Health Care Assistance Plan, Seventh-day Adventist Church

Coverage Period: 01/01/2013 – 12/31/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single + Family | **Plan Type: PPO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the plan document at **www.adventistrisk.org** or by calling **1-888-276-4732**. You may also access the Uniform Glossary at www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** individual/**$500** family Doesn't apply to **in-network** preventive care services or **in-network** office visits, or to benefits for emergency services, infertility treatments, hearing aids, dental care and vision benefits.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. **Network Providers:** **$2,000** individual/**$4,000** family **Non-Network Providers:** **$4,500** individual/**$9,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Health care this plan doesn't cover, penalties for failure to follow plan rules, premiums, **balance-billing** charges, **deductibles**, **copays**, benefits for infertility treatments, refractive eye surgery, hearing aids, vision care, and prescription drugs	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.adventistrisk.org** or call **1-888-276-4732** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Questions: Call 1-888-276-4732 or visit **www.adventistrisk.org**. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or call 1-877-267-2323 ext. 61565 to request a copy.

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Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your plan document for additional information about **excluded services**.

- **Copayments (copays)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay	35% coinsurance	——————none——————
	Specialist visit	$20 copay	35% coinsurance	——————none——————
	Other practitioner office visit	Alternative therapy benefits: 20% coinsurance for acupuncture and chiropractic care 50% coinsurance for massage therapy		Benefits limited to (1) combined 45 alternative therapy visits per Plan Year and (2) 30 visits in any single alternative therapy category. Participants under age 10 are not eligible for any alternative therapy benefits. Participants under age 18 are not eligible for massage benefits. Massage therapy maximum allowable charge is $90 per visit. Benefits for chiropractic treatment are limited to expenses for spinal manipulation.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Preventive care/screening/ immunization	No charge	35 % coinsurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	35% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	35% coinsurance	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com or call 1-800-841-5396	Generic drugs	$10 copay retail $20 copay mail order/prescription		Copays cover up to a 30-day supply (retail prescription); 31- to 90-day supply (mail order prescription). Separate out-of-pocket maximums of $400 individual/$800 family for prescription drugs. Prior authorization required for certain drugs. Benefits for certain drugs subject to step-therapy (must try lower cost drugs prior to receiving benefits for higher cost drugs)
	Preferred (formulary) brand drugs	$15 copay retail $30 copay mail order/prescription		
	Non-preferred (non-formulary) brand drugs	$25 copay retail $50 copay mail order/prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	35% coinsurance	——————none——————
	Physician/surgeon fees	20% coinsurance	35% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	$50 copay plus 20% coinsurance	35% coinsurance	——————none——————
	Emergency medical transportation	20% coinsurance	35% coinsurance	——————none——————
	Urgent care	$20 copay (office visit) or $50 copay plus 20% coinsurance	35% coinsurance	In-network may be paid as office visit or as an emergency room visit, depending upon urgent care center contract. Facility fees for office visits not paid.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	35% coinsurance	Pre-certification required for non-emergency hospital stays (except for maternity services).
	Physician/surgeon fee	20% coinsurance	35% coinsurance	

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Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	$20 copay	35% coinsurance	——————none——————
	Mental/behavioral health inpatient services	20% coinsurance	35% coinsurance	Pre-certification required for hospitalization benefits except in emergency cases.
	Substance use disorder outpatient services	$20 copay	35% coinsurance	——————none——————
	Substance use disorder inpatient services	20% coinsurance	35% coinsurance	Pre-certification required for hospitalization benefits except in emergency cases.
If you are pregnant	Prenatal and postnatal care	$20 copay for office visits; all other expenses: 20% coinsurance	35% coinsurance	——————none——————
	Delivery and all inpatient services	20% coinsurance	35% coinsurance	——————none——————
If you need help recovering or have other special health needs	Home health care	20% coinsurance	35% coinsurance	Pre-certification required. Coverage limited to 52 visits per calendar year.
	Rehabilitation services	20% coinsurance	35% coinsurance	Coverage limited to 30 visits per calendar year each for physical, occupational, and speech therapy.
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	20% coinsurance	35% coinsurance	Pre-certification required. Coverage limited to 120 days per calendar year.
	Durable medical equipment	20% coinsurance	35% coinsurance	Coverage is limited to $8000 per calendar year, and charges above $500 must be pre-certified.
	Hospice service	No charge	35% coinsurance	Pre-certification required for inpatient or respite care benefits.
If your child needs dental or eye care	Eye exam	20% coinsurance		$560 maximum per calendar year for vision care benefits
	Glasses			
	Dental check-up	No charge	No charge	Plan year maximums of $3000 individual/ $9000 family for dental care

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery;
- Habilitation services;
- Long-term care;
- Non-emergency care when traveling outside the U.S.; and
- Weight-loss programs.

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture – covered with some limitations;
- Bariatric surgery –covered with some limitations;
- Chiropractic care – covered with some limitations;
- Dental care (Adult and Children) – covered with some limitations;
- Glasses – covered with some limitations;
- Hearing aids – covered with some limitations;
- Infertility treatment – covered with some limitations;
- Private-duty nursing – covered with some limitations;
- Routine eye care; and
- Routine foot care.

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, 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.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Adventist Risk Management, Member Appeals Unit, P.O. Box 4288, Silver Spring, MD 20914; or by email to healthcare@adventistrisk.org or by phone at **1-888-276-4732**.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-888-276-4732**

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-888-276-4732**

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码 1-888-276-4732**

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-888-276-4732**

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,640
- **Patient pays** $1,900

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$250
Copays	$100
Coinsurance	$1,400
Limits or exclusions	$150
Total	**$1,900**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,230
- **Patient pays** $1,170

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$250
Copays	$600
Coinsurance	$240
Limits or exclusions	$80
Total	**$1,170**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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