	2024 **Engaged! Plan** Non-California Members		Comments/Explanations
	AH (includes OHSU Health Network & Medical Staff (M))	**PPO**	**(M) = Must be medical staff and participate in PPO** **(D) = Deductible Applies** *** Fixed dollar co-payments apply to annual out-of-pocket maximums. Fixed dollar co-payments apply PER visit/admission/occurrence.**
Deductible (applies first -before OOP)	$0	$500- per individual	Common deductible and out-of-pocket. An additional deductible applies for each enrollee you cover, except as limited by the Plan's Medical out-of-pocket maximum.
Out-of-pocket for medical (applies after deductible)	Individual max: $1,700 Family max: $5,100		Common deductible and out-of-pocket. Max OOP of Medical and Pharmacy***:

	Individual Max	Family Max
Medical OOP Max:	$1,700	$5,100
Pharmacy OOP Max:	$3,700	$4,500
Total OOP Max:	**$5,400**	**$9,600**

Facility/Ambulatory Services			
Inpatient Hospital Services	100%	0%**	**80% PPO for (i) covered employees whose primary worksite is outside of Oregon (and their covered dependents), and (ii) for Western Health Resources covered employees (and their covered dependents) with no assigned AH facility.
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%	0%**	**80% PPO for (i) covered employees whose primary worksite is outside of Oregon (and their covered dependents), and (ii) for Western Health Resources covered employees (and their covered dependents) with no assigned AH facility.
Habilitation/Rehabilitation Services Inpatient (PT/OT/Speech)	100%	0%**	If no inpatient rehabilitation at *AH facility* , AH coverage will apply at PPO level. **80% PPO for (i) covered employees whose primary worksite is outside of Oregon (and their covered dependents), and (ii) for Western Health Resources covered employees (and their covered dependents) with no assigned AH facility.
Habilitation/Rehabilitation Services Outpatient (PT/OT/Speech)	100% AH Facility & AH Clinics $20 Co-pay* - Physicians	100% $30 Co-pay*	If no outpatient rehabilitation at *AH facility* , AH co-pay will apply at PPO level.
Outpatient Diabetic Instruction (Facility Based)	100%	0%**	Utilization review required for visits in excess of 10 visits per calendar year. **80% PPO for (i) covered employees whose primary worksite is outside of Oregon (and their covered dependents), and (ii) for Western Health Resources covered employees (and their covered dependents) with no assigned AH facility.
Maternity Hospital Care	100%	0%**	**80% PPO coverage for Western Health Resources *covered employees* (and their *covered dependents*) with no assigned *AH facility* .

Bariatric Management Program Bariatric Surgery	100%	n/a	AH Facilities (defined 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. (For Adventist Health Corporate employees whose primary worksite is in Missouri and their dependents only, coverage is also available at the Bariatric Center of Kansas City.)
Preventive Health Care (Wellness)			
Preventive Health: Hospital Services	100%	0%**	**100% PPO for (i) covered employees whose primary worksite is outside of Oregon (and their covered dependents), and (ii) for Western Health Resources covered employees (and their covered dependents) with no assigned AH facility. Benefits discussed further in the Preventive Health Care section of the Benefits Description chapter.
Preventive Health: Provider Services	100%	100%	
Weight Watchers	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*	
Physician Visits Physician Visits While Hospitalized	100%	80%	
Surgeon/Assistant Surgeon	100%	80% (D)	
Outpatient Diabetic Instruction	100%	80% (D)	Utilization review required for visits in excess of 10 visits per calendar year.
Home Visit	100%	80%	
Physician Services - Inpatient/ Outpatient/ Hospital / Mental Health Facility - Assigned per contract	100%	80%	e.g., Pathology, anesthesiology, radiology, emergency and hospitalist service if performed in AH or PPO facility or in emergency at an out-of-network facility
Physician Services - Other (non-office visits such as minor surgery, x-rays, labs, sleep labs)	AH Clinics 100% 90% Non-AH Clinics	80% (D)	AH Clinics = Adventist Health Physician Services entity and AH Tax Ids. Covered services rendered by Myriad Genetic Laboratories will be covered at the PPO level.
Second and Third Surgical Opinion	100%	80% (D)	
Maternity Fees/Provider	100%	80% (D)	

Provider administered medications (injections, infusions, chemotherapy - office)	100%	80% (D)	
Vision Therapy	100%	$30 Co-Pay*	12 visits annual individual maximum for ages eighteen and younger.
E-Visits & Telehealth	$5 Co-Pay* AHOnDemand	$30 Co-Pay*	Benefits include telehealth group sessions or family therapy sessions for a mental health condition and/or substance abuse. $0 copayment for e-visit, telehealth, and telehealth group or family therapy sessions rendered by a Synchronous Health ("SyncTalk") mental health provider for a mental health condition and/or substance abuse.
Outpatient Chemotherapy (Provider's Office)	100%	80% (D)	
Emergency Care* **			***All emergency and urgent care includes non-PPO coverage. If services at non-PPO facility/provider, PPO co-insurance and deductible will apply.
Emergency Care: Emergency Services	100% $100 Co-Pay*	100% $100 Co-Pay*	*Emergency room co-pay waived if admitted.
Emergent In-Patient Hospital Admission	75% / 100%	75% / 100% (D)	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.
Ambulance (Ground)	80% after $50 Co-Pay*	80% after $50 Co-Pay*	If you receive a balance bill from an out-of-network ambulance provider, please contact Benefits Administration for assistance negotiating the bill.
Ambulance (Air)	80% after $200 Co-Pay*	80% after $200 Co-Pay*	
Urgent Care	100% $20 Co-Pay*	100% $30 Co-Pay*	
Mental Health			
Mental Health and Chemical Dependency (Facility) Inpatient	100%	0%**	**80% PPO for (i) covered employees whose primary worksite is outside of Oregon (and their covered dependents), and (ii) for Western Health Resources covered employees (and their covered dependents) with no assigned AH facility.
Mental Health and Chemical Dependency (Facility) Outpatient	100%	0%**	**80% PPO for (i) covered employees whose primary worksite is outside of Oregon (and their covered dependents), and (ii) for Western Health Resources covered employees (and their covered dependents) with no assigned AH facility.
Mental Health and Chemical Dependency (Facility) Residential	100%	80% (D)	
Mental Health and Chemical Dependency Office Visit	100% $20 Co-pay *	100% $30 Co-pay *	Benefits include telehealth group sessions or family therapy sessions for a mental health condition and/or substance abuse. $0 copayment for e-visit, telehealth, and telehealth group or family therapy sessions rendered by a Synchronous Health ("SyncTalk") mental health provider for a mental health condition and/or substance abuse.
Other Services			
Sterilization Procedures: Vasectomy/Tubal Ligation	100%	80% (D)	
Skilled Nursing Facility Care	100%	80% (D)	100 day annual maximum

Hospice Care	100%	80% (D)	Benefits include bereavement counseling for covered family members. Refer to plan guidelines.
Home Health Care	100%	80%	
Home Infusion Therapy	100%	80% (D)	
Durable Medical Equipment	100%	80%	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%	
Diabetic Supplies	100%	80%	When applicable, diabetic supplies will be covered by pharmacy benefit.
Prosthetics and Orthotics	100%	80% (D)	Please refer to Durable Medical Equipment, Supplies, and Appliances section of the SPD.
Hearing Aid and Exam	100%	80% (D)	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%	
Disposable Supplies (provided in a Physician's office)	100%	80%	
Nutritional Counseling	100% $0 Co-Pay* (5 Visits)	100% $30 Co-Pay* (5 Visits)	Ten visit annual limit applies to all plans. Additional visits may be authorized through care management.
Chiropractic	100% $20 Co-pay*	100% $30 Co-pay*	$1,000 individual annual maximum
Unavailable Services			
Unavailable Services	n/a	80% (D)	Only applies when PPO services are not otherwise covered (i.e., 0% coverage) and an exception has been approved by the plan administrator via an Unavailable Service Request Form. For out-of-network services approved by the plan administrator via an Unavailable Service Request Form, enrollee cost sharing will be 20% after application of deductible.
Pharmacy			
Pharmacy	**See "Pharmacy"** (Next Page)		
All Other Covered Medical Expenses			
All Other Covered Medical Expenses	100%	80% (D)	Physician services only

Note:

AH -- Any Adventist Health Facility or Adventist Health Provider. AH Facility means Adventist Health, Adventist Health Columbia Gorge, LLUMC, LLMUC-Murrieta, Adventist Health Mendocino Coast, Oregon Health & Science University and the facilities owned by Rideout Health.

***Total 2024 out-of-pocket maximum for all covered benefits cannot exceed $9,450 for self-only coverage and $18,900 for other than self-only coverage

Pharmacy - All Groups:

	2024			
	Pharmacy OOP Individual Max: $3,700 Pharmacy OOP Family Max: $4,500			
	Tier 1 Generic [1]	**Tier 2 Preferred**	**Tier 3 Brand**	
				Comments
TRADITIONAL	$17	$45	$70	•Price is per 30-day supply, up to a 90-day supply •Save $10 per 30-day supply on your copay by using an Adventist Health In-House Pharmacy •Get 3 months for the price of 2 at Adventist Health In-House Pharmacies, Community Partner Pharmacies or OptumRx Home Delivery
SPECIALTY [2]	$45	20%; $200 Max	20%; $225 Max	•Specialty medications are limited to a 30-day supply maximum •Specialty medications can only be filled at Adventist Health In-House or OptumRx Specialty Pharmacies •Save $10 on generic, $20 on brand when using and Adventist Health In-House Pharmacy

Notes:

1. Members will pay $0.00 copay for select Generic Maintenance medications when filled at in-house, community partner, or mail-order pharmacies.
2. Refer to Optum formulary for identification of specialty medications.
3 The Plan will distribute a list of Community Partner pharmacies and will publish the list on the Plan's website at AdventistHealth.org/EmployeeHealthPlan. If a pharmacy listed as a Community Partner loses its network status with the Pharmacy Benefit Manager, it will no longer qualify as a Community Partner pharmacy under the Plan.
4 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.
5 Refer to the OptumRX formulary for identification of specialty medications by logging onto the OptumRx portal at www.optumrx.com.
6 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. Please refer to the "General Exclusions" chapter for additional Plan exclusions.