



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, log into your account at www.zenith-american.com or call 1.800-557-8701. 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 : \$600/individual or \$1,200/family Non-Preferred Providers : \$1,200/individual or, \$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 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 : \$2,000/ individual or \$4,000/ family Non-Preferred Providers : \$4,000/ individual or \$8,000/ 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 .	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 https://www.aetna.com/individuals-families/find-a-doctor.html or call Zenith American Solutions at 1-800-557-8701, option 2 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 office visits to treat an injury or illness	20% coinsurance	20% coinsurance in Alaska; 40% coinsurance outside Alaska	40% coinsurance non-preferred physical therapy providers; \$0.00 copay Coalition Health Center.
	Specialist visit	20% coinsurance	20% coinsurance in Alaska; 40% coinsurance outside Alaska	40% coinsurance non-preferred physical therapy providers; \$0.00 copay Coalition Health Center.
	Preventive care/screening/immunizations	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)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% 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 (retail & mail order)	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 (retail & mail order)	30% coinsurance (20% coinsurance mail order)	30% coinsurance (20% coinsurance mail order)	
	Non-preferred brand drugs (retail & mail order)	50% coinsurance	50% coinsurance	
	Specialty drugs	10% coinsurance up to \$200	10% coinsurance up to \$200	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None

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)	
	Physician/surgeon fees	20% coinsurance	20% coinsurance in Alaska; 40% coinsurance outside Alaska	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance in Alaska; 40% coinsurance outside Alaska	PPO provisions apply for non-emergency services.
	Emergency medical transportation			
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% 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	20% coinsurance	20% coinsurance in Alaska; 40% coinsurance outside Alaska	
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	20% coinsurance	20% coinsurance in Alaska; 40% coinsurance outside Alaska	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 .
	Mental/Behavioral health inpatient services			
	Substance use disorder outpatient services			
	Substance use disorder inpatient services			
If you are pregnant	Office visits (pre and postnatal care)	20% coinsurance	20% coinsurance in Alaska; 40% 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	20% coinsurance		
	Childbirth/delivery facility services	20% coinsurance		
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance in Alaska; 40% 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	20% coinsurance	20% coinsurance in Alaska; 40% coinsurance outside Alaska	
	Hospice services	20% coinsurance	Alaska	

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 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 exams	Not covered under medical; Covered under dental and vision plans		None

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](#).)

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| <ul style="list-style-type: none"> • Artificial insemination or in-vitro fertilization • Cellular and Gene Therapy • Charges in excess of Allowable Expense • Cosmetic surgery • Custodial care except as provided under Hospice • Dental care (adult) under medical plan; covered under the dental plan | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Chiropractic care • Cochlear implants | <ul style="list-style-type: none"> • 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) | <ul style="list-style-type: none"> • Private duty nursing (see Home Health Care and Skilled Nursing Care) • Routine foot care |
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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 those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1.866.444.3272 or www.dol.gov/ebsa, or the Center for Medicare and Medicaid Services at 1.877.267.2323, x61565 for the Health Insurance Hotline or www.cciio.cms.gov. 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 Health Trust Administrator 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 the 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 plan's overall deductible	\$600
■ Specialist coinsurance	20%
■ 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
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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
The total Peg would pay is	\$2,060

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 coinsurance	20%
■ 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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$600
Copayments	\$0
Coinsurance	\$900
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,520

Mia's Simple Fracture

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

■ The plan's overall deductible	\$600
■ Specialist coinsurance	20%
■ 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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$600
Copayments	\$0
Coinsurance	\$400
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,000