



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, please call 1-800-662-5851. 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 1-800-662-5851 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For participating providers: \$1,500 single / \$3,000 family for calendar year For non-participating providers: \$3,000 single / \$6,000 family for calendar year	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is 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?	For participating providers: \$3,550 single / \$7,100 family For non-participating providers: \$8,000 single / \$16,000 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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain preauthorization for services	Even though you 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.emihealth.com or call 1-800-662-5851 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). 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% <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>	No charge; <u>deductible</u> does not apply	Not covered	Coverage is limited to one visit per Year for some services. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u> / office visit	40% <u>coinsurance</u>	—————none—————
		20% <u>coinsurance</u> / outpatient visit		
		20% <u>coinsurance</u> / inpatient services		
	<u>Imaging</u> (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.emihealth.com .	Generic drugs	\$10 <u>copay</u> / prescription Retail \$20 <u>copay</u> / prescription Mail Order	Not covered	Up to a 30-day supply (retail prescription) per <u>copay</u> ; 31-90 day supply (mail order prescription) per <u>copay</u>
	Preferred brand drugs	\$35 <u>copay</u> / prescription Retail \$70 <u>copay</u> / prescription Mail Order	Not covered	Up to a 30-day supply (retail prescription) per <u>copay</u> ; 31-90 day supply (mail order prescription) per <u>copay</u>
	Non-preferred brand drugs	50% <u>coinsurance</u> Retail 50% <u>coinsurance</u> Mail Order	Not covered	Up to a 30-day supply (retail prescription) per <u>copay</u> ; 31-90 day supply (mail order prescription) per <u>copay</u>
	<u>Specialty drugs</u>	25% <u>coinsurance</u> (\$250 maximum <u>copay</u> / prescription)	Not covered	Covers 31-90 day supply (mail order prescription) per <u>copay</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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Some procedures require <u>preauthorization</u>
	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>	—————none—————
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	—————none—————
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Requires <u>preauthorization</u>
	Physician/surgeon fee	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u> office visit and other outpatient services	40% <u>coinsurance</u>	Medications for substance abuse not covered
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Requires <u>preauthorization</u>
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Cost sharing does not apply to certain <u>preventive</u> services. Depending on the type of services, a <u>copayment</u> or <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Coverage limited to 20 outpatient visits and 40 inpatient days per Year.
	<u>Habilitation services</u>	Not covered	Not covered	—————N/A—————
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Coverage limited to 30 days per Year. Admission must be within 5 days of a discharge from Hospital Confinement.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Requires <u>preauthorization</u>
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating <u>Provider</u> (You will pay the least)	Non-Participating <u>Provider</u> (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Routine: No charge; <u>deductible</u> does not apply	Routine: Not covered	Limited to one <u>preventive</u> visit per Year.
		Non-routine: 20% <u>coinsurance</u>	Non-routine: 40% <u>coinsurance</u>	_____none_____
	Children's glasses	Not covered	Not covered	_____N/A_____
	Children's dental check-up	Not covered	Not covered	_____N/A_____

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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|--|---|---|
| <ul style="list-style-type: none">• Acupuncture• Bariatric surgery• Cosmetic surgery• Dental care (Adult) | <ul style="list-style-type: none">• Habilitation services• Hearing aids• Infertility treatment• Long-term care | <ul style="list-style-type: none">• Private-duty nursing• Routine foot care• Weight loss programs |
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Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

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|---|--|--|
| <ul style="list-style-type: none">• Chiropractic care | <ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none">• Routine eye care (Adult) |
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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 plan at 1-800-662-5851, your state insurance department, the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov, or for plans subject to ERISA: the Department of Labor's Employee Benefits 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: EMI Health at 852 E. Arrowhead Lane, Murray Utah 84107, by phone at 801-662-5851 or toll free at 1-800-662-5851. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-44-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, if the dispute is regarding a determination of medical necessity, appropriateness, healthcare setting, level of care, or effectiveness of the healthcare service or treatment, you have the voluntary option to submit the adverse benefit determination for an independent review. You may obtain additional information about an independent review from the Utah Insurance Commissioner by mail at Suite 3110 State Office Building, Salt Lake City, Utah 84114, by phone at 801-538-3077, or electronically at healthappeals.uid@utah.gov.

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.

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

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 <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist</u> coinsurance	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*)

Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist</u> coinsurance	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*)

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist</u> coinsurance	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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,660

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$1,000
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$100
The total Joe would pay is	\$3,000

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,590

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