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, please visit www.zenith-american.com. 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 https://www.healthcare.gov/sbc-glossary/ .

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred Providers: $2,500/Individual or $5,000/family Non-Preferred Providers: $5,000/Individual, $10,000/family. Does not apply to preventive care or prescription drugs. Deductible period July 1 – June 30.	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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care and certain primary care 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?	Preferred Providers: $2,350 individual / $4,700 family Non-Preferred Providers: $4,700 individual / $9,400 family; For prescription drugs $1,500/individual or $3,000/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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, the deductible, outpatient mental/behavioral health and penalties assessed for not obtaining precertification.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a Preferred Provider?	Yes. See https://www.aetna.com/individuals-families/find-a-doctor.html or call Zenith American Solutions at 1-800-557-8701, option 1 for a list of Preferred providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. 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 permission from this plan.

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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% coinsurance	30% coinsurance in Alaska; 50% coinsurance outside Alaska	50% coinsurance non-preferred physical therapy providers; $0.00 copay Coalition Health Center.
	Specialist visit	30% coinsurance	30% coinsurance in Alaska; 50% coinsurance outside Alaska	50% coinsurance non-preferred physical therapy providers; $0.00 copay Coalition Health Center.
	Preventive care/screening/ immunization	No charge	No charge	Covered at 100% of the allowable expense, not subject to the deductible. 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)	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	10% coinsurance up to $50 per Rx	10% coinsurance up to $50 per Rx	Covers up to a 90-day supply for a retail prescription and a 31-90 day supply for a mail order prescription. If you choose a brand name medication when a generic equivalent is available, you will pay a $50 penalty in addition to the coinsurance. Specialty medications required preauthorization and are limited to a 30-day supply.
	Preferred brand drugs	30% coinsurance (20% coinsurance mail order)	30% coinsurance (20% coinsurance mail order)	
	Non-preferred brand drugs	50% coinsurance	50% coinsurance	
	Specialty drugs	$100 copayment	$100 copayment	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	None
	Physician/surgeon fees	30% coinsurance	30% coinsurance in Alaska; 50% coinsurance outside Alaska	
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance in Alaska; 50% coinsurance outside Alaska	PPO provisions apply for non-emergency services.
	Emergency medical transportation			
	Urgent care			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Precertification is required. If you do not pre-certify, and the services are medically necessary, you may be required to pay a $400 penalty. If a service is not medically necessary, it will not be covered by the Plan.
	Physician/surgeon fees	30% coinsurance	30% coinsurance in Alaska; 50% coinsurance outside Alaska	
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	30% coinsurance	30% coinsurance in Alaska; 50% coinsurance outside Alaska	Up to 30 visits; coinsurance does not apply to out-of-pocket limit.
	Mental/Behavioral health inpatient services			Up to 30 days; precertification required
	Substance use disorder outpatient services			Up to 30 visits
	Substance use disorder inpatient services			Up to 30 days; precertification required
If you are pregnant	Office visits	30% coinsurance	30% coinsurance in Alaska; 50% coinsurance outside Alaska	No less than 48 hours of inpatient care for mother and newborn following a vaginal delivery or 96 hours following a cesarean section, unless mother and physician agreed to earlier discharge.
	Childbirth/delivery professional services	30% coinsurance		
	Childbirth/delivery facility services	30% coinsurance		
If you need help recovering or have other special health needs	Home health care	30% coinsurance	30% coinsurance in Alaska; 50% coinsurance outside Alaska	Maximum 16 visits for spinal disorder and acupuncture treatment combined. 120 visit max on home health care; Precertification required for inpatient services or a penalty may apply.
	Rehabilitation services			
	Habilitation services			
	Skilled nursing care	None	None	
	Durable medical equipment	30% coinsurance	30% coinsurance in Alaska; 50% coinsurance outside Alaska	
	Hospice services	30% coinsurance	30% coinsurance in Alaska; 50% coinsurance outside Alaska	
If your child needs dental or eye care	Children's eye exam	Not covered under medical; Covered under dental and vision plans		None
	Children's glasses			
	Children's dental check-up			

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Artificial insemination or in-vitro fertilization
- Charges in excess of Allowable Expense
- Cosmetic surgery
- Custodial care in a psychiatric hospital or alcoholism treatment facility
- Dental care (adult) under medical plan; covered under the dental plan
- Experimental or Investigational treatment or procedure
- Hearing aids under the medical plan; covered under the Audio benefit
- Hospital services for non-emergency care of elective procedure incurred outside the US, unless the hospital is accredited by the Joint Commission International
- Infertility treatment
- Long-term care
- Marriage and family counseling
- Routine eye care (Adult) under the medical plan; covered under the vision plan
- Travel expenses when services are available locally
- Weight loss programs
- See the **Plan** Booklet for other exclusions

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

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Cochlear implants
- Most coverage provided outside the US (must use and accredited facility for non-emergency care)
- Non-emergency care when traveling outside the US (must use accredited facility)
- Private duty nursing (see Home Health Care and Skilled Nursing Care)
- Routine foot care

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 the Trust Office is 1-800-557-8701 or you may contact your state insurance department at 1-800-467-8725. 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 Trust Office at 1-800-557-8701.

Does this plan 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 plan meet Minimum Value Standards? 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 [1-800-557-8701]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [1-800-557-8701]
[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**[1-800-557-8701]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [1-800-557-8701]

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

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	$2,500
■ Specialist copayment	$0
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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	**$7,540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,578
Copayments	$0
Coinsurance	$772
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,410**

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

■ The plan's overall deductible	$2,500
■ Specialist copayment	$0
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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	**$5,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,191
Copayments	$0
Coinsurance	$1,159
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,405**

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

■ The plan's overall deductible	$2,500
■ Specialist copayment	$0
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,348
Copayments	$0
Coinsurance	$578
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**

Notes

Notes