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, call 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 www.dol.gov/ebsa/healthreform.com or call 1-800-251-5014 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$**200/Individual	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, 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. Routine physical exams, preventive care from contract providers, hearing aids, and outpatient prescription drugs 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?	Medical plan contract providers: $5,000/individual, $11,000/family. Medical plan non-contract providers: $10,000/individual. Prescription drugs (in-network): $1,600/individual, $2,200/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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Medical Out-of-Pocket Limit does not include premiums, balance-billing charges, dental & vision plan expenses, prescription drugs, penalties for failure to obtain preauthorization, amounts over the reference-based price for certain surgeries, amounts for certain treatment at Non-Center of Medical Excellence facility, health care this plan doesn't cover and Non-Contract provider copayments and coinsurance.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
	Prescription Drug Out-of-Pocket Limit does not include Medical expenses, premiums, balance-billing charges, dental and vision plan expenses, penalties for failure to obtain preauthorization, amounts over the max for PPI drugs, any difference in price between generic and brand name drugs, health care this plan doesn't cover, and Non-Participating Pharmacy expenses.	
Will you pay less if you use a network provider?	Yes, for contract providers in California, see www.anthem.com/ca or call 1-800-810-2583. For a list of Blue Card providers outside the state of California, see www.bluecares.com or call 1-800-810-2583. For alcoholism or chemical dependency providers, call the Assistance Recovery Program (ARP) at (800) 562-3277. For hearing aids, call (888) 432-7464 or (800) 442-8231.	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 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
		Contract Provider (You will pay the least)	Non-Contract 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	25% coinsurance	25% coinsurance plus balance billing	None.
	Specialist visit	25% coinsurance	25% coinsurance plus balance billing	None.
	Preventive care/screening/ Immunization	No charge.	Routine physical exam (employee and spouse only): No charge except balance billing. Mammogram, Pap smear, colorectal cancer screening, immunizations: 25% coinsurance plus balance billing. All other preventive services: Not covered.	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	Free-standing laboratory: No charge. All other: 25% coinsurance	25% coinsurance plus balance billing	None.
	Imaging (CT/PET scans, MRIs)	25% coinsurance	25% coinsurance plus balance billing	Preauthorization by American Imaging Management is required for Cat Scan, MRI, Nuclear Cardiology, PET scan and echocardiography if you are not Medicare eligible.
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 copayment/script. Mail order: No charge	You pay 100% of the cost of the drug at purchase and must send a claim to OptumRx. Your reimbursement will be limited to the contracted amount a participating pharmacy would have charged less the copayments shown for generic and brand name drugs.	• Retail pharmacy 34-day supply; Mail order pharmacy 100-day supply. • For PPI drugs (primarily used for acid reflux), you are responsible for the difference between the cost of the drug and the benefit maximum of $30 for retail or $90 for mail order. Any excluded amounts do not count toward the out-of-pocket limit. • Compound Drugs are subject to the brand name drug $35 copay (those that cost more than $150 will be subject to review). • If the cost of the drug is less than the copay, you pay drug cost. • Some drugs are subject to step therapy, quantity limits and preauthorization. For example, compounded drugs that cost more than $150 are subject to preauthorization. • No charge for ACA-required generic preventive care drugs (such as contraceptives) or brand name drugs if a generic is medically inappropriate. • The difference in price between generic and brand name drugs does not count toward the prescription drug Out-of-Pocket limit.
	Preferred brand drugs	Retail: $15 copayment/script. Mail order: $10 copayment/script		
	Non-preferred brand drugs	Retail (including all compound drugs): $35 copayment/script plus difference in price between generic and brand drug (unless provider specifies "no generic substitution"). Mail order: $40 copayment/script		
	Specialty drugs	Generic: 20% coinsurance up to a $50 max copayment/script, Brand Preferred: 20% coinsurance up to a $100 max	Not covered.	Call OptumRx at (855) 672-3644 for information on Specialty drugs.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
		copayment/script, Non-Preferred: 20% coinsurance up to a $200 max copayment/script		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	25% coinsurance plus any amount over the per surgery maximum of $500 (maximum does not apply if you are eligible for Medicare)	• If you are not Medicare eligible, preauthorization by Anthem is required. • If you are not Medicare eligible, a max of $6,000 is payable for arthroscopy, $2,000 for cataract surgery and $1,500 for colonoscopy for the hospital facility charge. • If you are not Medicare eligible, a max of $34,000 is payable for a routine hip or knee replacement surgery for the hospital facility charge. • Charges over these limits do not count toward the out-of-pocket limit. • Semi-private room, intensive care unit or cardiac care unit covered.
	Physician/surgeon fees	25% coinsurance	25% coinsurance plus balance billing	None.
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	• Professional/physician charges may be billed separately. • Balance billing will not apply to covered air ambulance services.
	Emergency medical transportation	25% coinsurance	25% coinsurance plus balance billing	
	Urgent care	25% coinsurance	25% coinsurance plus balance billing	
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	25% coinsurance plus balance billing	• If you are not Medicare eligible, preauthorization by Anthem is required. • If you are not Medicare eligible, a max of $34,000 is payable for a routine hip or knee replacement surgery for the hospital facility charge. Charges over these limits do not count toward the out-of-pocket limit. • No benefits for any organ and tissue transplants or bariatric surgery performed at a hospital or facility

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
				that is not an Anthem Blue Cross Center of Medical Excellence (CME) or a Blue Distinction Center.
	Physician/surgeon fees	25% coinsurance	25% coinsurance plus balance billing	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits and other outpatient services: 25% coinsurance.	Office visit: 25% coinsurance plus balance billing	Chemical dependency services are not covered for dependent children.
	Inpatient services	25% coinsurance	25% coinsurance plus balance billing	• Mental Health: If you are not Medicare eligible, preauthorization by Anthem is required. • Chemical Dependency: If you are not Medicare eligible, preauthorization by ARP is required. • Chemical dependency services are not covered for dependent children.
If you are pregnant	Office visits	No charge.	25% coinsurance plus balance billing	• Cost sharing does not apply for preventive services. • Depending on the type of services, coinsurance may apply. • Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	25% coinsurance	25% coinsurance plus balance billing	Preauthorization by 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	25% coinsurance	25% coinsurance plus balance billing	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	25% coinsurance plus balance billing	None.
	Rehabilitation services	25% coinsurance	25% coinsurance plus balance billing	Outpatient physical and occupational therapy maximum of 40 visits/calendar year (combined with chiropractic care).
	Habilitation services	Not covered	Not covered	You must pay 100% of this service, even in-network.
	Skilled nursing care	25% coinsurance	25% coinsurance plus balance billing	Maximum of 100 days/calendar year. For Retirees not eligible for Medicare, preauthorization by Anthem is required. For Medicare Retirees, the Fund will use Medicare's determination of medical necessity.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
	Durable medical equipment	25% coinsurance	25% coinsurance plus balance billing	Preauthorization is recommended for equipment costing over $500.
	Hospice services	25% coinsurance	25% coinsurance plus balance billing	Covered if terminally ill.
If your child needs dental or eye care	Children's eye exam	$7.50 copayment/exam	$7.50 copayment/exam plus any amount over $45	Vision coverage is available under a separate vision plan. Your cost sharing does not count toward the medical plan's out-of-pocket limit.
	Children's glasses	No charge	Any amount over $34	
	Children's dental check-up	No charge	No charge except balance billing.	Dental coverage is available under the low option or high option separate dental plan. Your cost sharing does not count toward the medical plan's out-of-pocket limit.

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
- Habilitation services
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs (except as required by the health reform law)

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

- Acupuncture (up to 16 visits/treatment series)
- Bariatric Surgery (if preauthorized as medically necessary)
- Chiropractic care (up to 40 visits per year combined with physical/occupational therapy)
- Dental care (Adult) (available only through a separate dental plan)
- Hearing aids (100% up to $1,350/ear every 4 years)
- Infertility treatment (only services to diagnose are covered)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (available only through a separate vision plan)

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, kwiijigo holne' (800) 251-5014.

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**	**$200**
■ **Specialist coinsurance**	**25%**
■ **Hospital (facility) coinsurance**	**25%**
■ **Other coinsurance**	**25%**

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	
Deductibles	$200
Copayments	$10
Coinsurance	$2,730
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$2,960**

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

■ **The plan's overall deductible**	**$200**
■ **Specialist coinsurance**	**25%**
■ **Hospital (facility) coinsurance**	**25%**
■ **Other coinsurance**	**25%**

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	
Deductibles	$200
Copayments	$610
Coinsurance	$240
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,050**

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

The plan's overall deductible	**$200**
■ **Specialist coinsurance**	**25%**
■ **Hospital (facility) coinsurance**	**25%**
■ **Other coinsurance**	**25%**

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	
Deductibles	$200
Copayments	$10
Coinsurance	$650
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$860**

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