



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, contact Zenith at 1-800-251-5014. 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> or call 1-800-251-5014 to request a copy.

| Important Questions | Answers | Why This Matters: |
|--|--|--|
| What is the overall deductible? | \$350/Individual, \$1,050/Family | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your deductible? | Yes. Most <u>preventive care</u> , the hearing aid benefit, substance abuse services, dental and vision services, and outpatient <u>prescription drugs</u> are covered before you meet your <u>deductible</u> . | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. |
| Are there other deductibles for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the out-of-pocket limit for this plan? | There is no <u>out-of-pocket limit</u> on all types of <u>cost sharing</u> , but there is a \$5,000/Individual and \$10,000/Family limit on the amount of <u>coinsurance</u> that you must pay for covered services in a year. | This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses. |
| What is not included in the out-of-pocket limit? | Not Applicable. | This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses. |
| Will you pay less if you use a network provider? | Yes, See www.anthem.com or call the Trust Fund Office at (800) 251-5014 for a list of Participating <u>providers</u> in Utah. See www.bluecares.com or call (800) 810-2583 for a list of Participating <u>providers</u> outside Utah. Call Assistance Recovery Program (ARP) at (800) 562-3277 for Participating substance abuse <u>providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a referral to see a specialist? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |



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 |
|--|--|--|--|--|
| | | Participating Provider (You will pay the least) | Non-Participating 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% <u>coinsurance</u> | 40% <u>coinsurance</u> | None. |
| | <u>Specialist</u> visit | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None. |
| | <u>Preventive care/screening/immunization</u> | Routine exam for employee/spouse, flu shot, diagnostic x-rays, well-child office visits, child immunizations, routine mammogram, pap smear, bone density scan: no charge, <u>deductible</u> does not apply. Routine colonoscopy, sigmoidoscopy: no charge after <u>deductible</u> . All other services: 20% <u>coinsurance</u> after <u>deductible</u> . | Routine exam for employee/spouse, flu shot, diagnostic x-rays: no charge, <u>deductible</u> does not apply. Routine colonoscopy, sigmoidoscopy: no charge after <u>deductible</u> . Well-child office visits, child immunization, routine mammogram, pap smear, bone density scan: 40% <u>coinsurance</u> , <u>deductible</u> does not apply. All other services: 40% <u>coinsurance</u> after <u>deductible</u> . | You pay any amount over \$25 for a flu shot with any <u>provider</u> . |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | Professional/physician charges may be billed separately |
| | Imaging (CT/PET scans, MRIs) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com | Generic drugs | Retail: \$10 <u>copayment</u> per script Mail order: \$5 <u>copayment</u> per script | You pay 100% up front and submit a <u>claim</u> for reimbursement. The <u>Plan</u> will reimburse the <u>allowed amount</u> , less the applicable <u>copayment</u> and a \$0.90 dispensing fee. | <ul style="list-style-type: none"> • <u>Deductible</u> does not apply. • Retail: 34-day supply, Mail order: 90-day supply. • Some drugs required <u>preauthorization</u> by OptumRx. • You must contact OptumRx to order injectable medications (other than <u>specialty drugs</u>). • Your <u>cost sharing</u> for <u>prescription drugs</u> does not count toward the <u>plan's coinsurance</u> maximum. |
| | Preferred brand drugs | Retail: the greater of \$25 <u>copayment</u> per script or 30% <u>coinsurance</u> , not to exceed \$60 <u>copayment</u> per script. Mail order: the greater of \$20 <u>copayment</u> per script or 30% of the cost of the drug, not to exceed \$50 <u>copayment</u> per script. | | |
| | Non-preferred brand drugs | Retail: the greater of \$25 <u>copayment</u> per script or 30% of the cost of the drug. Mail order: the greater of \$20 <u>copayment</u> per script or 30% of the cost of the drug | | |
| | <u>Specialty drugs</u> | Same <u>copayments</u> as Retail for Generic and Brand name drugs | Not covered. | Call OptumRx at (855) 672-3644 or (866) 218-5445 for Specialty pharmacy services. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None. |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None. |
| If you need immediate medical attention | <u>Emergency room care</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | <ul style="list-style-type: none"> • Professional/physician charges may be billed separately • 20% <u>coinsurance</u> for covered air ambulance services with a Participating or Non-Participating <u>provider</u>. • You will not be <u>Balance Billed</u> for covered emergency air ambulance services. |
| | <u>Emergency medical transportation</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | |
| | <u>Urgent care</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|--|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | Pre-notification to Anthem is required. Private room covered up to cost of semi-private room. |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office visits and other outpatient services: 20% <u>coinsurance</u> | Office visits and other outpatient services: 40% <u>coinsurance</u> | <ul style="list-style-type: none"> • Substance abuse benefits are available only for the employee and the spouse. • <u>Deductible</u> does not apply to substance abuse services. |
| | Inpatient services | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | <ul style="list-style-type: none"> • <u>Deductible</u> does not apply to substance abuse services. • Pre-notification to ARP is required for substance abuse. • Substance abuse benefits are available only for the employee and the spouse. • Private room covered up to cost of semi-private room. • Pre-notification to Anthem is required for mental health or behavioral health. |
| If you are pregnant | Office visits | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | <ul style="list-style-type: none"> • Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). • Not covered for dependent children. |
| | Childbirth/delivery professional services | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | <ul style="list-style-type: none"> • Pre-notification to Anthem is required only if hospital stay is longer than 48 hours for vaginal delivery or 96 hours for C-section. |
| | Childbirth/delivery facility services | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | <ul style="list-style-type: none"> • Private room covered up to cost of semi-private room. • Not covered for dependent children. |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | Pre-notification to Anthem is required. |
| | <u>Rehabilitation services</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | Inpatient rehabilitation requires pre-notification to Anthem. |
| | <u>Habilitation services</u> | Not covered | Not covered | You must pay 100% of this service, even <u>in-network</u> . |
| | <u>Skilled nursing care</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | Pre-notification to Anthem is required. Semi-private room covered. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|----------------------------------|---|--|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | Pre-notification to Anthem is encouraged for high cost items. |
| | <u>Hospice services</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | Covered if terminally ill. Semi-private room covered. |
| If your child needs dental or eye care | Children's eye exam | \$10 <u>copayment</u> | You are reimbursed up to \$45 for an exam. | Medical <u>plan deductible</u> does not apply. Limit one exam per calendar year, one pair of lenses per calendar year, and one frame every two calendar years. |
| | Children's glasses | No charge for lenses and up to \$140 for frames then 20% off any remaining balance. | You are reimbursed up to \$100 for frames and \$30 for single vision lens. | |
| | Children's dental check-up | 20% <u>coinsurance</u> , medical <u>plan deductible</u> does not apply. | 20% <u>coinsurance</u> , medical <u>plan deductible</u> does not apply. | Dental coverage is available under a separate dental <u>plan</u> . Your <u>coinsurance</u> for dental services does not count toward the medical <u>plan's coinsurance</u> maximum. |

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 .) | | |
|--|--|---|
| <ul style="list-style-type: none"> Acupuncture Bariatric Surgery Cosmetic surgery | <ul style="list-style-type: none"> <u>Habilitation services</u> Infertility treatment Private-duty nursing | <ul style="list-style-type: none"> Routine foot care (except for trimming of nails for diabetics) Weight loss programs |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
| <ul style="list-style-type: none"> Chiropractic care (limited to 40 visits per year) Dental care (Adult) (available through a separate EMI Health dental <u>plan</u> up to \$1,500 per person per calendar year) | <ul style="list-style-type: none"> Hearing aids (limited to 1 hearing aid per ear, up to \$2,025 per ear, every 4 years) Long-term care (at a long-term acute care facility when patient is receiving rehabilitation therapy immediately after or instead of an acute inpatient <u>hospitalization</u> if preauthorized as <u>medically necessary</u>) | <ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. Routine eye care (Adult) (unless you elect to opt-out of vision coverage) |

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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 on how 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 Zenith at (800) 251-5014. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 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 (800) 251-5014.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 251-5014.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (800) 251-5014.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 251-5014.

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

GRANDFATHERED HEALTH PLAN UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (THE AFFORDABLE CARE ACT)

This group health plan believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Trust Fund Office at 510-433-4422.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or <http://www.dol.gov/ebsa/healthreform/>. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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 <u>deductible</u> | \$350 |
| ■ <u>Specialist coinsurance</u> | 20% |
| ■ Hospital (facility) <u>coinsurance</u> | 20% |
| ■ Other <u>coinsurance</u> | 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 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$350 |
| <u>Copayments</u> | \$50 |
| <u>Coinsurance</u> | \$2,440 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,900 |

Managing Joe's Type 2 Diabetes

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

| | |
|--|-------|
| ■ The plan's overall <u>deductible</u> | \$350 |
| ■ <u>Specialist coinsurance</u> | 20% |
| ■ Hospital (facility) <u>coinsurance</u> | 20% |
| ■ Other <u>coinsurance</u> | 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 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$350 |
| <u>Copayments</u> | \$130 |
| <u>Coinsurance</u> | \$1,100 |
| What isn't covered | |
| Limits or exclusions | \$180 |
| The total Joe would pay is | \$1,760 |

Mia's Simple Fracture

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

| | |
|--|-------|
| ■ The plan's overall <u>deductible</u> | \$350 |
| ■ <u>Specialist coinsurance</u> | 20% |
| ■ Hospital (facility) <u>coinsurance</u> | 20% |
| ■ Other <u>coinsurance</u> | 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 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|--------------|
| <u>Deductibles</u> | \$350 |
| <u>Copayments</u> | \$10 |
| <u>Coinsurance</u> | \$490 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$850 |