



2022 PNMG Provider Health Plan - HDHP				Comments/Explanations
AH (see definition below); includes UC Davis Health (includes Medical Staff (M)) Tier 1	California Foundation for Medical Care (CFMC) providers (and First Health PPO providers and facilities when outside of California only); No Tier 2 facility coverage in California, except for Valley Children's Hospital Tier 2	Out-of-Network (coverage for California providers/facilities only, except for emergency services, air ambulances, urgent care, and Covid testing/vaccination) Tier 3	<p>(M) = Must be either (i) medical staff of Adventist Health, Rideout Health, Adventist Health Mendocino Coast, LLMUC, or LLUMC-Murrieta and participate in the Incentive Health IPA Tier 1 or the CFMC PPO network (i.e., Incentive Health IPA Tier 2); or (ii) a member of UC Davis Medical Group, or a physician or professional provider that has contracted with UC Davis Health to provide services under this Plan</p> <p>* Fixed dollar co-payments apply to annual out-of-pocket maximums. Fixed dollar co-payments apply PER visit/admission/occurrence. Deductible Applies to All Services/Supplies, except preventive care and COVID-19 treatment.</p>	
Deductible (applies first -before OOP)	Individual: \$2,250 Family: \$2,800 per individual/\$4,500 Family Maximum			If you have family coverage, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the family deductible. Pharmacy and medical have a combined deductible.
Out-of-pocket for medical & pharmacy (applies after deductible)	Individual max: \$3,500 Family max: \$7,000	Individual max: \$6,000 Family max: \$12,000	Pharmacy and medical have combined out-of-pocket limits.	
Facility/Ambulatory Services				
Inpatient Hospital Services	100%	80%	80%	
Outpatient Hospital Services Outpatient Surgery and Invasive Diagnostic Procedures (Facility charges) Routine Lab and Diagnostic Imaging (X-ray, Ultrasound, Mammography) Other Imaging (DEXA, MRI, MRA, CT, PET and Nuclear Medicine) Radiation Oncology Services	100%	80%	80%	
Rehabilitation Services Inpatient (PT/OT/Speech)	100%	80%	80%	
Rehabilitation Services Outpatient (PT/OT/Speech)	100% AH Facility \$20 Co-pay* - Physicians	100% \$30 Co-pay*	100% \$30 Co-pay*	
Outpatient Diabetic Instruction (Facility Based)	100%	80%	80%	Utilization review required for visits in excess of 10 visits for newly diagnosed members and 2 follow up visits per calendar year.
Maternity Hospital Care	100%	80%	80%	
Bariatric Management Program Bariatric Surgery	100%	n/a	n/a	AH facilities (see below) that are MBSAQIP (Metabolics and Bariatric Surgery Accreditation Quality Improvement Program) accredited, and select AH facilities that are in the process of seeking their MBSAQIP accreditation and have met the plan administrator's criteria for offering bariatric surgery to Plan enrollees. (Contact Benefits Administration for a list of such facilities.) Coverage is subject to criteria. Benefits discussed further in the Bariatric Surgery section of the Benefits Description chapter. \$500 co-payment will apply to a second bariatric surgery.
Preventive Health Care (Wellness)				
Preventive Health: Hospital Services	100%	100%	80%	Deductible does not apply to Preventive Health Care. Benefits discussed further in the Preventive Health Care section of the Benefits Description chapter.

Preventive Health: Provider Services	100%	100%	100%	Deductible does not apply to Preventive Health Care.
CHIP (Complete Health Improvement Program)	100%	100%	100%	Lifetime maximum of two (2) programs -- with physician's prescription only. Member will pay program costs and the Plan will reimburse member upon completion of 80% of the sessions with proof of attendance attached to the medical claim form. Deductible does not apply to Preventive Health Care. Benefits discussed further in the Preventive Health Care section of the Benefits Description chapter. The Complete Health Improvement Program ("CHIP") takes participants through an intensive educational program with 18 sessions running over three months. While the program includes some additional elements, such as blood draws and health risk assessments, the primary purpose of the program is health education. The program is run as an all-inclusive package and is billed to the Plan and to enrollees as such.
Weight Watchers	100%	100%	100%	Lifetime maximum of 24 months. This program covers group meetings. Physician's prescription is required with the submission of the first month's claim. Member will pay monthly program costs to Weight Watchers. Then the health plan will reimburse 100% of program fees upon completion of 80% of the sessions with proof of attendance attached to each claim submitted monthly. (This benefit excludes online and Weight Watchers for diabetes.)
Physician/Provider Services				
Physician Office Visits Primary Care Physician, Specialists	100% \$20 Co-pay*	100% \$30 Co-pay*	100% \$30 Co-pay*	
Physician Visits Physician Visits While Hospitalized	100%	80%	60%	
Surgeon/Assistant Surgeon	100%	80%	60%	
Outpatient Diabetic Instruction	100%	80%	60%	Utilization review required for visits in excess of 10 visits for newly diagnosed members and 2 follow up visits per calendar year.
Home Visit	100%	80%	60%	
Physician Services - Inpatient/ Outpatient/ Hospital / Mental Health Facility - Assigned per contract	100%	80%	60%	e.g., Pathology, anesthesiology, radiology, and hospitalist service if performed in a facility
Physician Services - Other (non-office visits such as minor surgery, x-rays, labs)	AH Clinics 100% Lab and X-ray only 90%	80%	60%	AH Clinics = Adventist Health Physician Services entity and AH Tax Ids - Applies to labs and x-ray services only. Covered services rendered by Myriad Genetic Laboratories will be covered at the "Tier 2" level.
Second and Third Surgical Opinion	100%	80%	60%	
Maternity Fees/Provider	100%	80%	60%	Deductible does not apply for routine prenatal care classified as preventive care, to the extent allowable by federal law.
Provider administered medications (injections, infusions, chemotherapy - office)	100%	80%	60%	
Vision Therapy	100%	100% \$30 Co-Pay*	100% \$30 Co-pay*	12 visits annual individual maximum for ages eighteen and younger.
E-Visits & Telehealth	\$5 Co-Pay* AHOnDemand	\$30 Co-Pay*	\$30 Co-Pay*	Benefits include telehealth group sessions or family therapy sessions for a mental health condition and/or substance abuse.
Outpatient Chemotherapy (Provider's Office)	100%	80%	60%	
Emergency Care				
Emergency Care: Emergency Services	100% \$100 Co-Pay*	100% \$100 Co-Pay*	100% \$100 Co-Pay*	*Emergency room co-pay waived if admitted.
Emergent In-Patient Hospital Admission	75% / 100%	75% / 100%	75% / 100%	The 'Plan Pays' percentage for Emergent In-Patient Hospital Admission will be increased from 75% to 100% if you or the health care provider notify the Plan within two (2) business days of your hospital admission. (See "Health Care Management Program" section for more detail.)
Ambulance (Ground)	80% after \$50 Co-Pay*	80% after \$50 Co- Pay*	80% after \$50 Co- Pay*	
Ambulance (Air)	80% after \$200 Co-Pay*	80% after \$200 Co-Pay*	80% after \$200 Co-Pay*	

Urgent Care	100% \$20 Co-Pay*	100% \$30 Co-Pay*	100% \$30 Co-Pay*	
Mental Health				
Mental Health and Chemical Dependency (Facility) Inpatient	100%	80%	80%	
Mental Health and Chemical Dependency (Facility) Outpatient	100%	80%	60%	
Mental Health and Chemical Dependency (Facility) Residential	100%	80%	60%	
Mental Health and Chemical Dependency Office Visit	100% \$20 Co-pay *	100% \$30 Co-pay *	100% \$30 Co-pay *	Benefits include telehealth group sessions or family therapy sessions for a mental health condition and/or substance abuse.
Other Services				
Sterilization Procedures: Vasectomy/Tubal Ligation	100%	80%	80%	
Skilled Nursing Facility Care	100%	80%	80%	100 day annual maximum
Hospice Care	100%	80%	80%	Benefits include bereavement counseling for covered family members. Refer to plan guidelines.
Home Health Care	100%	80%	60%	
Home Infusion Therapy	100%	80%	60%	
Durable Medical Equipment	100%	80%	60%	Benefits include purchase or rental, not to exceed the purchase price of the equipment. Requires utilization review for equipment of ≥ \$2,000. Exception: CPM devices, and Dynasplints always require prior authorization.
Supplies and Appliances	100%	80%	60%	
Diabetic Supplies	100%	80%	60%	When applicable, diabetic supplies will be covered by pharmacy benefit.
Prosthetics and Orthotics	100%	80%	60%	Please refer to Durable Medical Equipment, Supplies, and Appliances section of the SPD.
Hearing Aid and Exam	100%	80%	60%	Limited to \$5,000 for one ear and \$10,000 for two ears every two years. Hearing aids may be obtained from outside vendors, such as warehouse stores, etc.
Wigs due to Chemotherapy, Radiation therapy and Pathological Change	100%	100%	100%	
Disposable Supplies (provided in a Physician's office)	100%	80%	60%	
Nutritional Counseling	100% \$0 Co-Pay*	100% \$30 Co-Pay*	100% \$30 Co-Pay*	Five visit annual limit applies to all plans. Additional visits may be authorized through care management.
Chiropractic	100% \$20 Co-pay	100% \$30 Co-pay	100% \$30 Co-pay	\$1,000 individual annual maximum
Pharmacy				
Pharmacy	See "Pharmacy" (Next Page)			
All Other Covered Medical Expenses				
All Other Covered Medical Expenses	100%	80%	60%	Physician services only

Note:

AH -- Any Adventist Health Facility or Adventist Health Provider. AH Facility generally means Adventist Health, LLUMC, LLUMC-Murrieta, Adventist Health Mendocino Coast, facilities owned by Rideout Health and UC Davis Health, and (except for bariatric surgery coverage) any other Incentive Health IPA Tier 1 Facility, but see SPD for details.

Pharmacy - HDHP

2022			
Pharmacy and Medical have a combined deductible and maximum out-of-pocket. ^{1,5} Deductible: Individual \$2,250 Family Deductible: \$2,800 per individual, \$4,500 family max Out-of-pocket Max - Tier One & Tier Two: Individual \$3,500, Family \$7,000 Out-of-pocket Max - Tier Three: Individual \$6,000, Family \$12,000			
	Tier 1 GENERIC	Tier 2 PREFERRED BRAND ²	Tier 3 NON-PREFERRED BRAND ²
Retail 1-90 Day Supply			
OPTUM RETAIL NETWORK 3 (co-pay applies for each 30-day supply)	\$10	\$25	\$40
Home Delivery 31-90 Day Supply			
OPTUM HOME DELIVERY ³	\$20	\$50	\$80
Specialty 1-30 Day Supply			
OPTUM SPECIALTY PHARMACY ⁴	30%; \$250 Max	30%; \$250 Max	30%; \$250 Max

Notes:

1. Deductible waived for drugs classified as preventive care drugs (including certain drugs for chronic conditions, to the extent allowable by federal law). Deductible also waived for drugs used for the treatment of COVID-19 during the COVID-19 pandemic.
2. If a generic version of the drug is available but you use the brand drug, you will be responsible for the cost difference between the brand and generic drug in addition to the applicable copayment for the brand drug. This “brand-over-generic fee” does not contribute to your out-of-pocket maximum. This fee may be waived when (i) you have tried and failed the generic drug option, and (ii) you have received prior authorization to use the brand version of the drug.
3. The Pharmacy Benefit Manager is OptumRX. When using a Pharmacy Benefit Manager pharmacy, you may pay less than the above-listed copayment because the maximum you will be charged is the lesser of (1) the above-listed copayment (plus any applicable brand-over-generic fee), (2) the contractual rate the Plan pays for the medication, or (3) the pharmacy’s retail price.
4. Refer to the OptumRX formulary for identification of specialty medications by logging onto the OptumRx portal at www.optumrx.com. Specialty medications must be filled at Optum Specialty Pharmacy.
5. Pharmacy products that are Plan exclusions or carveouts do not contribute to the pharmacy out-of-pocket maximum. Some examples of products that are not covered by the Plan are abortifacients, cosmetic medications, hair growth agents, homeopathic medications, fertility agents, vitamins, fluoride products, over-the-counter (OTC) medications, OTC equivalents, medical foods and non-FDA approved medications. Continuous glucose monitors (CGMs) are carved out of the pharmacy benefit, but are available through the medical benefit durable medical equipment benefit. Please refer to the “General Exclusions” chapter of the SPD for additional Plan exclusions.