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 including your plan's Plan document/Summary plan description, visit www.zenith-american.com or call the Administrative Office (Zenith) at 1-702-734-8601. 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 or call the Administrative Office (Zenith) at 1-702-734-8601 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Providers per calendar year: $500/individual; $1,500/family. Out-of-Network Providers per calendar year: $1,500/individual; $4,500/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. Preventive care performed by network providers, hospitalist services, LiveHealth Online Doctor visit, 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?	Yes, $100 deductible/person per network hospital admission. $1,000 deductible/person for out-of-network hospital admission. $500 deductible/person for air ambulance trip. There are other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical Plan Network Provider: $5,600/individual; $11,200/family per calendar year. Out-of-Network Provider: No out-of-pocket limit. Outpatient prescription drugs per calendar year: $1,000/individual; $2,000/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?	For the Medical Plan: Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain preauthorization, dental & vision plan expenses, outpatient retail/mail order drug expenses (which have a separate out-of-pocket limit), and out-of-network cost sharing except an ER visit in case of an emergency, The outpatient prescription drug out-of-pocket limit does not include premiums, balance-billing charges, medical plan, dental plan or vision plan expenses, plus drugs and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. Medical network, see www.anthem.com or call Anthem at 702-734-8601. Mental health/substance abuse network, see www.harmonyhc.com or call Harmony Health Care at 702-251-8000 or 1-800-363-4874. Network Health Services Coalition (HSC) Hospitals in Southern Nevada call 1-702-734-8601. Vision network: see www.vsp.com or call VSP 1-800-877-7195.	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
		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	$10 copayment/visit.	50% coinsurance.	Preauthorization of certain diagnostic tests and medical procedures required to avoid a 50% reduction in plan payment. LiveHealth Online Doctor visit: $10 copayment/visit; Deductible does not apply.
	Specialist visit	$15 copayment/visit.	50% coinsurance.	
	Preventive care/screening/immunization	No charge. Deductible does not apply.	50% coinsurance.	Plan covers required preventive services and supplies described at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/. Age and frequency guidelines apply to covered preventive care. You may have to pay for services that aren't preventive care. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	**Lab services**: $5 copayment per visit. **Radiology services**: $15 copayment per visit.	50% coinsurance.	Physician/provider's professional fees may be billed separately.
	Imaging (CT/PET scans, MRIs)	$50 copayment per test.	50% coinsurance.	Preauthorization of MRI, CT and PET scans is required to avoid a 50% reduction in plan payment. Physician/provider's professional fees may be billed separately.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.elixirsolutions.com or call Elixir at 1-800-361-4542.	Generic drugs	Retail Pharmacy for 30-day supply: $5 copayment. Mail Order for 90-day supply: No charge. No charge for FDA-approved generic contraceptives.	Not covered.	• Deductible does not apply. • You pay the lesser of the copayment or the drug cost. • Some prescriptions are subject to preauthorization (to avoid non-payment), quantity limits or step therapy requirements. • Certain over-the-counter (OTC) and prescription drugs are payable at no charge with a prescription. • If you purchase a brand drug when a generic drug is available you pay the brand drug cost sharing plus the difference in cost between the brand drug and generic drug. • Your cost sharing counts toward the prescription drug out-of-pocket limit, not the medical plan out-of-pocket limit. • No charge for diabetic supplies purchased at an In-Network pharmacy. • Certain CDC recommended vaccinations are payable at 100% when obtained at an in-Network retail pharmacy.
	Preferred brand drugs	Retail Pharmacy for 30-day supply: you pay the greater of 20% coinsurance or $20 copayment per prescription. Mail Order for 90-day supply: $30 copayment per prescription. No charge for FDA-approved brand name contraceptives if a generic is medically inappropriate.		
	Non-preferred brand drugs	Retail Pharmacy for 30-day supply: you pay the greater of 45% coinsurance or $45 copayment per prescription; Mail Order for 90-day supply: $60 copayment per prescription.		
	Specialty drugs	$50 copayment per prescription for up to a 30-day supply.	Not covered.	Deductible does not apply. Specialty drugs require preauthorization (to avoid non-payment): call Elixir: 1-800-361-4542.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 copayment per visit.	Not covered.	Preauthorization of outpatient surgery is required to avoid a 50% reduction in plan payment. You pay 100% out-of-network services.
	Physician/ surgeon fees	Surgeon: $50 copayment per visit. Assistant surgeon: No charge after deductible met. Anesthesia services: $100 copayment.	Not covered.	

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	$25 copayment/visit for facility and $25 copayment/visit for ER physician.	$25 copayment/visit for facility and $25 copayment/visit for ER physician.	Physician/provider's professional fees may be billed separately. ER visit copayment waived if hospitalized within 24 hrs. For non-emergency but medically necessary services received in an emergency room the Plan pays a maximum of $75/visit.
	Emergency medical transportation	Ground: $50 copayment per trip. Air: $500 deductible per trip.	Ground: $50 copayment/trip. Air: $500 deductible/trip.	Preauthorization of non-emergency ambulance transportation is required to avoid a 50% reduction in plan payment. Balance Billing will not apply to covered air ambulance services.
	Urgent care	$15 copayment/visit.	50% coinsurance.	Physician/provider's professional fees may be billed separately.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 inpatient deductible plus 10% coinsurance up to $500/person ($1,500/family) of coinsurance per year, then no charge.	$1,000 inpatient deductible plus 50% coinsurance.	Preauthorization of elective hospital admission, transplant services, cochlear implant and certain other services is required to avoid a 50% reduction in plan payment. Private room payable only if medically necessary or the hospital only has private rooms.
	Physician/ surgeon fees	Hospitalist: No charge. Deductible does not apply. Specialist visit: $15 copayment per visit. Non-specialist visit: $10 copayment per visit. Surgeon: $50 copayment per visit. Assistant surgeon: No charge after deductible met. Anesthesia services: $100 copayment.	50% coinsurance.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Intake Assessment: $10 copayment. Individual & Family therapy visits: no charge for the first 8 visits, then you pay a $7.50 copayment/visit. Group therapy: $5.50 copayment/visit.	50% coinsurance.	Plan covers up to 8 free EAP visits through Harmony Health Care at 702-251-8000 or 1-800-363-4874.
	Inpatient services	$100 inpatient deductible plus 10% coinsurance up to $500/person ($1,500/family) of coinsurance per year, then no charge. Specialist visit: $15 copayment/ visit.	Hospital: $1,000 inpatient deductible plus 50% coinsurance. Residential treatment facility: not covered.	Preauthorization of elective hospital admission and residential treatment program admission is required to avoid a 50% reduction in plan payment. You pay 100% for out-of-network residential treatment.

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 are pregnant	Office visits	Female employee, spouse, or daughter: No charge for office visits and ACA-required preventive services. Deductible does not apply.	For employee and spouse: 50% coinsurance.	• Cost sharing does not apply for network preventive services. • Depending on the type of services, a copayment, coinsurance or deductible may apply. • Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). • Prenatal care (other than office visits, ultrasounds and ACA-required preventive screening) is not covered for dependent children.
	Childbirth delivery professional services	Physician obstetrical care: $100 copayment. Anesthesia services: $100 copayment. Hospitalist: No charge. Deductible does not apply. Specialist visit: $15 copayment per visit. Non-specialist visit: $10 copayment per visit.	For employee and spouse: 50% coinsurance.	You must pay 100%, even in-network, for delivery expenses for a dependent child. Preauthorization is required to avoid a financial penalty only if hospital stay is longer than 48 hours for vaginal delivery or 96 hours for C-section.
	Childbirth delivery facility services	$100 inpatient deductible plus 10% coinsurance up to $500/person ($1,500/family) of coinsurance per year, then no charge.	$1,000 inpatient deductible plus 50% coinsurance.	
If you need help recovering or have other special health needs	Home health care	$10 copayment/visit.	50% coinsurance.	Plan covers part-time or intermittent skilled nursing care. Preauthorization of home health and home infusion therapy services is required to avoid a 50% reduction in plan payment.
	Rehabilitation services	Outpatient visits: $15 copayment per therapy modality. Inpatient Rehab. admission: $100 inpatient deductible plus 10% coinsurance up to $500/person ($1,500/family) of coinsurance per year, then no charge.	Outpatient visits: 50% coinsurance. Inpatient Rehab. admission: Not covered.	• Outpatient physical and speech therapy maximum benefit is 40 visits/calendar year. Outpatient occupational therapy maximum benefit is 40 visits/calendar year. • Preauthorization of speech therapy and inpatient rehabilitation admission is required to avoid a 50% reduction in plan payment. • For In-Network inpatient rehab admission: maximum benefit is 60 days/calendar year combined with skilled nursing facility admission. You pay 100% for out-of-network inpatient rehabilitation admission.

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)	
	Habilitation services	Outpatient visits: $15 copayment/therapy modality.	Outpatient visits: 50% coinsurance.	Speech therapy for developmentally delayed individuals payable to a maximum of 20 visits/calendar year.
	Skilled nursing care	$100 inpatient deductible plus 10% coinsurance up to $500/person ($1,500/family) of coinsurance per year, then no charge.	Not covered.	• Preauthorization of skilled nursing facility admission is required to avoid a 50% reduction in coinsurance. • For skilled nursing facility admission: maximum benefit is 60 days/calendar year combined with inpatient rehab admission. • You pay 100% for out-of-network inpatient skilled nursing facility admission.
	Durable medical equipment	$50 copayment per device.	50% coinsurance.	Preauthorization of durable medical equipment over $500/item is required to avoid a 50% reduction in plan payment. No charge from network providers for breastfeeding pump and supplies needed to operate pump.
	Hospice services	Home hospice: $10 copayment/visit. Inpatient hospice: $100 inpatient deductible plus 10% coinsurance up to $500/person ($1,500/family) of coinsurance per year, then no charge.	Home hospice: 50% coinsurance. Inpatient hospice: $1,000 inpatient deductible plus 50% coinsurance.	Covered if terminally ill. Deductible waived if transferred directly from a hospital.
If your child needs dental or eye care	Children's eye exam	$15 copayment/visit. Medical plan deductible does not apply.	You pay 100%. Plan reimburses up to $45 per exam (minus the $15 copayment for the exam & eyeglasses). You pay any amount over $45 for exam. Medical plan deductible does not apply.	• If you elect vision coverage, it will be available under a separate vision plan. • One vision exam payable each 12 months. • One frame is payable each 24 months One pair lenses payable each 12 months. • Your cost sharing for vision services does not count toward the medical plan's out-of-pocket limit.
	Children's glasses	No charge for lenses. No charge for frames up to $200/frame. You pay frame costs over $200/frame. Medical plan deductible does not apply.	You pay 100%. Plan reimburses up to $70/frame and up to $30/single lens. You pay any amount over $70/frame and $30/single lens. Medical plan deductible does not apply.	

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)	
	Children's dental check-up	No charge. Medical plan deductible does not apply to these dental services.	20% coinsurance. Medical plan deductible does not apply to these dental services.	If you elect dental coverage, it will be available under a separate dental plan. Your cost sharing for dental services 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.)

- Bariatric Surgery
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs, except as required by 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 to15 visits/calendar year.)
- Chiropractic care (up to 15 visits/calendar year).
- Dental care (Adult) (if you elect dental coverage, payable up to $2,000/calendar year)
- Hearing aids (up to $600/ear every 5 years for adults and once every 3 years for a child)
- Routine eye care (Adult) (if you elect vision coverage).
- Routine foot care (covered when treating diabetic, neurological or vascular insufficiency affecting the feet.)

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 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 Administrative Office (Zenith) at 1-702-734-8601 or 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.** 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 1-702-734-8601. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-702-734-8601. Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-702-734-8601. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-702-734-8601.

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 (delivery)	$100
Hospital (facility) coinsurance	10%
Hospital deductible	$100

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	$600
Copayments	$450
Coinsurance	$500
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$1,570**

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	$15
Hospital (facility) coinsurance	10%
Hospital deductible	$100

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	$500
Copayments	$320
Coinsurance	$620
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,440**

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

The plan's overall deductible	$500
Specialist copayment	$15
Hospital (facility) ER copayment	$25
ER physician copayment	$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	$500
Copayments	$330
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$830**

The **plan** would be responsible for the other costs of these EXAMPLE covered services. 5708893v1/13405.010/ngf