



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 <u>deductible</u> ?	Individual: Tier 1: \$2,000; Tier 2: \$3,000. <u>Copayments</u> don't count toward <u>deductible</u> . Family: Tier 1: \$4,000; Tier 2: \$6,000. <u>Copayments</u> don't count toward <u>deductible</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. Each enrollee must meet their own individual <u>deductible</u> , and a separate <u>deductible</u> applies to each enrollee.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> , primary care office visits, hospital services, inpatient/outpatient mental health services and rehabilitation services, and certain other services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes.	You must meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this plan?	Individual: Tier 1: \$4,500; Tier 2: \$6,200. Family: Tier 1: \$9,000; Tier 2: \$12,400.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Your required <u>premiums</u> *, <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See AdventistHealth.org/EmployeeHealthPlan or call 1-800-441-2524 for a list of <u>network providers</u> .	You pay the least if you use a <u>provider</u> in Tier 1. If covered, you will pay more if you use a <u>provider</u> in Tier 2. If covered, you will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your plan pays (<u>balance-billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a referral. (But some specialists require <u>preauthorization</u> .)

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Adventist Health High Deductible Health Plan

Coverage Period: 01/01/2027 – 12/31/2027
Coverage for: Individual + Dependents | **Plan Type:** PPO



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 Adventist Health In-House Pharmacy (You will pay the least)	What You Will Pay If You Use a Tier 2 Provider or Medimpact or Community Partner Pharmacy (You will pay more)	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	10% coinsurance	30% coinsurance	<u>Deductible</u> does apply.
	<u>Specialist</u> visit	10% coinsurance	30% coinsurance	<u>Deductible</u> does apply.
	Other practitioner office visit	10% coinsurance for nutritional counseling; 10% coinsurance for vision therapy; 10% coinsurance for chiropractic services	30% coinsurance for nutritional counseling; 10% coinsurance for vision therapy; 30% coinsurance for chiropractic services	<u>Deductible</u> does apply. 12-visit annual limit on vision therapy (age 18 and under). \$1,000 annual chiropractic limit.
	<u>Preventive care/ screening/ immunization</u>	No charge	No charge	<u>Deductible</u> does not apply. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% coinsurance	100% coinsurance without an approved unavailable services request form ("USRF"); 20% coinsurance with an approved USRF.	<u>Preauthorization, including USRF</u> , required for Tier II and <u>out-of-network</u> facility services. <u>Deductible</u> does apply to facility charges and AH Clinic lab and x-rays services.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	100% coinsurance without an approved USRF; 20% coinsurance with an approved USRF.	<u>Preauthorization, including USRF</u> , required for Tier II and <u>out-of-network</u> facility services. <u>Deductible</u> does apply to facility charges and AH Clinic x-ray services.

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If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available by calling us at 1-800-441-2524 or Medimpact at 1-844-282-5331	Generic drugs (Tier 1)	\$7 copay for 1-30-day supply; \$14 copay for 31-90-day supply	\$17 copay for each 1-30-day retail supply, up to 90 days. \$34 copay for 31-90 day supply at Medimpact Home Delivery and Community Partner Pharmacies	<u>Preauthorization</u> required for certain drugs. <u>Deductible</u> does apply. \$0 copay for select Generic Maintenance medications used to treat asthma, depression, diabetes, heart disease/high blood pressure, and high cholesterol when filled at Adventist Health In-House pharmacies, Community Partners, or Pharmacy Benefit Manager pharmacies This table does not apply to anti-obesity medications. Refer to the Summary Plan Document for additional information.
	Preferred brand drugs (Tier 2)	\$35 copay for 1-30-day supply; \$70 copay for 31-90-day retail supply	\$45 copay for each 1-30-day retail supply, up to 90 days. \$90 copay for 31-90 day supply at Medimpact Home Delivery and Community Partner Pharmacies	<u>Preauthorization</u> required for certain drugs. <u>Deductible</u> does 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 <u>copayment</u> for the brand drug, unless you have tried and failed the generic drug option and have received <u>preauthorization</u> to use the brand drug.
	Non-preferred brand drugs (Tier 3)	\$60 copay for 1-30-day supply; \$120 copay for 31-90-day supply	\$70 copay for each 1-30-day retail supply, up to 90 days. \$140 copay for 31-90-day supply at Medimpact Home Delivery and Community Partner Pharmacies	Specialty drug prescriptions must be filled by Adventist Health In-House pharmacies or Medimpact Specialty Pharmacies. Participation in Medimpact Assist may be required for some specialty and brand-name traditional drugs. This table does not apply to anti-obesity medications. Refer to

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	Specialty drugs	1-30-day retail supply: \$35 copay for generic; 20% coinsurance with \$180/Rx maximum for preferred brand; 20% coinsurance with \$205/Rx maximum for non-preferred brand	1-30-day retail supply: \$45 copay for generic; 20% coinsurance with \$200/Rx maximum for preferred brand; 20% coinsurance with \$225/Rx maximum for non-preferred brand	the Summary Plan Document for additional information.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	100% coinsurance without an approved USRF; 20% coinsurance with an approved USRF.	<u>Preauthorization</u> , including <u>USRF</u> , required for Tier II and <u>out-of-network</u> facility services. <u>Deductible</u> does apply.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	<u>Preauthorization</u> required. <u>Deductible</u> does apply.
If you need immediate medical attention	Emergency room services	10% coinsurance	30% coinsurance	<u>Copayment</u> waived if admitted to hospital. <u>Deductible</u> does apply.
	Emergency medical transportation	30% coinsurance for ground and air transport	30% coinsurance for ground and air transport	<u>Deductible</u> does apply.
	Urgent care	10% coinsurance	30% coinsurance	<u>Deductible</u> does apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	100% coinsurance without an approved USRF; 20% coinsurance with an approved USRF	<u>Preauthorization</u> , including <u>USRF</u> , required for Tier II and <u>out-of-network</u> facility services. <u>Deductible</u> does apply.

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	Physician/surgeon fee	10% coinsurance	30% coinsurance	Surgical <u>preauthorization</u> required. <u>Deductible</u> does apply.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health and Substance use disorder outpatient services	10% coinsurance	30% coinsurance for office visits; 100% coinsurance for all other services without an approved USRF; 20% coinsurance with an approved USRF	<u>Preauthorization, including USRF</u> , required for Tier II and <u>out-of-network</u> facility services for all inpatient and some outpatient services. <u>Deductible</u> does apply. Benefits include telehealth group sessions or family therapy sessions for mental health, behavioral health, or substance abuse needs. \$0 copay for e-visit, telehealth, and telehealth group or family therapy sessions rendered by a Thriveworks mental health provider for mental health, behavioral health, or substance abuse needs. Residential services covered separately.
	Mental/Behavioral health and Substance use disorder inpatient services	10% coinsurance	100% coinsurance without an approved USRF; 20% coinsurance with an approved USRF	
If you are pregnant	Prenatal and postnatal care	10% coinsurance	100% coinsurance for hospital care without an approved USRF; 20% coinsurance for hospital care with an approved USRF; 30% coinsurance for provider fees.	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). <u>Deductible</u> does apply to Tier 1 services or to any facility services. <u>Preauthorization</u> required for all non-emergency deliveries and inpatient services, except for a normal delivery in a Tier 1 facility with a Tier 1 provider. <u>Deductible</u> does apply to facility services.
	Delivery and all inpatient services	10% coinsurance	100% coinsurance for hospital care without an approved USRF; 20% coinsurance for hospital care with an approved USRF; 30% coinsurance for provider fees.	
	Home health care	10% coinsurance	30% coinsurance	<u>Preauthorization</u> required. <u>Deductible</u> does apply.

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If you need help recovering or have other special health needs	Rehabilitation services	10% coinsurance	30% coinsurance for outpatient services; 100% coinsurance for inpatient services without an approved USRF; 20% coinsurance for inpatient services with an approved USRF.	<u>Preauthorization</u> required. <u>Deductible</u> does apply.
	Habilitation services (referred to as physical therapy, occupational therapy and speech therapy in the Plan)	10% coinsurance	30% coinsurance for outpatient services; 100% coinsurance for inpatient services without an approved USRF; 20% coinsurance for inpatient services with an approved USRF.	
	Skilled nursing care	10% coinsurance	30% coinsurance	<u>Preauthorization</u> required. 100-day annual limit. <u>Deductible</u> does apply.
	Durable medical equipment	10% coinsurance	30% coinsurance	<u>Preauthorization</u> required for CPM and Dynasplints, and all charges of \$2,000 or more. <u>Deductible</u> does apply.
	Hospice service	10% coinsurance	30% coinsurance	<u>Preauthorization</u> required. <u>Deductible</u> does apply.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Coverage offered under separate vision plan.
	Glasses	Not covered	Not covered	
	Dental check-up	Not covered	Not covered	Coverage offered under separate dental plan.

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
- Infertility treatment
- Private-duty nursing
- Cosmetic surgery
- Long-term care
- Routine eye care (Adult)
- Dental care
- Non-emergency care when traveling outside the U.S.
- 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 is a state agency that can help if you want to continue your coverage after it ends. The contact information for that agency is: CA 1-800-300-1506 coveredca.com. 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: 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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall <u>deductible</u>	\$2,000	■ The plan's overall <u>deductible</u>	\$2,000	■ The plan's overall <u>deductible</u>	\$2,000
■ <u>Specialist copayment</u>	\$0	■ <u>Specialist copayment</u>	\$0	■ <u>Specialist copayment</u>	\$0
■ Hospital (facility) <u>coinsurance</u>	10%	■ Hospital (facility) <u>coinsurance</u>	10%	■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%	■ Other <u>coinsurance</u>	10%	■ Other <u>coinsurance</u>	30%
This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)		This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$2,000	Deductibles	\$2,000	Deductibles	\$2,000
Copayments	\$0	Copayments	\$0	Copayments	\$0
Coinsurance	\$2,540	Coinsurance	\$1,120	Coinsurance	\$1,120
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions (OTC drugs)	\$60	Limits or exclusions (OTC drugs)	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$4,600	The total Joe would pay is	\$3,140	The total Mia would pay is	\$2,800

THE ABOVE EXAMPLES ASSUME: ALL SERVICES AND SUPPLIES ARE RECEIVED FROM TIER 1 PROVIDERS; ALL PRESCRIPTION MEDICATIONS ARE RECEIVED FROM AH IN-HOUSE PHARMACIES; PRIOR AUTHORIZATION IS OBTAINED WHEN REQUIRED. NOTE THAT TIER 2 AND OUT-OF-NETWORK COST SHARING IS HIGHER (DEDUCTIBLES, COPAYMENTS, AND COINSURANCE).