 20%	\$250 + 30%	\$65
CC1T35-3000-3-7350ES	\$3,000 / \$6,000	\$7,350 / \$14,700	\$35 / \$75	30% / NA	30%	30%	30%	30% / 20%	\$250 + 30%	\$75
CC1T35-5000-3-7350ES	\$5,000 / \$10,000	\$7,350 / \$14,700	\$35 / \$75	30% / NA	30%	30%	30%	30% / 20%	\$250 + 30%	\$75
CC1T50-5000-3-7350ES	\$5,000 / \$10,000	\$7,350 / \$14,700	\$50 / \$100	30% / NA	30%	30%	30%	30% / 20%	\$250 + 30%	\$100
CC1T50-7000-3-8150ES	\$7,000 / \$14,000	\$8,150 / \$16,300	\$50 / \$100	30% / NA	30%	30%	30%	30% / 20%	\$250 + 30%	\$100
CommunityCare 3T										
CC3T10-0-2-4500DX	\$0 / \$0	\$4,500 / \$9,000	\$10 / \$50	20% / 40%	20%	20%	20%	20% / 10%	\$250 + 20%	\$50
CC3T10-500-2-4500DX	\$500 / \$1,000	\$4,500 / \$9,000	\$10 / \$50	20% / 40%	20%	20%	20%	20% / 10%	\$250 + 20%	\$50
CC3T10-750-2-5500DX	\$750 / \$1,500	\$5,500 / \$11,000	\$10 / \$50	20% / 40%	20%	20%	20%	20% / 10%	\$250 + 20%	\$50
CC3T15-1000-2-5500DX	\$1,000 / \$2,000	\$5,500 / \$11,000	\$15 / \$55	20% / 40%	20%	20%	20%	20% / 10%	\$250 + 20%	\$55
CC3T15-1000-3-5500ES	\$1,000 / \$2,000	\$5,500 / \$11,000	\$15 / \$55	30% / 50%	30%	30%	30%	30% / 20%	\$250 + 30%	\$55
CC3T10-1500-2-5500DX	\$1,500 / \$3,000	\$5,500 / \$11,000	\$10 / \$50	20% / 40%	20%	20%	20%	20% / 10%	\$250 + 20%	\$50
CC3T20-2000-2-6000DX	\$2,000 / \$4,000	\$6,000 / \$12,000	\$20 / \$60	20% / 40%	20%	20%	20%	20% / 10%	\$250 + 20%	\$60
CC3T20-2000-3-6000ES	\$2,000 / \$4,000	\$6,000 / \$12,000	\$20 / \$60	30% / 50%	30%	30%	30%	30% / 20%	\$250 + 30%	\$60
CC3T25-3000-2-7350DX	\$3,000 / \$6,000	\$7,350 / \$14,700	\$25 / \$65	20% / 40%	20%	20%	20%	20% / 10%	\$250 + 20%	\$65
CC3T25-3000-3-7350ES	\$3,000 / \$6,000	\$7,350 / \$14,700	\$25 / \$65	30% / 50%	30%	30%	30%	30% / 20%	\$250 + 30%	\$65
CC3T35-3000-3-7350ES	\$3,000 / \$6,000	\$7,350 / \$14,700	\$35 / \$75	30% / 50%	30%	30%	30%	30% / 20%	\$250 + 30%	\$75
CC3T35-5000-3-7350ES	\$5,000 / \$10,000	\$7,350 / \$14,700	\$35 / \$75	30% / 50%	30%	30%	30%	30% / 20%	\$250 + 30%	\$75
CC3T50-5000-3-7350ES	\$5,000 / \$10,000	\$7,350 / \$14,700	\$50 / \$100	30% / 50%	30%	30%	30%	30% / 20%	\$250 + 30%	\$100
CC3T50-7000-3-8150ES	\$7,000 / \$14,000	\$8,150 / \$16,300	\$50 / \$100	30% / 50%	30%	30%	30%	30% / 20%	\$250 + 30%	\$100

(continued)


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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
CommunityCare 1T HDHP5										
CC1T25-3000-2-6600-HD80	\$3,000 / \$6,000	\$6,600 / \$13,200	\$25 / \$65	20% / NA	20%	20%	20%	20% / 10%	\$250 + 20%	\$65
CC1T35-3000-3-6750-HD70	\$3,000 / \$6,000	\$6,750 / \$13,500	\$35 / \$75	30% / NA	30%	30%	30%	30% / 20%	\$250 + 30%	\$75
CC1T35-5000-2-6600-HD80	\$5,000 / \$10,000	\$6,600 / \$13,200	\$35 / \$75	20% / NA	20%	20%	20%	20% / 10%	\$250 + 20%	\$75
CC1T35-5000-3-6600-HD70	\$5,000 / \$10,000	\$6,600 / \$13,200	\$35 / \$75	30% / NA	30%	30%	30%	30% / 20%	\$250 + 30%	\$75
CommunityCare 3T HDHP5										
CC3T25-3000-2-6600-HD80	\$3,000 / \$6,000	\$6,600 / \$13,200	\$25 / \$65	20% / 40%	20%	20%	20%	20% / 10%	\$250 + 20%	\$65
CC3T25-3000-3-6600-HD70	\$3,000 / \$6,000	\$6,600 / \$13,200	\$25 / \$65	30% / 50%	30%	30%	30%	30% / 20%	\$250 + 30%	\$65
CC3T35-5000-2-6600-HD80	\$5,000 / \$10,000	\$6,600 / \$13,200	\$35 / \$75	20% / 40%	20%	20%	20%	20% / 10%	\$250 + 20%	\$75
CC3T35-5000-3-6600-HD70	\$5,000 / \$10,000	\$6,600 / \$13,200	\$35 / \$75	30% / 50%	30%	30%	30%	30% / 20%	\$250 + 30%	\$75
PPO HDHP5										
HDE28008060 w/HD80	\$2,800 / \$5,600	\$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%
HD300010060 w/HD100	\$3,000 / \$6,000	\$3,000 / \$6,000	0%	0% / 40%	0%	0%	0%	0%	0%	0%
HDE650010060 w/HD100	\$6,500 / \$13,000	\$6,500 / \$13,000	0%	0% / 40%	0%	0%	0%	0%	0%	0%

Alternative Care plans

Alternative Care ⁶ 	Member pays			
	Chiropractic office visit (visit are unlimited)	Acupuncture office visit (visit limits apply)	Massage Therapy office visit (visit limits apply)	Out-of-network
Base	\$15	\$15 (24 visits)	\$25 (18 visits)	Not covered
Buy-Up 1 w/OON	\$15	\$15 (24 visits)	\$25 (18 visits)	20%
Buy-Up 2	\$15	\$15 (36 visits)	\$25 (27 visits)	Not covered
Buy-Up 3 w/OON	\$15	\$15 (36 visits)	\$25 (27 visits)	20%

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	12 / Not covered / Not covered

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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%

Pharmacy plans⁸

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%
CommunityCare and PPO HDHP Rx⁵ (No MAC)					
HD70	30%	30%	30%	Yes	30%
HD80	20%	20%	20%	Yes	20%
HD100	0%	0%	0%	Yes	0%

(continued)

2022

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 Coinsurance is subject to the annual deductible.

4 Deductible is waived.

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

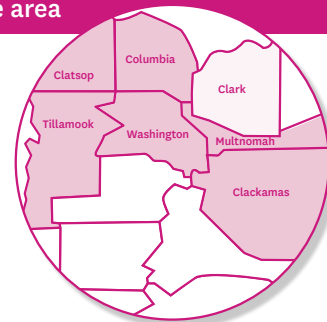
6 All copayments accumulate to the medical out-of-pocket maximum.

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

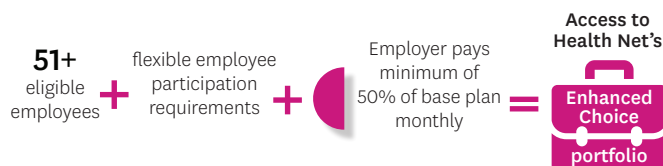
8 Prescription drug tiers are Tier 1: Generic; Tier 2: Brand Preferred; Tier 3: Non-Preferred; SP: Specialty. Retail pharmacy – members may receive a 90-day fill at a retail pharmacy; one copayment coinsurance applies per 30-day supply. Tier 1, 2 or 3 prescription drugs may apply. Deductible waived unless 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 Oregon Essential RX Drug List.

CommunityCare coverage area

- Employer groups must be located in Multnomah, Clackamas, Washington, Clatsop, Columbia, and Tillamook counties.
- Employees must live in Multnomah, Clackamas, Washington, Clatsop, Columbia, and Tillamook counties, and Clark County, WA.



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.

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