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 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. Most preventive care, the hearing aid benefit, substance abuse services, dental and vision services, 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.
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?	There is no out-of-pocket limit on all types of cost sharing, but there is a $5,000/Individual and $10,000/Family limit on the amount of coinsurance that you must pay for covered services in a year.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable.	This plan does not have an out-of-pocket limit 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 providers in Utah. See www.bluecares.com or call (800) 810-2583 for a list of Participating providers outside Utah. Call Assistance Recovery Program (ARP) at (800) 562-3277 for Participating substance abuse 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 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
		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% coinsurance	40% coinsurance	None.
	Specialist visit	20% coinsurance	40% coinsurance	None.
	Preventive care/screening/ immunization	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, deductible does not apply. Routine colonoscopy, sigmoidoscopy: no charge after deductible. All other services: 20% coinsurance after deductible.	Routine exam for employee/spouse, flu shot, diagnostic x-rays: no charge, deductible does not apply. Routine colonoscopy, sigmoidoscopy: no charge after deductible. Well-child office visits, child immunization, routine mammogram, pap smear, bone density scan: 40% coinsurance, deductible does not apply. All other services: 40% coinsurance after deductible.	You pay any amount over $25 for a flu shot with any provider.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Professional/physician charges may be billed separately
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	

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 copayment per script Mail order: $5 copayment per script	You pay 100% up front and submit a claim for reimbursement. The Plan will reimburse the allowed amount, less the applicable copayment and a $0.90 dispensing fee.	• Deductible does not apply. • Retail: 34-day supply, Mail order: 90-day supply. • Some drugs required preauthorization by OptumRx. • You must contact OptumRx to order injectable medications (other than specialty drugs). • Your cost sharing for prescription drugs does not count toward the plan's coinsurance maximum.
	Preferred brand drugs	Retail: the greater of $25 copayment per script or 30% coinsurance, not to exceed $60 copayment per script. Mail order: the greater of $20 copayment per script or 30% of the cost of the drug, not to exceed $50 copayment per script.		
	Non-preferred brand drugs	Retail: the greater of $25 copayment per script or 30% of the cost of the drug. Mail order: the greater of $20 copayment per script or 30% of the cost of the drug		
	Specialty drugs	Same copayments 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% coinsurance	40% coinsurance	None.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	• Professional/physician charges may be billed separately • 20% coinsurance for covered air ambulance services with a Participating or Non-Participating provider.
	Emergency medical transportation	20% coinsurance	40% coinsurance	
	Urgent care	20% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Pre-notification to Anthem is required. Private room covered up to cost of semi-private room.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None.

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 mental health, behavioral health, or substance abuse services	Outpatient services	Office visits and other outpatient services: 20% coinsurance	Office visits and other outpatient services: 40% coinsurance	• Substance abuse benefits are available only for the employee and the spouse. • Deductible does not apply to substance abuse services.
	Inpatient services	20% coinsurance	40% coinsurance	• Deductible 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% coinsurance	40% coinsurance	• 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% coinsurance	40% coinsurance	• Pre-notification to Anthem is required only if hospital stay is longer than 48 hours for vaginal delivery or 96 hours for C-section. • Private room covered up to cost of semi-private room. • Not covered for dependent children.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Pre-notification to Anthem is required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Inpatient rehabilitation requires pre-notification to Anthem.
	Habilitation services	Not covered	Not covered	You must pay 100% of this service, even in-network.
	Skilled nursing care	20% coinsurance	40% coinsurance	Pre-notification to Anthem is required. Semi-private room covered.
	Durable medical equipment	20% coinsurance	40% coinsurance	Pre-notification to Anthem is encouraged for high cost items.
	Hospice services	20% coinsurance	40% coinsurance	Covered if terminally ill. 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)	
If your child needs dental or eye care	Children's eye exam	$25 copayment	You are responsible for amounts over $45 for an exam.	Medical plan deductible does not apply. You will be given an annual opportunity to opt out of vision coverage.
	Children's glasses	You are responsible for amounts over $100.	You are responsible for amounts over $100 for frames and $30 for single vision lens.	
	Children's dental check-up	20% coinsurance, medical plan deductible does not apply.	20% coinsurance, medical plan deductible does not apply.	If you elect dental coverage, it will be available under a separate dental plan. Your coinsurance for dental services does not count toward the medical plan's coinsurance 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.)

- Acupuncture
- Bariatric Surgery
- Cosmetic surgery
- Habilitation services
- Infertility treatment
- Private-duty nursing
- 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.)

- Chiropractic care (limited to 40 visits per year)
- Dental care (Adult) (available through a separate EMI Health dental plan up to $1,500 per person per calendar year)
- Hearing aids (limited to 1 hearing aid 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 hospitalization if preauthorized as medically necessary)
- 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, kwiijigo 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 deductible** **$350**
- **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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$350
Copayments	$50
Coinsurance	$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 deductible** **$350**
- **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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$350
Copayments	$130
Coinsurance	$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 deductible** **$350**
- **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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$350
Copayments	$10
Coinsurance	$490
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$850**

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