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, visit **www.zenith-american.com** or call **1-800-242-8923**. 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.cciio.cms.gov or call **1-800-242-8923** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$ 500 per person, $ 1,000 per family**	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (January 1). See the chart on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	Yes. Preventive care services (In-Network) 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, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	**$4,000 per person, $8,000 per family**	The **out-of-pocket limit** is the most you could pay during a coverage period (one year) for your share of the cost of covered services. This limit does not apply to out-of-network co-insurance expenses. This limit helps you plan for your expenses.
What is not included in the out-of-pocket limit?	• **Member contributions** • **Expenses not covered by plan**	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**. For a list of CareFirst **network providers**, see www.carefirst.com or call **1-800-235-5160.**	This plan uses the CareFirst PPO 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 may see the **specialist** you choose without permission from this plan. The **specialist** must be an in-network provider for you to receive the higher reimbursement rate.

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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	20%	50%	None
	Specialist visit	20%	50%	None
	Preventive care/screening/ immunization	0%	50%	**Women:** Mammogram – 1 for age 35-39; 1 per year for women age 40 and older. **Men:** Prostate Test – 1 for men age 40 and older.
If you have a test	Diagnostic test (x-ray, blood work)	20%	50%	None
	Imaging (CT/PET scans, MRIs)	20%	50%	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com.	Generic drugs	$0	$0	None
	Preferred brand drugs	$45	$45	If you choose brand name when generic is available, you will pay the co-pay plus any cost difference.
	Non-preferred brand drugs	$75	$75	See note above
	Specialty drugs	Excluded	Excluded	Certain drugs allowed only after STEP Therapy program. See list of exclusions in Summary Plan Description.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20%	50%	None
	Physician/surgeon fees	20%	50%	None

IMPORTANT NOTE: If you are entitled to Medicare, you must sign up for Medicare Part D and a Medicare prescription drug program in order to continue your Prescription Drug Coverage. The Plan will provide you with a subsidy to help you pay for your Medicare prescription drug program if you provide timely written documentation of having purchased such coverage. Please contact the Fund Office at 1-800-242-8923 as soon as you become Medicare eligible.

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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 need immediate medical attention	Emergency room care	20%	20%	None
	Emergency medical transportation	20%	20%	None
	Urgent care	20%	20%	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20%	50%	You or your doctor must contact American Health Holdings at 800-641-5566 in advance of hospital admission.
	Physician/surgeon fees	20%	50%	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20%	50%	None
	Inpatient services	20%	50%	None
If you are pregnant	Office visits	20%	50%	Only member or spouse – dependents are not covered.
	Childbirth/delivery professional services	20%	50%	Only member or spouse – dependents are not covered.
	Childbirth/delivery facility services	20%	50%	Only member or spouse – dependents are not covered.
If you need help recovering or have other special health needs	Home health care	20%	50%	None
	Rehabilitation services	20%	50%	None
	Habilitation services	20%	50%	None
	Skilled nursing care	20%	50%	None
	Durable medical equipment	20%	50%	Must obtain a letter of medical necessity from the treating physician
	Hospice services	20%	50%	None
	Children's eye exam	0%	100%	

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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 your child needs dental or eye care				Must use Spectera Vision Plan; one exam every 12 months
	Children's glasses	0%	100%	Must use Spectera Vison Plan; one lens every 12 months & one frame every 24 months.
	Children's dental check-up	0%	0%	Preventive

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.)

- Cosmetic surgery
- In-vitro fertilization or infertility
- Custodial or nursing home care
- Hypnotism/ Biofeedback/Stress Mgmt
- Warfare while in armed forces, attempted suicide, Self-inflicted, or Workers comp
- Orthopedic shoes
- Weight control and obesity treatments, bariatric surgery.
- Travel and lodging
- Acupuncture
- TMJ
- Speech or occupational therapy
- Repair or replacement of prosthetic
- Elective Abortion

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

- Chiropractic modalities
- Dental care – Adults and Children
- Hearing Aids
- Private duty nursing
- Routine Vision Care – Adults and Children
- Routine foot care
- Contraceptives

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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. 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. 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. For more information on your rights to continue coverage, contact the plan at 1-800-242-8923.

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 plan at 1-800-242-8923.

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 [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 [insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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	$500
Specialist copayment	$0
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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$60
Coinsurance	$2,519
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,079**

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

The plan's overall deductible	$500
Specialist copayment	$0
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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$585
Coinsurance	$685
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,770**

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

The plan's overall deductible	$500
Specialist *copayment*	$0
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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$385
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$885**

The **plan** would be responsible for the other costs of these EXAMPLE covered services. Please visit https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/index.html for details on how the above examples were calculated.