



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](http://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 <a href="#">deductible</a> ?	<a href="#">Preferred Providers</a> : \$600/Individual or \$1,200/family <a href="#">Non-Preferred Providers</a> : \$1,200/Individual, \$2,400/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 <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and certain primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">Preferred Providers</a> : \$2,000 individual / \$4,000 family <a href="#">Non-Preferred Providers</a> : \$4,000 individual / \$8,000 family; For prescription drugs \$1,500/individual or \$3,000/family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billed</a> charges, health care this <a href="#">plan</a> doesn't cover, the <a href="#">deductible</a> , outpatient mental/behavioral health and penalties assessed for not obtaining precertification.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">Preferred Provider</a> ?	Yes. See <a href="https://www.aetna.com/individuals-families/find-a-doctor.html">https://www.aetna.com/individuals-families/find-a-doctor.html</a> or call Zenith American Solutions at 1-800-557-8701, option 1 for a list of <a href="#">Preferred providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without permission from this <a href="#">plan</a> .



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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> in Alaska; 40% <a href="#">coinsurance</a> outside Alaska	40% <a href="#">coinsurance</a> non-preferred physical therapy providers; \$0.00 copay Coalition Health Center.
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> in Alaska; 40% <a href="#">coinsurance</a> outside Alaska	40% <a href="#">coinsurance</a> non-preferred physical therapy providers; \$0.00 copay Coalition Health Center.
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge	Covered at 100% of the allowable expense, not subject to the <a href="#">deductible</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Generic drugs	10% <a href="#">coinsurance</a> up to \$50 per Rx	10% <a href="#">coinsurance</a> 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% <a href="#">coinsurance</a> (20% <a href="#">coinsurance</a> mail order)	30% <a href="#">coinsurance</a> (20% <a href="#">coinsurance</a> mail order)	
	Non-preferred brand drugs	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	<a href="#">Specialty drugs</a>	\$100 <a href="#">copayment</a>	\$100 <a href="#">copayment</a>	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> in Alaska; 40% <a href="#">coinsurance</a> outside Alaska	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> in Alaska; 40% <a href="#">coinsurance</a> outside Alaska	PPO provisions apply for non-emergency services.
	<a href="#">Emergency medical transportation</a>			
	<a href="#">Urgent care</a>			

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)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	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 <a href="#">Plan</a> .
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> in Alaska; 40% <a href="#">coinsurance</a> outside Alaska	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Mental/Behavioral health outpatient services	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> in Alaska; 40% <a href="#">coinsurance</a> outside Alaska	Up to 30 visits; <a href="#">coinsurance</a> does not apply to <a href="#">out-of-pocket limit</a> .
	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
<b>If you are pregnant</b>	Office visits	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> in Alaska; 40% <a href="#">coinsurance</a> 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	20% <a href="#">coinsurance</a>		
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>		
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> in Alaska; 40% <a href="#">coinsurance</a> 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.
	<a href="#">Rehabilitation services</a>			
	<a href="#">Habilitation services</a>			
	<a href="#">Skilled nursing care</a>	None	None	
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> in Alaska; 40% <a href="#">coinsurance</a> outside Alaska	
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> in Alaska; 40% <a href="#">coinsurance</a> outside Alaska	
<b>If your child needs dental or eye care</b>	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](http://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, kwijigo 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$600
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$7,540</b>
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**In this example, Peg would pay:**

Cost Sharing	
Deductibles	\$600
Copayments	\$0
Coinsurance	\$1,400
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,080</b>

**Managing Joe's type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$600
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,400</b>
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**In this example, Joe would pay:**

Cost Sharing	
Deductibles*	\$600
Copayments	\$0
Coinsurance	\$1,369
What isn't covered	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$2,024</b>

**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$600
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$1,925</b>
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**In this example, Mia would pay:**

Cost Sharing	
Deductibles*	\$600
Copayments	\$0
Coinsurance	\$385
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$985</b>