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 www.AscendToWholeness.org or call 1-888-276-4732. 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 1-888-276-4732 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$600/individual or $1,200/family. Copayments don't count toward deductible.	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 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?	Yes. $250/individual and $750/family for in-network dental; $500/individual and $1,500/family out-of-network dental.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out–of–pocket limit for this plan?	Individual: $7,150 ($5,600 for medical benefits and $1,550 for pharmacy benefits). Family: $14,300 ($11,200 for medical benefits, $3,100 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 www.AscendToWholeness.org or call 1-888-276-4732 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. 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 pre-certification.)

* 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 Network Provider (You will pay the least)	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	$50 copay/visit	Not covered	Deductible does not apply.
	Specialist visit	$50 copay/visit	Not covered	Deductible does not apply.
	Other practitioner office visit	Chiropractic: 50% coinsurance Diabetes Self-Management Training: 0% coinsurance	Same as network since network utilization not required for these services.	Deductible does not apply. For chiropractic benefits, participants under age 10 are not eligible. Benefits for chiropractic treatment are limited to expenses for spinal manipulation plus one office visit and x-ray per plan year. Maximum of 30 visits/year for chiropractic services. Diabetes Self-Management Training is up to 10 hours (1 hour private and 9 hours group) in the first plan year and then 2 hours in subsequent years.
	Preventive care/ screening/immunization	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	None.
If you need drugs to treat your illness or condition	Generic drugs	$10 copay/prescription for 30-day retail supply; $20 copay/prescription for 90-day mail-order supply	Not covered	Pre-certification required for some drugs. Deductible does not apply. Benefits for certain drugs subject to step therapy (must try lower cost drug prior to receiving
	Preferred (formulary) brand drugs	$50 copay/prescription for 30-day retail supply; $100 copay/prescription for 90-day mail-order supply	Not covered	

Common Medical Event	Services You May Need	What You Will Pay If You Use a Network Provider (You will pay the least)	What You Will Pay If You Use an Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
More information about prescription drug coverage is available by calling Express Scripts at 1-800-841-5396.	Non-preferred (non-formulary) brand drugs	$100 copay/prescription for 30-day retail supply; $200 copay/prescription for 90-day mail-order supply	Not covered	benefits for higher cost drug). Some maintenance drugs require use of mail order or are subject to penalty.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Pre-certification required.
	Physician/surgeon fees	20% coinsurance	Not covered	Pre-certification required.
If you need immediate medical attention	Emergency room services	20% after $200 copay/visit	20% after $200 copay/visit	Copay waived if admitted to hospital. Emergency hospital admission covered out-of-network at 20% coinsurance until patient stable for transfer.
	Emergency medical transportation	20% coinsurance.	20% coinsurance.	None.
	Urgent care	20% after $200 copay/visit	20% after $200 copay/visit	Facility fees for office visits not paid.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Pre-certification required. Emergency hospital admission covered out-of-network at 20% coinsurance until patient stable for transfer.
	Physician/surgeon fee	20% coinsurance	Not covered	Surgical pre-certification required.

Common Medical Event	Services You May Need	What You Will Pay If You Use a Network Provider (You will pay the least)	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	$50 copay/visit for office visits; 20% coinsurance for other services.	Not covered	Pre-certification required for inpatient services, intensive outpatient, partial hospitalization, and residential care.
	Mental/Behavioral health inpatient services	20% coinsurance	Not covered	
	Substance use disorder outpatient services	$50 copay/visit for office visits; 20% coinsurance for other services.	Not covered	
	Substance use disorder inpatient services	20% coinsurance	Not covered	
If you are pregnant	Prenatal and postnatal care	20% coinsurance	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Delivery and all inpatient services	20% coinsurance	Not covered	None.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Pre-certification required. Coverage limited to 120 visits/ year.
	Rehabilitation services	20% coinsurance	Not covered	Therapeutic services include physical therapy, occupational therapy, speech therapy, and vision therapy. Collectively, there is a 90-visit/year limit for all therapeutic services. There is a maximum of 60 visits/ year for any single therapeutic service. Vision therapy and any inpatient services require pre-certification.
	Habilitation services (referred to as therapeutic services in the plan)	20% coinsurance	Not covered	
	Skilled nursing care	20% coinsurance	Not covered	Pre-certification required. Coverage limited to 120 days/ year.
	Durable medical equipment	20% coinsurance	Not covered	$8,000 maximum payable per plan year. Pre-certification required for all charges above $1,500.
	Hospice service	No charge	Not covered	Pre-certification required.
If your child	Eye exam	20% coinsurance	Not covered	$225 maximum payable per plan year for vision care benefits.
	Glasses	20% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay If You Use a Network Provider (You will pay the least)	What You Will Pay If You Use an Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
needs dental or eye care	Dental check-up	No charge for preventive services; 20% coinsurance for restorative care in-network; 50% for restorative care out-of-network.	Not covered	Maximum payable per plan year for dental care is $1,250/individual and $3,750/family.

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
- Long-term care
- Non-emergency care when traveling outside the U.S.

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

- Bariatric surgery (if medically necessary)
- Chiropractic care (limitations described above)
- Dental care
- Hearing aids (maximum payable $3,200/year)
- Infertility treatment (50% coinsurance; lifetime maximum $16,000)
- Private-duty nursing (limitations described above)
- Routine eye care
- Routine foot care
- Weight loss programs (if medically necessary)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information, contact the plan at 1-888-276-4732. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For a list of state-based healthcare exchanges, see https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/state-marketplaces.html. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

* For more information about limitations and exceptions, see plan or policy document at www.AscendToWholeness.org.

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: Adventist Risk Management, P.O. Box 4288, Silver Spring, MD 20914-4288, Phone: (888) 276-4732, www.adventistrisk.org. Additionally, a consumer assistance program may be help you file your appeal. For a list of state consumer assistance programs, see https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/#statelisting.

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 888-276-4732.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-276-4732.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 888-276-4732.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 888-276-4732.

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	$600
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$600
Copayments	$40
Coinsurance	$2400
What isn't covered	
Limits or exclusions (OTC drugs)	$60
The total Peg would pay is	$3100

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

The plan's overall deductible	$600
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$600
Copayments	$1400
Coinsurance	$300
What isn't covered	
Limits or exclusions (OTC drugs)	$60
The total Joe would pay is	$2360

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

The plan's overall deductible	$600
Specialist copayment	$50
Hospital (facility) coinsurance	20%
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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1100

THE ABOVE EXAMPLES ASSUME: PPO FACILITIES AND PPO PROVIDERS; ALL PRESCRIPTION MEDICATIONS ARE RECEIVED VIA EXPRESS SCRIPTS; PRE-CERTIFICATION IS OBTAINED WHEN REQUIRED.