**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, view the complete terms of coverage at www.zenith-american.com or call 1-702-734-8601 to request a copy. 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.zenith-american or by calling 1-725-238-5768 to request a copy.

| Important Questions | Answers | | Why This Matters: |
|---|---|---|---|
| | In-Network | Out-of-Network | |
| **What is the overall deductible?** | **$0** | **$500** person/ $**1,500** family | See the Common Medical Events Chart below for your costs for in-network services this plan covers. You must pay for all of the costs from providers up to the deductible amount before this plan begins to pay for out-of-network services. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. All in-network services and out-of-network Preventive care, Emergency room care, Emergency medical transportation, Urgent care, and routine prenatal care 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. |
| **Are there other deductibles for specific services?** | There are no other specific deductibles. | | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | **$5,200** person/year | No maximum. | 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 services. This plan does not have an out-of-pocket limit for out-of-network services. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, prescription drug copayments, penalties for failure to obtain prior authorization, health care this plan doesn't cover, out-of-network copayments and coinsurance. | | Even though you may be required to 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 www.zenith-american.com or call 1-702-734-8601 for a list of network 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). Your network provider may use an out-of-network provider for some services, so check with the provider before you get services. |
| **Do you 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 or a referral. |

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 |
|---|---|---|---|---|
| | | In-Network PPO Provider (You pay the least) | Out-of-Network Non-PPO Provider (You pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $15 copay per visit ($0 copay for telemedicine benefit) | 40% coinsurance | ---None--- |
| | Specialist visit | $30 copay per visit | 40% coinsurance | ---None--- |
| | Other practitioner visit | $30 copay per visit | 40% coinsurance | Prior authorization may be required. Member pays full cost of services or 50% benefit reduction if prior authorization is not obtained. Chiropractic care is limited to 20 visits per year from an in-network provider, and limited to $1,000 per year and a $5,000 lifetime limit from an out-of-network provider. |
| | Preventive care/screening/ immunization | No charge | 40% coinsurance. | Ask your provider if the services you need are preventive, and check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $15 copay per test | 40% coinsurance | Prior authorization is required for imaging (not for x-ray). |
| | Imaging (CT/PET scans, MRIs) | $750 copay per PET Scan<br>$30 copay per MRI or CT Scan | 40% coinsurance | |
| **If you need drugs to treat your illness or condition** For more information about **prescription drug coverage**, please contact Sav-Rx at 1-866-912-7425 | Preferred generic drugs (Tier 1) | $7 copay per fill (retail);<br>$14 copay per fill (mail order) | Not Covered | You have a 3-Tier pharmacy plan. Covers up to a 30-day retail supply or up to a 90-day mail order supply. Prior authorization is required for certain medications. Member pays for cost of services if prior authorization or step therapy is not obtained for certain medications. Mandatory generic applies when a generic is available. |
| | Preferred brand drugs (Tier 2) | $30 copay per fill (retail);<br>$60 copay per fill (mail order) | Not Covered | |
| | Non-preferred generic or brand drugs (Tier 3) | $50 copay per fill (retail); Mail Order Not Covered | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $50 copay per admission | 40% coinsurance | Prior authorization is required. Member pays for cost of services or 50% benefit reduction if prior authorization is not obtained. |
| | Physician/surgeon fees | $50 copay per surgery<br>$150 copay per surgery for anesthesia | 40% coinsurance per surgery<br>40% coinsurance per surgery per anesthesia | |
| **If you need immediate medical attention** | Emergency room care | $75 copay per visit. Deductible does not apply. | $75 copay per visit. Deductible does not apply. | Copay waived for in-patient admissions. You may be balance billed from Non-PPO Plan Providers. |
| | Emergency medical transportation | $50 copay per trip (ground services only)<br>Deductible does not apply. | $50 copay per trip (ground services only)<br>Deductible does not apply. | 50% coinsurance per trip for air services only (in-network only) |
| | Urgent care | $20 copay per visit | $40 copay per visit.<br>Deductible does not apply. | --None-- |
| | Facility fee (e.g., hospital room) | $400 copay per admission | 40% coinsurance | |

| | | | | |
|---|---|---|---|---|
| **If you have a hospital stay** | Physician/surgeon fees | $100 copay per surgery | 40% coinsurance | Prior authorization is required. Member pays for cost of services or 50% benefit reduction if prior authorization is not obtained. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services ***(includes Attention Deficit Disorder (ADD) & Attention Deficit Hyperactivity Order (ADHD) Therapies)*** | $15 copay per group therapy visit;<br>$30 copay per individual, family and partial care therapy visit<br>$0 copay for telemedicine benefit | 40% coinsurance | Prior authorization is required. Member pays for cost of services or 50% benefit reduction if prior authorization is not obtained. Partial care therapy must be for a minimum of 4 hours per session. |
| | Inpatient services | $400 copay per admission | 40% coinsurance | |
| **If you are pregnant** | Office visits | $15 copay per visit | 40% coinsurance. Deductible does not apply for routine prenatal care. | Cost sharing does not apply to certain preventive services, including routine prenatal care. Depending on the type of services, copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery services (c-section) | $400 copay per admission;<br>$150 copay for anesthesia;<br>$100 copay per surgery | 40% coinsurance | ---None--- |
| | Childbirth/delivery services (natural birth) | $400 copay per admission;<br>$150 copay for anesthesia | 40% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | $0 copay per visit | 40% coinsurance | Prior authorization is required. Member pays for cost of services or 50% benefit reduction if prior authorization is not obtained. Out-of-network coverage is limited to 30 visits/calendar year. |
| | Rehabilitation services | $15 copay per visit for outpatient services.<br>$400 per admission for inpatient services. | 40% coinsurance | Prior authorization is required for inpatient services. Member pays for cost of services or 50% benefit reduction if prior authorization is not obtained. Rehabilitation Coverage is limited to a combined in-network and out-of-network benefit of 60 visits per calendar year. |
| | Habilitation services | Not Covered | Not Covered | |
| | Skilled nursing care | $400 copay per admission | 40% coinsurance | Prior authorization is required. Member pays for cost of services or 50% benefit reduction if prior authorization is not obtained. Coverage is limited to 100 days per calendar year. |
| | Durable medical equipment ("DME") | $100 copay per device or 50% coinsurance of purchase or rental price (whichever is lower) | 40% coinsurance | Prior authorization required. Member pays cost of services or 50% benefit reduction if prior authorization is not obtained. Coverage has an out-of-network lifetime limit of $4,000. |

| | | | | |
|---|---|---|---|---|
| | Hospice services | $400 copay per admission. No charge for outpatient services. | Not Covered | Prior authorization required. Member pays cost of services or 50% benefit reduction if prior authorization is not obtained. Hospice not covered out-of-network. |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | Your Plan may include certain vision and/or dental services. Please refer to you Plan documents for more information. |
| | Children's glasses | Not covered | Not covered | |
| | Children's dental check-up | Not covered | Not covered | |

**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.)**

- Acupuncture
- Children's dental check-up
- Children's eye exam
- Children's glasses
- Cosmetic surgery
- Dental care (adult)
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Limited infertility treatment
- Private-duty nursing

**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: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform (Department of Labor's Employee Benefits Security Administration); 1-877-267-2323 x61565 or www.cciio.cms.gov (Department of Health and Human Services Center for Consumer Information and Insurance Oversight). 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: 1-702-734-8601 or www.zenith-american.com (Zenith); 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform (Department of Labor's Employee Benefits Security Administration).

**Does this plan provide Minimum Essential Coverage?** **Yes**.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.
**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 [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].]

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*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 | $0 |
| Specialist copayment | $30 |
| Hospital (facility) copayment | $400 |
| Other coinsurance | 0% |

**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** | **$13,036** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $983 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1043** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $30 |
| Hospital (facility) copayment | $400 |
| Other coinsurance | 0% |

**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** | **$7,495** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $0 |
| Copayments | $1,027 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$1,082** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $30 |
| Hospital (facility) copayment | $400 |
| Other coinsurance | 0% |

**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** | **$2,051** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $0 |
| Copayments | $515 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$515** |

The **plan** would be responsible for the other costs of these EXAMPLE covered services.