The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium*) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to **AdventistHealth.org/EmployeeHealthPlan** or call **1-800-441-2524**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform** or call 1-800-441-2524 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	AH providers: no deductible. Non-AH PPO providers: $500/enrollee. Copayments don't count toward deductible.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Each enrollee must meet their own individual deductible and a separate deductible applies to each enrollee.
Are there services covered before you meet your deductible?	Yes. Preventive care, primary care office visits, hospital services, inpatient/outpatient mental health services and rehabilitation services, and certain other services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	Individual: $5,400 ($1,700 for medical benefits and $3,700 for pharmacy benefits). Family: $9,600 ($5,100 for medical benefits, $4,500 for pharmacy benefits).	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Your required premiums*, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See AdventistHealth.org/EmployeeHealthPlan or call 1-800-441-2524 for a list of network providers.	You pay the least if you use an AH provider. If covered, you will pay more if you use a Non-AH PPO provider. If covered, you will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance-billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral. (But some specialists require preauthorization.)

* **Please note that, because the plan is self-funded and not insured, the term "premiums" actually means your employee-share contribution.**

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay If You Use an AH Provider or AH In-House Pharmacy (You will pay the least)	What You Will Pay If You Use a Non-AH PPO Provider* or an OptumRX or Community Partner Pharmacy (You will pay more)	What You Will Pay If You Use an Out-of-Network Provider* (You will pay the most)	Limitations, Exceptions, & Other Important Information*
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	$30 copay/visit	Not covered	Deductible does not apply.
	Specialist visit	$20 copay/visit	$30 copay/visit	Not covered	Deductible does not apply.
	Other practitioner office visit	No charge for nutritional counseling session; no charge for vision therapy; $20 copay/chiropractor visit	$30 copay/nutritional counseling; $30 copay/vision therapy; $30 copay/chiropractor	Not covered	Deductible does not apply. 5-visit annual limit on nutritional counseling before authorization. 12-visit annual limit on vision therapy (age 18 and under). $1,000 annual chiropractic limit.
	Preventive care/ screening/ immunization	No charge	No charge	Not covered	Deductible does not apply. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Covid-19 vaccination is covered with no charge at all levels, including out-of-network.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for AH facility charges or AH Clinic lab and x-rays; 10% coinsurance for all other professional services	No coverage for PPO facility charges*; 20% coinsurance for professional services	Not covered	Deductible does not apply to AH facility charges or AH Clinic lab and x-ray services. Covid-19 testing is covered with no charge at all levels, including out-of-network. *See below for Non-AH PPO facility coverage for select enrollees.
	Imaging (CT/PET scans, MRIs)	No charge for AH facility charges or AH Clinic x-rays; 10% coinsurance for all other professional services	No coverage for PPO facility charges*; 20% coinsurance for professional services	Not covered	Preauthorization required. Deductible does not apply to AH facility charges or AH Clinic x-ray services. *See below for Non-AH PPO facility coverage for select enrollees.

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Common Medical Event	Services You May Need	What You Will Pay If You Use an AH Provider or AH In-House Pharmacy (You will pay the least)	What You Will Pay If You Use a Non-AH PPO Provider* or an OptumRX or Community Partner Pharmacy (You will pay more)	What You Will Pay If You Use an Out-of-Network Provider* (You will pay the most)	Limitations, Exceptions, & Other Important Information*
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling us at 1-800-441-2524 or OptumRX at 1-866-534-7205	Generic drugs (Tier 1)	$7 copay for 1-30-day retail supply; $14 copay for 31-90-day retail supply (no mail-order)	$17 copay for 1-30-day retail supply; $34 copay for 31-90-day retail or mail-order supply	Not covered	Preauthorization required for certain drugs. Deductible does not apply.
	Preferred brand drugs (Tier 2)	$35 copay for 1-30-day retail supply; $70 copay for 31-90-day retail supply (no mail-order)	$45 copay for 1-30-day retail supply; $90 copay for 1-90-day retail or mail-order supply	Not covered	Preauthorization required for certain drugs. Deductible does not apply. If a generic version of the drug is available but you use the brand drug, you will pay the cost difference between the brand and generic drug ("brand-over-generic fee") in addition to the applicable copayment for the brand drug, unless you have tried and failed the generic drug option and have received preauthorization to use the brand drug. The brand-over-generic fee will not be applied to your out-of-pocket maximum. Specialty drug prescriptions must be filled by Adventist Health in-house pharmacies, Community Partner pharmacies, or the Optum Specialty Pharmacy.
	Non-preferred brand drugs (Tier 3)	$60 copay for 1-30-day retail supply; $120 copay for 31-90-day retail supply (no mail-order)	$70 copay for 1-30-day retail supply; $140 copay for 31-90-day retail or mail-order supply	Not covered	
	Specialty drugs	1-30-day retail supply: $35 copay for generic; 20% coinsurance with $180/prescription maximum for preferred brand; 20% coinsurance with $205/prescription maximum for non-preferred brand	1-30-day retail supply: $45 copay for generic; 20% coinsurance with $200 maximum/ prescription for preferred brand; 20% coinsurance with $225/prescription maximum for non-preferred brand	Not covered	

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Common Medical Event	Services You May Need	What You Will Pay If You Use an AH Provider or AH In-House Pharmacy (You will pay the least)	What You Will Pay If You Use a Non-AH PPO Provider* or an OptumRX or Community Partner Pharmacy (You will pay more)	What You Will Pay If You Use an Out-of-Network Provider* (You will pay the most)	Limitations, Exceptions, & Other Important Information*
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No coverage for Non-AH PPO facility charges*	Not covered	Preauthorization required. Deductible does not apply. *See below for Non-AH PPO facility coverage for select enrollees.
	Physician/surgeon fees	No charge	20% coinsurance	Not covered	Preauthorization required. Deductible does not apply to physician visits while hospitalized, but deductible does apply to Non-AH PPO surgeons and assistant surgeons.
If you need immediate medical attention	Emergency room services	$100 copay/visit	$100 copay/visit	$100 copay/visit	Copayment waived if admitted to hospital. Deductible does not apply.
	Emergency medical transportation	20% coinsurance after $50 copay/ground transport or $200 copay/air transport	20% coinsurance after $50 copay/ground transport or $200 copay/air transport	20% coinsurance after $50 copay/ground transport or $200 copay/air transport	Deductible does not apply.
	Urgent care	$20 copay/visit	$30 copay/visit	$30 copay/visit	Deductible does not apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No coverage for Non-AH PPO facility charges*	Not covered	Preauthorization required. Deductible does not apply. Emergency hospital admission covered at all levels. *See below for Non-AH PPO facility coverage for select enrollees.
	Physician/surgeon fee	No charge	20% coinsurance	Not covered	Surgical preauthorization required. Deductible does not apply to physician visits while hospitalized, but deductible does apply to Non-AH PPO surgeons and assistant surgeons.

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Common Medical Event	Services You May Need	What You Will Pay If You Use an AH Provider or AH In-House Pharmacy (You will pay the least)	What You Will Pay If You Use a Non-AH PPO Provider* or an OptumRX or Community Partner Pharmacy (You will pay more)	What You Will Pay If You Use an Out-of-Network Provider* (You will pay the most)	Limitations, Exceptions, & Other Important Information*
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay/visit for office visits; no charge for other services	$30 copay/visit for office visits; No coverage for Non-AH PPO facility charges*	Not covered	Preauthorization required for inpatient services and some outpatient services. Deductible does not apply. *See below for Non-AH PPO facility coverage for select enrollees. Residential services covered separately.
	Mental/Behavioral health inpatient services	No charge	No coverage for Non-AH PPO facility charges*	Not covered	
	Substance use disorder outpatient services	$20 copay/visit for office visits; no charge for other services	$30 copay/visit for office visits; No coverage for Non-AH PPO facility charges*	Not covered	
	Substance use disorder inpatient services	No charge	No coverage for Non-AH PPO facility charges*	Not covered	
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance for professional services; No coverage for Non-AH PPO facility charges*	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Deductible does not apply to AH providers or to any facility services. *See below for Non-AH PPO facility coverage for select enrollees.
	Delivery and all inpatient services	No charge	No coverage for Non-AH PPO facility charges*; 20% coinsurance for professional services	Not covered	Deductible does not apply to facility charges. Preauthorization required for all non-emergency deliveries and inpatient services, except for a normal delivery in an AH facility with an AH provider. *See below for Non-AH PPO facility coverage for select enrollees.

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Common Medical Event	Services You May Need	What You Will Pay If You Use an AH Provider or AH In-House Pharmacy (You will pay the least)	What You Will Pay If You Use a Non-AH PPO Provider* or an OptumRX or Community Partner Pharmacy (You will pay more)	What You Will Pay If You Use an Out-of-Network Provider* (You will pay the most)	Limitations, Exceptions, & Other Important Information*
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Not covered	Preauthorization required. Deductible does not apply.
	Rehabilitation services	No charge for inpatient; $20 copay/outpatient visit	No coverage for Non-AH PPO facility charges*; $30 copay/outpatient visit	Not covered	Preauthorization required. Deductible does not apply. If services not available at AH facility, Non-AH PPO benefits will be covered at AH level. *See below for Non-AH PPO facility coverage for select enrollees.
	Habilitation services (referred to as occupational therapy in the Plan)	No charge for inpatient; $20 copay/outpatient visit	No coverage for Non-AH PPO facility charges*; $30 copay/outpatient visit	Not covered	
	Skilled nursing care	No charge	20% coinsurance	Not covered	Preauthorization required. 100-day annual limit. Deductible does not apply to AH providers.
	Durable medical equipment	No charge	20% coinsurance	Not covered	Preauthorization required for CPM and Dynasplints, and all charges of $2,000 or more. Deductible does not apply.
	Hospice service	No charge	20% coinsurance	Not covered	Preauthorization required. Deductible does not apply to AH providers.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered	Coverage offered under separate vision plan.
	Glasses	Not covered	Not covered	Not covered	
	Dental check-up	Not covered	Not covered	Not covered	Coverage offered under separate dental plan.

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your plan document for more information and a list of other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (except for diabetes or severe peripheral vascular disease)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery ($500 copay for second surgery)
- Chiropractic care ($1,000/enrollee annual limit)
- Hearing aids ($5,000/ear every two years)
- Weight loss programs (only with prescription; attendance requirements and lifetime maximums apply)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: OR 1-855-268-3767 healthcare.oregon.gov; MO 1-800-726-7390 insurance.mo.gov/consumers. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Customer Service, ONE Adventist Way, Roseville, CA 95661, Phone: (800) 441-2524, Fax: (916) 781-2441. Additionally, a consumer assistance program may be able to help you file your appeal. Contact: OR 1-888-877-4894 www.insurance.oregon.gov/consumer/health-insurance/health.html; MO 1-800-726-7390 insurance.mo.gov/consumers.

Does this Coverage Provide Minimum Essential Coverage? **Yes.**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? **Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-441-2524.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions (OTC drugs)	$60
The total Peg would pay is	**$70**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions (OTC drugs)	$20
The total Joe would pay is	**$220**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

THE ABOVE EXAMPLES ASSUME: ALL SERVICES AND SUPPLIES ARE RECEIVED FROM AH FACILITIES AND AH PROVIDERS WHO ARE ALSO PART OF THE PPO NETWORK; ALL PRESCRIPTION MEDICATIONS ARE RECEIVED FROM AH IN-HOUSE PHARMACIES; PRIOR AUTHORIZATION IS OBTAINED WHEN REQUIRED. NOTE THAT NON-AH PPO COST SHARING IS HIGHER (DEDUCTIBLE, COPAYMENTS, AND COINSURANCE).