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?	Individual coverage: $2,250 deductible. Family coverage: $2,800 deductible per individual, $4,500 family maximum deductible.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services and certain other limited services (if allowed by both federal law and the Plan document) 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?	Tier 1 and Tier 2 combined out-of-pocket limit: $3,500 individual, $7,000 family. Tier 3 out-of-pocket limit: $6,000 individual, $12,000 family.	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 a provider in Tier 1. If covered, you will pay more if you use a provider in Tier 2. If covered, you will pay the most if you use an out-of-network provider (Tier 3), 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 a Tier 1 Provider or an OptumRX Pharmacy (You will pay the least)	What You Will Pay If You Use a Tier 2 Provider (You will pay more)	What You Will Pay If You Use an Out-of-Network* Tier 3 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	$30 copay/visit*	
	Specialist visit	$20 copay/visit	$30 copay/visit	$30 copay/visit*	
	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	$30 copay for nutritional, vision therapy, and chiropractor*	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	No charge*	Deductible does not apply to preventive care. 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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for facility services or AH Clinic lab and x-ray services; 10% coinsurance for all other professional services	20% coinsurance	40% coinsurance for professional services; 20% coinsurance for facility services*	Preauthorization required for out-of-network facility services. (Tier 2 facility coverage within CA is limited; facility must be listed at AdventistHealth.org/EmployeeHealthPlan.) Deductible does not apply to Covid-19 testing. Covid-19 testing is covered with no charge at all tier levels.
	Imaging (CT/PET scans, MRIs)	No charge for Tier 1 facility services or AH Clinic x-rays; 10% coinsurance for all other professional services	20% coinsurance	40% coinsurance for professional services; 20% for facility services*	Preauthorization required. 20% coinsurance for (Tier 2 facility coverage within CA is limited; facility must be listed at AdventistHealth.org/ EmployeeHealthPlan.)

* **NO OUT-OF-NETWORK COVERAGE OUTSIDE OF CALIFORNIA, except for emergency services, air ambulance, urgent care, and Covid testing/ vaccination. In certain situations, out-of-network providers working in in-network facilities (both in CA and not in CA) will be covered and cost-sharing reduced to in-network levels. For more information about limitations/exceptions, see the Plan document at AdventistHealth.org/EmployeeHealthPlan.**

Common Medical Event	Services You May Need	What You Will Pay If You Use a Tier 1 Provider or an OptumRX Pharmacy (You will pay the least)	What You Will Pay If You Use a Tier 2 Provider (You will pay more)	What You Will Pay If You Use an Out-of-Network* Tier 3 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)	$10 copay for 1-30-day retail supply; $20 copay for 31-90-day mail order supply	Not covered	Not covered	Preauthorization required for certain drugs. Deductible does not apply for drugs classified as preventive care drugs (including certain drugs for chronic conditions, to the extent allowable by federal law).
	Preferred brand drugs (Tier 2)	$25 copay for 1-30-day retail supply; $50 copay for 31-90-day mail order supply	Not covered	Not covered	Preauthorization required for certain drugs. Deductible does not apply for drugs classified as preventive care drugs (including certain drugs for chronic conditions, to the extent allowable by federal law). 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 your applicable cost sharing 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 deductible or out-of-pocket maximum. Specialty drug prescriptions must be filled by the Optum Specialty Pharmacy.
	Non-preferred brand drugs (Tier 3)	$40 copay for 1-30-day retail supply; $80 copay for 31-90-day mail order supply	Not covered	Not covered	
	Specialty drugs	30% coinsurance with $250/prescription maximum	Not covered	Not covered	

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Common Medical Event	Services You May Need	What You Will Pay If You Use a Tier 1 Provider or an OptumRX Pharmacy (You will pay the least)	What You Will Pay If You Use a Tier 2 Provider (You will pay more)	What You Will Pay If You Use an Out-of-Network* Tier 3 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	20% coinsurance	20% coinsurance*	Preauthorization required. (Tier 2 facility coverage within CA is limited; facility must be listed at AdventistHealth.org/EmployeeHealthPlan.)
	Physician/surgeon fees	No charge	20% coinsurance	40% coinsurance*	Preauthorization required.
If you need immediate medical attention	Emergency room services	$100 copay/visit	$100 copay/visit	$100 copay/visit	Copayment waived if admitted to hospital.
	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	
	Urgent care	$20 copay/visit	$30 copay/visit	$30 copay/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	20% coinsurance*	Preauthorization required. (Tier 2 facility coverage within CA is limited; facility must be listed at AdventistHealth.org/EmployeeHealthPlan.)
	Physician/surgeon fee	No charge	20% coinsurance	40% coinsurance*	Surgical preauthorization required.

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Common Medical Event	Services You May Need	What You Will Pay If You Use a Tier 1 Provider or an OptumRX Pharmacy (You will pay the least)	What You Will Pay If You Use a Tier 2 Provider (You will pay more)	What You Will Pay If You Use an Out-of-Network* Tier 3 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/office visit; no charge for other services	$30 copay/office visit; 20% coinsurance for Tier 2 facility services	$30 copay/office visit; 40% coinsurance for other services*	Preauthorization required for all inpatient services and some outpatient services. (Tier 2 facility coverage within CA is limited; facility must be listed at AdventistHealth.org/ EmployeeHealthPlan.) Residential services covered separately.
	Mental/Behavioral health inpatient services	No charge	20% coinsurance	20% coinsurance*	
	Substance use disorder outpatient services	$20 copay/office visit; no charge for other services	$30 copay/office visit; 20% coinsurance for Tier 2 facility services	$30 copay/visit; 40% coinsurance for other services*	
	Substance use disorder inpatient services	No charge	20% coinsurance	20% coinsurance*	
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance	40% coinsurance*	Cost sharing does not apply for preventive services. Deductible does not apply for routine prenatal care classified as preventive care, to the extent allowable by federal law. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). (Tier 2 facility coverage within CA is limited; facility must be listed at AdventistHealth.org/ EmployeeHealthPlan.)
	Delivery and all inpatient services	No charge	20% coinsurance	20% coinsurance*	Preauthorization required for all non-emergency deliveries and inpatient services, except for a normal delivery in a Tier 1 facility with a Tier 1 provider. (Tier 2 facility coverage within CA is limited; facility must be listed at AdventistHealth.org/EmployeeHealthPlan.)

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Common Medical Event	Services You May Need	What You Will Pay If You Use a Tier 1 Provider or an OptumRX Pharmacy (You will pay the least)	What You Will Pay If You Use a Tier 2 Provider (You will pay more)	What You Will Pay If You Use an Out-of-Network* Tier 3 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	40% coinsurance*	Preauthorization required.
	Rehabilitation services	No charge for inpatient services; $20 copay/ outpatient visit	$30 copay /outpatient visit; 20% coinsurance for Tier 2 facility services	20% coinsurance for inpatient services; $30 copay/outpatient visit*	Preauthorization required. (Tier 2 facility coverage within CA is limited; facility must be listed at AdventistHealth.org/ EmployeeHealthPlan.)
	Habilitation services (referred to as occupational therapy in the Plan)	No charge for inpatient services; $20 copay/ outpatient visit	$30 copay/ outpatient visit; 20% coinsurance for Tier 2 facility services	20% coinsurance for inpatient services; $30 copay/outpatient visit*	
	Skilled nursing care	No charge	20% coinsurance	20% coinsurance*	Preauthorization required. 100-day annual limit. (Tier 2 facility coverage within CA is limited; facility must be listed at AdventistHealth.org/ EmployeeHealthPlan.)
	Durable medical equipment	No charge	20% coinsurance	40% coinsurance*	Preauthorization required for CPM and Dynasplints, and all charges of $2,000 or more.
	Hospice service	No charge	20% coinsurance	20% coinsurance*	Preauthorization required.
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.

* **NO OUT-OF-NETWORK COVERAGE OUTSIDE OF CALIFORNIA, except for emergency services, air ambulance, urgent care, and Covid testing/ vaccination. In certain situations, out-of-network providers working in in-network facilities (both in CA and not in CA) will be covered and cost-sharing reduced to in-network levels. For more information about limitations/exceptions, see the Plan document at AdventistHealth.org/EmployeeHealthPlan.**

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; and coveredca.com at 1-800-300-1506. 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 the Plan at Customer Service, ONE Adventist Way, Roseville, CA 95661, Phone: (800) 441-2524, Fax: (916) 781-2441, or contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program may be able to help you file your appeal. Contact: CA 1-888-466-2219 healthhelp.ca.gov.

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

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid (Medi-Cal), CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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	$2,250
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	$2,250
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions (OTC drugs)	$60
The total Peg would pay is	**$2,320**

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

The plan's overall deductible	$2,250
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	$2,250
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions (OTC drugs)	$20
The total Joe would pay is	**$2,670**

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

The plan's overall deductible	$2,250
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	$2,250
Copayments	$80
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,330**

THE ABOVE EXAMPLES ASSUME: ALL SERVICES AND SUPPLIES ARE RECEIVED FROM TIER 1 PROVIDERS; ALL PRESCRIPTION MEDICATIONS ARE RECEIVED FROM OPTUMRX PHARMACIES (AND VIA MAIL ORDER, WHEN AVAILABLE); PRIOR AUTHORIZATION IS OBTAINED WHEN REQUIRED. NOTE THAT TIER 2 AND OUT-OF-NETWORK (TIER 3) COST SHARING IS HIGHER (COPAYMENTS AND COINSURANCE), AND TIER 3 (OUT-OF-NETWORK) HAS A HIGHER OUT-OF-POCKET LIMIT.